CTU 3

Orientation Manual 2012--2013

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Orientation for Team 3

Dear Residents,

Welcome to your Team 3 Rotation. I hope you have a good learning experience with us. Please don't hesitate to contact your Chief Residents, Heather Bahn and Andrea Mucci at macpedschiefs@gmail.com if you have any questions or concerns. Dr. MacNay is the Team 3 educational lead and Dr Ladhani is the CTU Director. The CTU administrative support is Skye Levely at levelys@mcmaster.ca. Please find included in this letter a brief orientation, a copy of your schedule, responsibilities, educational objectives and call responsibilities.

With respect to your first day, please show up for handover at **7:15am sharp in room 3H40**. Weekend handover is at 8:30am in the 3C conference room. Your attending for the month will meet you the first day, answer any questions you have and sign your learning contract. Below is a list of the Team 3 staff. Physician attendings rotate through every 28 days.

Additional resources for you to access during your rotation include the "Green Book" (resident's survival guide). You should have received a copy of this from Dr. Ladhani's office. If you have lost it, you can purchase one for $10.00. Please contact Skye Levely at Ext 75639. It is also available online at http://www.macpeds.com/resources_for_residents.html

A general review of expectations and resources is also available at: http://www.macpeds.com/general_pediatrics.html

You will be provided with a monthly schedule of teaching sessions and relevant rounds on your first day of your rotation. Please be prompt for each of these sessions. This can also be found at:

http://www.macpeds.com/mcmaster_CTU_teaching_schedule.html

For any further educational questions specific to this rotation, please don't hesitate to contact Dr. MacNay through paging at McMaster ext. 75030 or by my email at rmacnay@gmail.com.

Sincerely,

Ramsay MacNay

1. Introduction to the Division of General Pediatrics

The Division of General pediatrics is the largest division within the Department of Pediatrics. The division consists of 20 pediatricians. The pediatricians provide consulting services at **McMaster Children's Hospital** and **St. Joseph's Healthcare Hamilton.** All pediatricians are affiliated with **McMaster University**.

General pediatrician work in four teams – teams 1, 2 and 3 at McMaster and team 4 at St. Joseph's Hospital. Team 1 and 2 have up to forty general pediatric ward patients. Team 3 covers twelve Level II neonatal patients and up to six chronic complex pediatric patients. As well, pediatricians on team 1, 2 and 3 provide consults to the Emergency Department, new born nursery, surgical teams, as well as consult requests from the regional hospitals and regional community physicians.

At St. Joseph's Healthcare, we are responsible for up to 18 Level II neonatal patients. In addition we attend deliveries, see consult requests from the newborn nursery and rarely from the emergency room.

The Division of General Pediatrics provides 24/7 on-call coverage at both hospitals. In addition to on-service and on-call work in these hospitals, our group has a commitment to the medical needs of the children within Hamilton and the surrounding regions. Care provided is based on the best available evidence in a family-centred environment.

Team 3 is covered by a core group of 4 pediatricians, each covering the service for 4 weeks. In addition, team 3 has a number of nurse specialists, a respiratory therapist, and a clinical associate who are all specialized in caring for chronic complex children.

The Team 3 Staff:

Madan Roy

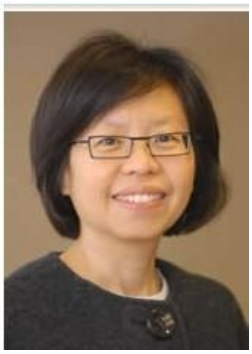
In 2004, Dr. Roy was recruited to McMaster Children's Hospital as Chief of the Division of General Pediatrics and Associate Professor, McMaster University, from his consulting pediatric practice in Brantford. Dr. Roy completed his medical training in India, his pediatric training in the U.K. and his neonatal sub-specialty training at McMaster Children's Hospital.

