WELCOME TO THE PEDIATRIC SURGERY SERVICE

RESIDENTS: GENERAL SURGERY, PEDIATRICS, UROLOGY, PLASTICS

We're happy to welcome you to the Pediatric Surgery team and think you will enjoy your rotation.
If you haven't done much pediatrics, sick children can be a bit intimidating but you will quickly discover a few things: it's easy to recognize a sick child, children communicate honestly, and mothers are usually right!

We have a team of 5 surgeons, 2 fellows, 3-4 residents, and up to 2 medical students at any one time. Plus we are supported by 2 administrative assistants (Mary and Denise), 2 clinic nurses (Lida and Lisa) and Julia our research coordinator extraordinaire. Communication is very important – everyone needs to know all the patients. Urgency may be required to get an xray, obtain a consultation, or get a child to the OR. It's always best to follow through personally, speak directly with those whose help you need, and ask for help when you need it.

This package contains some of the information that will help you get oriented and get you through your first night oncall. If you have any other questions, the fellows will help you out. Don't hesitate to come to Dr. Cameron or any of the faculty with any concerns.

Resources:

a. The **Resident Manual** outlines your responsibilities and contains lots of useful information – read it and carry it with you.
b. The handout attached is supplemental
c. Read the **pediatric surgery chapter** from any surgical text (ex. Sabiston) during the rotation.
d. There is a good **online handbook** at: http://home.coqui.net/titolugo/handbook.htm
e. The **computer in 4E10** has several .ppt presentations in folder "Pediatric Surgery Educational .."
f. Ask the fellow to go over the .ppt on **"Tubes and Lines"** with you during your rotation.

Rounds: You will present one Monday rounds – see the guidelines in the handout. There are also some suggestions on making powerpoint slides, and the CanMEDS framework outline to make your objectives.

Research: Speak to Julia Pemberton about our ongoing research studies and how you can be involved.

Evaluation: Ask your department to send one copy of your final webeval to me to fill out; I will get feedback from the rest of the team and meet with you at the end of your rotation. If your rotation is longer than a month, we will do an informal mid-rotation evaluation as well; that template is attached.

Have a great rotation!

The Pediatric General Surgery Unit
At McMaster Children's Hospital, Hamilton

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	09:00 – 12:00 2Q clinic	8 - 3 OR	9 – 3 OR	9:00 – 12:00 Teaching Rounds (4E10)	8 – 3 OR
PM	12:00 – 13:00 Pediatric Surgery Rounds (4E20) ———————— 13:00 – 16:00 2Q Clinic	OR ———————— 13:00 – 16:00 2Q Clinic	OR —————————	12:00 - 13:00 Pediatric Grand Rounds (4E20) 13:00 – 16:00 2Q Clinic	OR —————————

Pediatric Surgery Team	**Pager**	**Office**
Dr. Karen Bailey	2766	75230
Dr. Peter Fitzgerald	2340	75227
Dr. Brian Cameron	2317	75222
Mary Lovas (Secretary)		75231
Dr. Mark Walton	**page via locating x76443**	75228
Dr. Helene. Flageole	**page via locating x76443**	73552
Denise Allen (Secretary)		75244

Important Phone numbers :

3CN	=	76345/76344	Short Stay Unit	=	75564 / 75565
3CS	=	65971/76972	Lida Jones	=	75545 / 73618
3B	=	76120/76123	2Q Clinic	=	75094 / 73457 / 75772
ER	=	75020	Radiology	=	75279
OR	=	75645	Ultrasound	=	75316
PICU	=	75693	Film Library	=	73351
NICU	=	76146	Interventional	=	75288 / 73729
Level 2	=	73753	G.I. xray area	=	75321
Admitting	=	75100	Pathology	=	76419
Bed Booking	=	75106	Pharmacy	=	75019

Information Access:

Fellows will provide access codes for master team Meditech patient list.

The Meditech patient list is to be maintained up-to-date, and includes only patients admitted or consulted by the Pediatric General Surgery service.

Radiology Reports can be heard through the **RTAS** system, x75077, code 4345.

CENTRICITY – get and use your own password .

Daily Work:

1) **Rounds**
   a. Start at 0630-0700 hrs on 3C and are expected to finish before going to OR.
   b. Obtain handover from the person on call, including admissions / problems.
   c. Update patient list on the Meditech system.

2) **OR**
   a. Elective MUMC OR days are Tuesdays and Fridays at 0800 and Wednesdays at 0900.
   b. Check the OR schedule a day before the OR so you can be prepared.
   c. Assigned personnel are to report to the OR no later than 0755.
   d. Be familiar with the patient's history prior to scrubbing in, and examine the patient if practical.
   e. Be aware of any ER / Standby cases- on "add list" whiteboard in OR.

3) **Clinics**
   a. Check above schedule for days and time.
   b. Located at the 2Q clinic by the Emergency Department.

4) **Academic Activity**
   a. Monday 12:00 to 13:00
      i. Pediatric Surgery Rounds – 4E20
      ii. Topics to be discussed / Reviewed in advance with one of staff.
      iii. Use current cases and clinical examples, and gear towards medical students, and Residents (Surgery/Pediatrics) - *guidelines appended*.
   b. Thursday 9:00 –12:00 am
      i. Review patients with staff and team, present cases and be prepared to answer questions! Bring a relevant reference and educate us.

5) **Booking O.R. Cases:**
   a. Be sure that there are Pre-op orders, consent is signed, and patient is NPO.
   b. Emergent cases: [NB only Staff or Fellow can book OR cases]
      i. Go to or call the OR desk (x75645) with patient information including birthdate, NPO status, and admission plans.
      ii. Speak to the Anesthetist directly (generally done by Attending).
      iii. Ensure patient has an inpatient bed (bed-booking x75106)
   c. Elective cases are booked through Mary Lovas (x 75231), secretary to Drs Bailey, Fitzgerald and Cameron or Denise Allen (x75244), secretary to Drs. Walton and Flageole, Division of Pediatric General Surgery.

