Some Practical Tips on Being a Senior Pediatric Resident at McMaster

This document is meant to provide practical information to help Junior pediatric residents' transition to the Senior pediatric resident role. Challenges special to the SPR role include supervising junior residents and clinical clerks and delegating duties appropriately. As a manager and collaborating with ER and PICU staff, the SPR facilitates getting patients where they need to go. Being a medical expert is an important role as an SPR, but specific patient management is not the focus of this discussion. Experience will afford you your own style as an SPR, but there are some guidelines that every SPR should abide by, for patient safety. No rules apply for every scenario, but some general trends arise that are described here.

Consults to ER

What information do I need to get from the referring emergency physician?

Get the patient's name and location (locating your patient is often more difficult than you would imagine) as well as the name of the ER physician. Ask for vitals, general appearance, investigation and treatment done by the ER physician (e.g. back to back to back ventolins). You can also ask the emergency physician: "What are you most concerned about?" If the patient is unstable and you cannot go to the ER immediately, you can ask ER physician if they can watch the patient for 20 minutes and/or order some labs.

Should this consult really go to Peds? What if a consult seems inappropriate?

You should not refuse any consult, no matter how simplistic it seems. If you think a consult is inappropriate or can be seen on an outpatient basis, run the referral by your staff person. Some consults however require urgent management by another service (e.g. testis torsion) and needs to be redirected appropriately.

Note that we admit some complex patients under a different service (e.g. surgery) for whom pediatrics will be the primary care service (e.g. the "quarterback"). G tubes go to surgery; G-J tubes go to general pediatrics (interventional radiology is required).

If you are asked to see a patient without an official consult, please ask for an official consult. Every patient we see is on a consultation basis.

If you are ever unsure about any aspect of a consult (referral, assessment, management) then please ask your staff.

The SPR should redirect all outside calls (parent or physician), to the staff.

How do I deal with ER consults?

You must at least "eyeball" every patient. (Try and take a learner down when assessing the patient). This entails assessing general appearance, vitals and treatment to date. If there is any uncertainty regarding the patient's stability, take whatever action is necessary immediately (call

your staff if not 100% sure of your management, and if the patient seems like they may crash, page PICU 1000). If the patient is clearly stable, write bridging orders (preferably with the learner present), delegate the consult to a clerk or resident and advise him or her of how long it should take (e.g. 1 hour is reasonable for most consults).

You may advise your learner on how to approach the history/ physical and what to look for on their assessment. It is helpful to ask a clerk or junior something like, "Have you seen many kids with bronchiolitis?" to get an idea of how much direction they need before sending them into action. It also helps learners know that you are in touch with their learning needs. Triage patients appropriately, it is not a good learning experience to have the clinic clerk see the complex chronic patient.

Here is one of our Senior resident's take on ER consults:

> "Take the info from the consult, check the vitals and see the child for yourself. ALWAYS check vitals and then recheck HR and RR yourself. If the child is in any distress - you must stabilize them yourself (i.e. get the insulin, fluids and labs ordered in DKA, check neuro status and- if you're happy- get someone to do the whole consult while you keep an eye on them intermittently). If the child is not clearly well (nor acutely sick), ask some pointed questions to determine the acuity of the situation.
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> Then decide who is most appropriate to see the consult (i.e. Peds Jr for more acute stuff and clerk for consults that can take an hour and it doesn't matter). Do all the consults you get. It's not our role to filter them (unless it's a life threatening mistake i.e. bowel perforation and surgery hasn't been called, then consider calling surgery yourself and offer to do the consult anyway). If there are recurrent inappropriate consults from the same person, mention it to staff - it's their role to discuss staff-staff. It is our role to keep the patients safe. We shouldn't get mixed up in consult politics.
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> If a patient is crashing (or might), call peds 1000 without delay. If they are stable, but have a bad story that makes you worry they might crash, call your senior/staff or peds 1000. This is not the time to prove yourself or be a hero. What is best for the patient always comes first. While you wait for help, stay calm and remember your A, B, C's, fluid boluses are good (unless they're obviously cardiac or fluid overloaded), think about STAT labs (CBC, cx, lytes, urea, Cr, glu, gas, lactate +/- more) and whether they need STAT meds (lorazepam, antibiotics, steroid, ventolin, epi). Remember that help is on the way and you are not alone.
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> Consider asking nursing to call peds 1000 while you stabilize. Delegate tasks to others, so you can concentrate on decision making.

When do I call a code (5555)?

If a patient is crashing (i.e. desaturating, apneic, symptomatic tachy/bradycardia, etc.) call a code (i.e. shout "call a code blue" or pick up the phone and dial 5555).

When do I consider paging PICU (1000)?