Dr. Roy is actively involved clinically, at both McMaster Children's Hospital and St. Joseph's Healthcare Hamilton, providing on-call coverage, inpatient and outpatient services. He is the lead pediatric care provider, along with his multidisciplinary team, to the chronic complex and mechanically dependent fragile children in Hamilton and the region. Dr. Roy is well recognized for his excellence in teaching pediatric residents, clerks and medical students.

Dr. Roy's interests are in improving quality of care, enhancing optimum hospital utilization and patient flow, and in promoting community-tertiary centre partnerships. Towards this end, he is the McMaster General Pediatric's lead for LHIN 4 and 3 and, as well, the lead instructor for the ACoRN course.

Under Dr. Roy's leadership, the Division of General Pediatrics has grown to 20 members, and is the largest division within the Department of Pediatrics. Ward rounds and general pediatric inpatient care has been remodeled, a research lead created, and educational experience of learners advanced, all while still retaining a very strong community consulting focus in pediatrics. Dr. Roy is currently the Acting Deputy Chief of Pediatrics.

Audrey Lim, MD, FRCPc, MSc.



Dr. Audrey Lim is an Assistant Professor at McMaster University. She completed her MD at McMaster University, followed by a residency in Pediatrics at McMaster University. Dr Lim received Fellowship training in Pediatric Critical Care Medicine at the Hospital for Sick Children, University of Toronto and at the BC Children's Hospital, University of British Columbia. Dr Lim also holds a Masters of Community Health Sciences from the University of Calgary.

Dr. Lim joined the Division of General Pediatrics at McMaster Children's Hospital in 2007. Clinically, Dr. Lim is a Consultant Pediatrician, providing service on the CTUs and runs an outpatient consultant practice. Her interests are in care of the chronic complex, technology-dependent children, education and clinical research.

Dr. Frank o•Toole

Dr. Frank O'Toole is an assistant professor in the division of general pediatrics. He completed his medical training and his pediatric residency at McMaster University and joined the division in 1991. He is our division's lead on palliative care in pediatric populations, and has special interests in management of chronic complex patients. He has been a medical consultant to the Children's Advocacy and Assessment Program since 1992. He also provides Consulting Pediatric Care to the community of Hamilton and surrounding regions.

Dr. Ramsay MacNay

Dr. MacNay completed his medical training at the University of Western Ontario and his pediatric residency at McMaster University. He joined our division in 2004. He is a recognized educator directing the senior pediatric resident clinic and co-directing pediatric education clinics within Hamilton's Family Practice units. Currently, he is the education lead on Team 3.

Joanne Dix

Joanne is a Clinical Nurse Specialist in pediatrics and the level 2 nursery. She graduated from Mohawk College with her nursing diploma and continued her education at McMaster University and D'Youville University in Buffalo, New York. Joanne has many years experience in the NICU and neonatal follow-up. She has a strong commitment in the medical teaching of our children in preparation for hospital discharge

Rose Francis-Clause

Rose-Francis Clause is a Pediatric Nurse Practitioner who works with medically fragile infants and children, commonly technology dependent. She obtained a Bachelor of Science in Nursing from University of Ottawa, a Masters of Health Sciences from McMaster University and an Acute Care Nurse Practitioner Diploma from University of Toronto. She is currently an assistant Clinical Professor with McMaster School of Nursing. Working with our large interdisciplinary team, her particular focus is on preparation for safe discharge home and continued support of families in the community after discharge to prevent readmission. She

Jeannie Kelso

Jeannie Kelso is a Respiratory Therapist who has been involved with the neonatal and pediatric population at McMaster Children's hospital for over 25 years. Jeannie is a graduate of the L.P.N. nursing program in Warren, Ohio and continued on her education to become a Registered Respiratory Therapist. Jeannie is committed to the inpatient population, discharge planning and the home care needs of our complex patients including tracheostomy and ventilated patients.