6) Admissions:

a. Emergent cases:
   i. Book a bed with bed-booking (x 75106) or (x 75100- after hrs).
   ii. Write up History and Physical with admission Orders.
   iii. Speak directly to nurses on 3C if special or urgent orders.
b. All Elective cases need a History and Physical note on the chart, old charts reviewed, and admission or pre-op Orders.

7) **Discharges:**

Discharge planning should begin when the patient is admitted. Home care and/or nutritional services that will be needed should be arranged well in advance of planned discharge. Ensure that adequate follow-up arrangements are clear, reasonable, and understood by the patients. Discharge plans to be written on the Order sheet should include instructions re diet, bathing, sutures, wound care, pain medicine, antibiotics, and office follow-up. Their family doctor or pediatrician away may follow uncomplicated patients from some distance; if there is a question confirm with the Attending surgeon. **The discharge face-sheet must be completed**; a summary must be dictated within 24 hrs for all patients with copies to the referring doctors.

8) Ward Records:

There should be a brief note on the chart each morning for each patient. It should summarize any new symptoms and signs, current lab work, x-ray and pathology results, and plans for new orders. Notes need to be legible, signed and dated. NB Read the other notes on the chart including nurses notes!!

9) Dictating:

1.Elective OR admissions with preop dictated histories still need a brief written H&P on the chart!
2.DICTATE all Consultations whether Inpatient or E.R.
3.Dictate ALL dictations as 'Inpatient' (otherwise transcription is delayed)
4.Send a copy of Consult and O.R. notes to the Referring Physician.

10) **O.R. Consents :**

Make sure that the patient/family understands what they are consenting to. The Attending surgeon should be directly involved in obtaining consent if the patient/parents seem to be confused or in doubt. Make sure you use Plain English and not medical lingo. Use translators if the family does not appear to understand.

1. Consent must be obtained from the child if over age 16, and may be obtained from a younger child who has a full understanding of the implications of the consent. Otherwise the legal guardian/parent must give consent.
2. Explain the procedure or draw a diagram (you may leave the diagram in the chart).
3. Describe the type of anesthetic, i.e. general vs. local / epidural.
4. Explain the reason for the procedure, the alternatives to surgery, and the benefits and risks.
5. Inform about possible complications including those that are more frequent (ex. infection, bleeding) or potentially serious (ex. ostomy, bowel obstruction).
6. Discuss complications of the disease process as well.
7. Telephone consent may be obtained, but details of the conversation should be recorded in the chart and a second witness must listen to confirmation of the consent and sign the consent form as well(on the back of the form).

11) **PARENTS:** **Remember!! Always listen to the family.** Mothers are usually right. Be diplomatic and be careful not to confuse the issues or contradict other team members.

12) **ON – CALL ISSUES:**

1. Call the Fellow or Attending after seeing a new patient. Do not send a patient home from the E.R. without discussing with the Attending.
2. If there is a problem with a patient on the ward, do not hesitate to call the person senior to you for advice or just to inform.

13) **Pediatric Trauma and the Pediatric Trauma Team**

The pediatric trauma team at the Children's Hospital consists of the pediatric intensive care unit resident (pager 1000=Peds 1000), the pediatric surgery resident or the general surgery resident on call, the pediatric intensivist, the pediatric general surgeon, emergency room physician, ER nurse, a respiratory technologist, pediatric intensive care unit transport nurse, and the emergency room social worker when available. The on-call radiology technician is also paged in the pediatric trauma fan out.

The pediatric trauma team will be called either by the emergency department or by the intensive care unit when a call is received about an injured child being en route. The pediatric trauma team is activated by calling the paging system and asking for the pediatric trauma team. The guidelines are to adopt an 'overcall policy', in other words to call more frequently than perhaps needed as consequences of injuries are hard to predict with children. You should not accept trauma referrals from other hospitals and instead these calls should be referred through the staff people. If you do get these calls by mistake from Critical or paging please take the referring doctors name and number and immediately contact the pediatric surgeon on call in order to coordinate the care. If you do get warning from the pediatric intensive care unit resident about an incoming trauma you should let the pediatric surgeon know on call and also other possible surgical specialties that may need to be involved.

If you are on call and receive a pediatric trauma team fan out page you will see a number of possible codes. The location of where the child is going will also appear on your pager and will either be the emergency department or the intensive care unit.

Pediatric trauma team *2 = that the child is coming in (usually by ambulance) within 6 to 15 minutes.
Pediatric trauma team *1 = that the child is coming in five minutes or less
Pediatric trauma team *0 = that the child is in the emergency department or ICU any need to proceed immediately.

The TTL (trauma team leader) is either the Pediatric Intensivist or the Pediatric General Surgeon. When you arrive at the trauma identify yourself to the TTL. Your role in the trauma is to perform an assessment in the ATLS manner and coordinate the surgical aspects of care. This means the timely involvement of neurosurgery, general surgery, orthopedics surgery, plastic surgery, urology as well as maxillofacial surgery. Remember that this is a team effort and cooperation will make the initial assessment and resuscitation work of the best. Contact specialists early as it may lead to some modification of the radiologic investigations (ie the CT scan technique). Whether you have done the ATLS course or not you will have timely backup from the pediatric general surgeon as well as the pediatric general surgery fellow.

Please assign a pediatric trauma score and Glasgow coma score in your assessment note.