If you think a patient needs to go to the ICU, Call PACE after discussion with the staff.

An unofficial, non evidence based, SPR opinion of when a patient needs ICU:
- FiO2 greater than 40%
- two doses of lorazepam and still possible seizing
- more than 2 boluses of 20cc/kg crystalloid with no obvious improvement

Remember the other people in house: PICU resident (+/- fellow, staff), PACE, ER physician, anesthesia…

When I'm in the ER seeing patients, when do I call the staff?

- The on-call attending is expected to review all the patients seen from 1700-2300 hrs. in person, after each consult not clustered. You must contact the attending after each consult.
- All consults after 2300 hrs will be discussed in person in clusters of no more than three. The residents should call the attending after a cohort of three consults; the attending shall review the consults over the phone or in person.
- The attending will determine the detail of review depending on the level of training of the SPR.
- The SPR will be reminded that if at any time they have concerns they should not hesitate to call the on-call pediatrician.

What if the patient does not need to be admitted but needs outpatient follow up?

You can refer the patient to the PERC clinic or senior resident clinic as follow up. Alternatively, the pediatrician you are working with at that moment may arrange to see the patient either in their outpatient office or in the hospital if they're on service.

What do I do in a trauma fan out (what is a trauma fan out)?

A "trauma fan out" is called by the ER physician in the case of trauma of sufficient severity to require the trauma team. The PICU resident, the trauma team leader (a staff, not necessarily PICU staff), the general surgery resident, and the anesthesia resident get paged. The SPR does not get paged for a trauma. Usually the role of trauma team leader (TTL) is assigned to the ER physician/ surgeon/ PCCU physician. The ER physician always assumes the role of TTL until the assigned TTL arrives on scene.

Teaching, Providing Feedback, and Debriefing Encounters with Juniors and Clerks

How should I provide positive feedback to clerks and juniors?

Try to give some specific positive feedback, such as, "It was great that you took a good social history because it will impact whether or not we can send this kid home," or "I liked that you included a broad differential and I agree that this kid needs antibiotics." Being a clerk or junior

resident is psychologically tough and positive feedback is not only appreciated but is arguably essential.

How should I provide negative feedback to clerks and juniors?

Criticism is always difficult to bear so it should at least be constructive. Acknowledge that many situations are new for clerks and residents and it's OK not to know everything. Try to fill in the gaps in the history, physical and encourage any attempts to formulate a differential and plan. Try to be specific in your criticism and provide some suggestions on how to improve. For example… 'you take a long time to complete a consult. Before seeing the patient, spend 1-2 minutes considering what details would be pertinent on history/physical as this will save you time when assessing your patient'.

How do I approach teaching clerks/juniors/FM/BCT?

A useful teaching session can take place in 5 minutes and you don't need to be an expert to execute one. It can be helpful to ask a clerk or junior a question like, "Do you know the risk factors for sepsis in a neonate?" especially when it relates to a case in front of you. If they already knew the answer, it helps their morale, and if they didn't, it's a digestible learning point. It's also good for the senior to review, and you often learn something new, or identify gaps in your knowledge when the junior turns the tables on you…

How should I debrief encounters with clerks and juniors?

After finishing a case, it is useful for learners when the senior asks, "Did you have any questions about that case?" If the learner asks a question you don't know the answer to (that's OK) you might say something like, "I don't know, I'll have to look that up or ask the staff," not a bad way demonstrate to clerks and juniors how you (as the senior) use cases to learn.

For emotionally draining cases (eg: non-accidental injuries), acknowledge the toll it might have on care providers. This will provide a safe forum.

Handover

What do I need to do during handover?

- Identify your team (juniors, clerks), write down their names and pager numbers.
- Get an updated patient list. Ask the juniors (and the outgoing senior), "Who is sick? Who needs to be seen?
- Have a fresh sheet of paper (or the back of the team lists) ready for the ER consults (that may be in various stages of waiting to be seen, being seen by a junior/clerk, or waiting for a bed).
- Get Heme/Onc handover from resident or staff on Heme/Onc (this may occur later- you can always call the staff on call for handover).
- Subspecialty handover (GI, endocrine, etc.): these services may or may not have inpatients, so the staff may give you handover. If you haven't received handover on weekends, and the nurse calls you about a patient, you can tell the nurse to call the subspecialty staff or fellow.

What should I do before handing over in the morning?

- Briefly reassess the status of the sickest patients, especially new admissions who are still in the ER.
- Check the list to see if it has been updated and remind juniors and clerks to update the list.
- Be prepared and on time or early for handover to set the tone for juniors and clerks.
- Review what patients you are going to identify to the new SPR as the sickest and requiring attention, as well as any consults waiting to be seen.