Fiona Commins

Fiona Commins hails from British Columbia. She received both her nursing degree and her Pediatric Acute Care Nurse Practitioner degree at University of Toronto. She returned home to gain pediatric experience at B.C. Children's Hospital before joining our Team as a nurse practitioner on our Level 2 unit.

Anil Chacko, Pediatric Fellow

Anil Chacko completed medical school at Bangalore University, India. His postgraduate pediatric training took place at RG University of Health Sciences, also in Bangalore India. Since 2004 he has studied in Glasgow Scotland receiving his MRCPCH, higher specialist training in paediatrics, and a fabulous Scottish accent. He has now taken on the role of Clinical Fellow on our Team. Anil's special interest is in neonatal intensive care.

2. Clinical Issues

a) Inpatients: Team 3 consists of three groups of patients.

Ward 4C is a well-baby nursery ward. All infants are >35 weeks. Our team generally follows 2-6 of these infants who have been referred to us by their family physician or midwife for a variety of issues like jaundice, heart murmurs, hypoglycemia, and minor anomalies picked up antenatally (hydronephrosis etc.)

Level 2 Nursery – This ward has 14 beds consisting of infants who require intensive care. These infants most often have multiple issues requiring subspecialist involvement. Issues include EVLBW or VLBW babies with chronic lung disease, short bowel syndrome, neurological disease (IVH, HIE), feeding issues, genetic syndromes and cardiac disease.

Chronic complex patients – There will be a maximum of six children on Team 3 admitted to wards 3B, 3C, or 3Y. They will have multiple system illnesses (3 or more) and are expected to be admitted for at least 2 weeks. These children are often technology and mechanically dependent patients (tracheostomy, G-tube, home oxygen, feeding pumps etc.)

b) Rounds:

A most responsible team member must write a progress note on each patient each day. A team member is responsible for keeping patient issues current on the patient list. Lab results may be accessed on computers equipped via “Meditech” or through any computer using “Citrix”.

Residents must properly document in the chart. This includes daily notes, completing details of the face sheet and timely completion of consultations and discharges. Physicians responsible for follow up of more acute concerns should be contacted by phone, as dictated notes may not be available to the receiving physician in sufficient time.

If a discharge is anticipated over the weekend, the learner should ensure that the face sheet is completed and the discharge note dictated in advance as a courtesy to the on-call person who may not be as familiar with the patient.

c) Call:

Handover occurs at 4:30 p.m. The call team consists of a senior resident, two junior residents and a clinical clerk. The senior resident with assign you patients to see as consults come in. All patients must be reviewed with the senior resident. If the senior resident is busy the cases will be reviewed with the attending. When the senior resident gets a consult they will “eyeball” the patient and write bridging orders. You should make an attempt to be with the senior during this time, as it is a good learning experience. Patient lists must be updated with new patients for the day team before morning handover. Post-call you are required to stay for teaching and are free to go home after the sessions end at 9:00 a.m.

d) Documentation/Admission Notes/Progress Notes/Orders:

Please see the “Green Book” for guidelines on this topic.

e) Patient Lists:

All team inpatients should be added to the daily Patient List. Ongoing or outstanding patient care issues should be added to the list AND relayed verbally during transfer of care, as required.

Information contained on these lists is confidential and therefore must be properly stored and carried. If the list is found off site or in non-confidential areas, you will not be permitted to carry a list.

f) Consultation Requests:

Team 3 provides consultations to NICU (Neonatal Intensive Care Unit), 4C Family Physicians, and Midwives, PCCU (Pediatric Critical Care Unit), Labour and Delivery, and General Pediatricians on Wards 3B, 3C, and 3Y. consultations should be prioritized by illness severity. Consults after 1700h are handled by the on-call Senior Pediatric Resident (SPR) who will delegate the learners to patients. Any pending consultations and/or admissions not completed at the time of handover must be handed over to the SPR.

Each consult must contain:

- Patient's name (stamp or sticker)
- Date and time (in 2400h clock) on each page
- LEGIBLE printed name, signature, training level and pager number
- Name of staff with whom case was discussed

All resident consultations must be reviewed with a staff or fellow.

g) PACE: Pediatric Assessment of Critical Events)

PACE is the McMaster Children's Hospital Medical Emergency Consultative Team whose goal is to detect patient's clinical deterioration before leading to a Code Blue, cardiac arrest, or unplanned PCCU admission.

PACE can be activated in several ways:

- Vital sign triggers
- Healthcare provider (HCP) concern about the patient's status
- Patient or family concern if RN or other HCP cannot be located

The Team should consider PACE consultation for children who have worsening medical status who may require transfer to the ICU.

PACE team consists of the PCCU Resident (Peds 1000 pager), PACE MD, (generally one of the pediatric Intensivists or PCCU Fellow), PCCU RN with additional training, pediatric RT and PCCU on-call resident.

Activate PACE by calling paging (ext. 76443). Provide patient's ward and room location. Paging will activate the team members.

All non-emergent PACE therapies and recommendations should be discussed with the patient's most responsible team. A member of the patient's most responsible team (staff, resident, fellow) should be present during the PACE activation. If they are not, then the most responsible house staff should be paged immediately after the PACE team arrives.

h) Calling in Sick:

Please contact your staff supervisor if you cannot come in to work by paging them directly, email communication is not acceptable. Please inform the CTU director of absences > 48 hours.

i) Evaluations:

The staff are encouraged to give midway evaluations. If they have not, please ask the staff for feedback midway through your rotation. You should arrange a time to meet your staff for a final face-to-face evaluation. It is preferred that during orientation you set a time near the end of the rotation to meet to discuss the final evaluation. The staff will also do one mini-cex/month and one Handover cex/month. It is your responsibility that these are completed.

j) Contacts:

Dr. Ramsay MacNay	CTU 3 Educational Lead rmacnay@hhsc.ca
Dr. Moyez Ladhani	CTU Director ladhanim@mcmaster.ca
Ms. Skye Levely	CTU Administrative Assistant, 3N11 levelys@mcmaster.ca
Chief Residents	macpedchiefs@mcmaster.ca

Allied Health Contact Numbers:

Joanne Dix	CNS	Pager 1409
Rose-Frances Clause	ACNP	Pager 1934
Jeannie Kelso	RT	Pager 1042
Clinical Nurse Specialist		
Clinical Associate		
Shari Gray	Pharmacist	Pager 1051
Aune Hjartarson	OT	Pager 1091
Julie Cornwell	OT	Pager 1555
Connie Stuart	Nutrition/Dietician	Pager 5035
Valerie Fines	Social Work	Pager 1230
Karla Schwarzer	Social Work	Pager 1112
Heidi Tigchelaar	Social Work	Pager 4179
Respiratory therapy		
Charge Nurse	Bed Management	

CTU 3 Weekly Schedule

Daily schedule for Junior Pediatric Resident

	Monday	Tuesday	Wednesday	Thursday	Friday
7:45 am	Handover	Handover	Handover	Handover	Handover
8:00 am	Pediatric Grand Rounds 4E20	Pediatric Resident Teaching	TEAM 3 Teaching	Grand Rounds MDCL 3020	TEAM teaching 3H40
9:00 am	See Patients	See Patients	See Patients	See Patients	See Patients
10:30 am	Rounds on L2N	Rounds on L2N	Rounds on L2N	Rounds on L2N	Rounds on L2N
12:30 am	LUNCH	LUNCH	LUNCH	LUNCH	LUNCH
1:00 pm	SEE PATIENTS	SEE PATIENTS	AHD	MDR rounds	SEE PATIENTS
2:00 pm	"	"	AHD	SEE PATIENTS	"
3:00 pm	Specialty Teaching	"	AHD	Teaching Session	"
4:00 pm	Update Patient Lists	Update Patient Lists	AHD	Update Patient Lists	Update Patient Lists
4:30 pm	Handover 3C Room 10	Handover 3C Room 10	Handover 3C Room 10	Handover 3C Room 10	Handover 3C Room 10

Attending will be at Huddle between 9:45 – 10:00

Teaching Sessions

It is expected that junior residents attend organized team teaching sessions from 8:00-9:00 a.m. Monday to Thursday with other residents. Please refer to the CTU teaching schedule for locations – this will be posted online.

Tuesdays from 08:00 to 09:00h – Teaching for all learners, except the third Tuesday which is for pediatric residents only.

Monday morning from 08:00-09:00h will be the Division of General Pediatric Rounds.

Wednesday is Academic Half Day for pediatric residents.

Thursdays from 08:00-09:00h – Pediatric Grand Rounds.

Fridays from 08:00-09:00h – Bedside teaching.

Informal teaching sessions will be encouraged once per week when time permits in the afternoons for topics determined by the resident. The following medical topics are likely to be encountered on this rotation:

Hypoglycemia
Jaundice
Nutritional requirements for the Ex-Prem infant
Retinopathy of prematurity
Tracheostomy and G-tube care
Management of a heart murmur in a well newborn
Management of chronic complex patients
Neonatal abstinence syndrome
POST discussions with families

As the resident, please identify any of these topics plus any others you would like to discuss with your attending during the rotation. Your attending will prioritize them to be covered with your bedside teaching session. It is expected that the resident will pre-read around each topic. There will be a list of 8-10 articles of interest you will be able to get from your attending on the first day. Many will cover the issues above. Secondly, it is strongly suggested that you read and know the full Neonatal section of the **"GREEN BOOK" (pages 64-111).**

EXPECTATIONS OF FACULTY

Staff Weekday Handover: Staff for CTU 3 handover by phone with the on-call pediatrician at 07:45h.

Staff Weekend Handover: Staff are expected to handover in person on Ward 3C at 08:00h

Service Handover will occur on the Monday at the beginning of the 4-week rotation.

Daily Schedule for Weekdays:

Staff are expected to be in hospital from 08:00h to 17:00h
Staff attend NICU huddle at 09:45h
Staff attend or oversee rounds at 10:30h

Orientation:

All learners will receive a welcome email from the General Pediatric Administrative staff one week prior to their rotation starting.

Learners will be expected to arrive for handover at 07:45h at the start of their rotation.

The attending will meet the senior resident at 09:00h to review objectives and sign the learning contract.

The attending will meet the junior resident and other learners at 09:30h to review objectives and sign the learning contract.

This would also be an opportune time to discuss the resident's vacations, half-day, make arrangements for mini CEX, and set time to discuss the mid-rotation and end-rotation evaluations.

Evaluations:

CTU 3 staff are expected to do mid-rotation feedback with each learner. If there are concerns with any of the residents' performance, the evaluation must be in writing. An evaluation is available on WebEval or contact Dr. Ladhani/Shirley Ferguson, who can send you a form.

A mini CEX must be completed for each pediatric resident once per month.

A handover CEX will be completed for each pediatric resident once per month. The handover mini CEX is an observation of the evening handover by the Senior and Junior Residents. There is a provider and recipient form.

http://www.macpeds.com/documents/HandoffEducationprovider.pdf

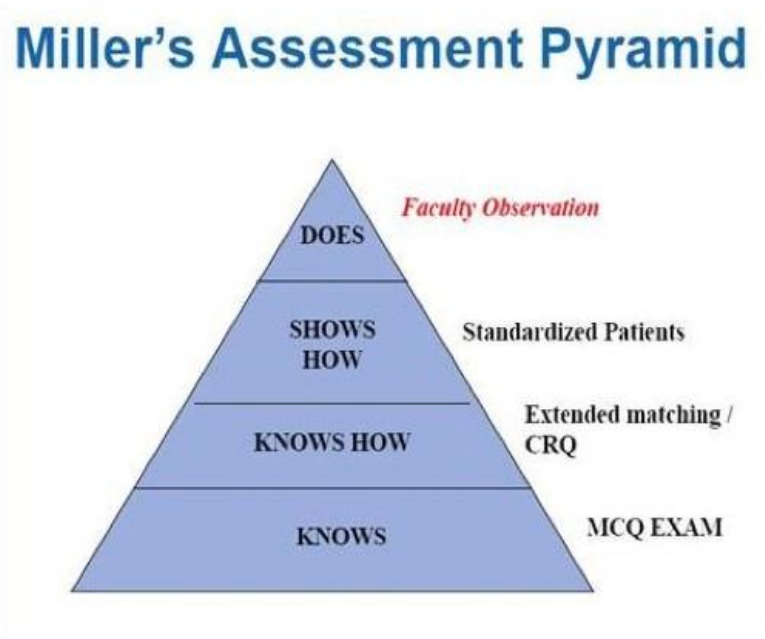
http://www.macpeds.com/documents/Handoffcexrecepient.pdf

Teaching:

Bedside teaching will occur every Friday morning from 08:00h to 09:00h. This will focus on interesting clinical findings and physical exam technique. At least once per week, there should be informal teaching sessions for the resident in the afternoon where time permits. Topics should be resident driven. A list of suggested topics is listed above. In addition, a list of important articles (6-8) relevant to our patient population will be given to the resident. It is expected that they will review these articles in detail. All residents will attend teaching on Monday, Tuesday, Wednesday and Thursday mornings from 08:00h to 09:00h.

Rounding:

- It is highly recommended that rounds be conducted in a walk around fashion.
- The Senior Resident is to act as a Junior Attending with appropriate supervision.
- At minimum each patient should be seen by all learners at least once per week.



ORIENTATION CHECKLIST FOR PEDIATRIC RESIDENTS ON CTU 3

- ☐ Welcome to Pediatrics
- ☐ Review Goals and Objectives
- ☐ Responsibilities to 4C, L2N, 3B, 3C, 3Y and L&D
- ☐ Review Website and Reading List
- ☐ Review contact list and pagers
- ☐ Discuss confidentiality

- ☐ **Daily schedule**: refer to green book/website
- ☐ 07:45 Handover
- ☐ 08:00 Teaching – Review teaching schedule for topic and location
- ☐ 09:00 "Pre Round" – see patients, check progress overnight, review labs, etc.
- ☐ 10:30 Team rounds with Sr. Resident and/or staff
- ☐ 13:00-15:00 Patient care – write notes, orders, arrange investigations, follow-up labs, Multidisciplinary rounds, etc.
- ☐ 15:00-16:00 Teaching – see teaching schedule for topic and location
- ☐ 16:00 Update Team Lists for evening handover, check labs, etc.
- ☐ 16:30 Handover

- ☐ **Daily progress notes**
- ☐ Outline chronic and active issues
- ☐ Full "summary note" on Thursdays, anticipating weekend coverage
- ☐ Arrange investigations as early as possible in morning, and follow results closely
- ☐ Keep "Patient Problem List" updated
- ☐ Update Team List of patients with **active** issues, management plans

- ☐ **Discharge procedures**
- ☐ Complete all discharges in the morning prior to rounds if possible
- ☐ Check will staff before discharging any pediatric patient
- ☐ Write discharge orders, scripts, follow-up appointment arrangements
- ☐ Fill out "face sheet" with all possible diagnoses etc., give a copy to parents
- ☐ Dictate discharge summary, write ID# on face sheet

- ☐ **On Call**
- ☐ Responsibilities on-call (Team 1, 2,3 Subspec, PICU etc), review 5301, 5302, 5303
- ☐ Location of call rooms, greens, lounge
- ☐ Call switches
- ☐ handover patients before leaving post-call, expected to stay until teaching done in morning when post-call.

- ☐ **Other**
- ☐ Arrange investigations as early as possible in morning and follow results closely
- ☐ Computer passwords etc. Email Skye with Citrix username to get access to patient lists
- ☐ Brief orientation to Meditech, PACS, etc.
- ☐ Show them where Team Lists are on each computer. Review www.macpeds.com and also let house staff know about the general pediatric article on line.

- ☐ **Tour**
- ☐ Show each of the wards (3B, 3C, 3Y)
  - ☐ White boards of patient lists
  - ☐ Charts
  - ☐ New forms: progress notes, orders, radiology reqs, etc.
  - ☐ Discharged charts (in drawers behind desk clerk)

- **Please emphasize:**
- Put contact person beside each patient with pager number – each day!
- Hand over all your patients before leaving for half-day, post-call, etc.
- Please arrive for handover on time and prepared with an updated patient list…. finish notes, dictations as necessary after handing over at 16:30h
- Dictate discharge summaries promptly – charts disappear in less than 48 hours
- Split up patients for optimal learning among the team members – assign a resident to supervise clerk patients too.

- **We are all here to learn and have fun!**

PATIENT CARE/CHARTING

Admissions:
Write full admission orders (include MRP on call, transfer to care of Team 3 in morning.
Ensure history and physical is documented on chart.

Charting:
- Admission note should include complete history & physical, assessment & plan
- Progress notes should be written daily on every patient
- all complex patients admitted to the hospital and residing in hospital for over a week should Have a summary of interval progress documented every Thursday by the resident or assigned learner. This should consist of a brief update of events of the week, significant physical findings, investigation results, and care provided during the preceding week. This will facilitate the provision of care over the weekend as well as help keep the numerous sub-specialists involved with each such patient updated. Further this weekly summary will be a great help in dictating the final discharge summary.
- Off-service notes (at the end of a month/rotation) are also helpful and expected.
- All patient care meeting such as those conducted with parents or multidisciplinary meetings should be documented in the chart by the learner assigned to the case, with a summary of the discussion.

Patient Referrals:
- All referrals to sub-specialists will take place with the explicit consent and request of the attending rather than a direct referral from the resident to the sub-specialist. The referral request will specify the question for which subspecialty input is required. Parents need to be aware of the request for a subspecialty consult, especially involving Mental Health/ Adolescent Medicine. The urgency of the consult should be relayed to the sub-specialist being called. The MRP should be fully aware of the patient's details, as should the resident/ learner calling the sub-specialist.

Transferring Patients:
- When transferring patients, please verbally notify the resident on the new service (staff to staff handover should also take place independently).
- Transfer orders to general pediatrics, Level 2 Nursery are expected.
- Dictate transfer summary and write a brief transfer summary in chart.

Discharging Patients:

- Dictate a discharge summary for every pediatric patient. This should include dates of admission/discharge, admission/discharge diagnosis, discharge mediations, follow-up plans, brief history & physical, pertinent investigation results and summary of course in hospital. See templates for general peds, Level II nursery, NICU, etc.
- Complete face sheet prior to patient leaving hospital – this will be faxed to family physician's office at the time of discharge. Face sheet completion prior to discharge is the responsibility of the learner. The face sheet will be completed in detail at the time of discharge. Information on this will include salient course in hospital, diagnosis at discharge and follow-up plan.
- Complete any prescriptions, CCAC requests, and other forms prior to discharge.

ROLE OF THE JUNIOR PEDIATRIC RESIDENT

- Primary responsibilities will include management of 4C and a select group of patients on L2N
- Will assist with management on chronic complex patients on general pediatric wards
- Coordinate activities of own patients (test results, examining patients and discharging)
- Brings any concerns to staff or Fellow/clinical associate

Daily Schedule

07:45 Handover
08:00 Teaching – Review Teaching schedule for topic and location
09:00 "Pre Round" – Examine patients , check progress overnight, review labs, etc.
10:30-12:00 Team rounds with Sr. resident and/or staff
12:00-13:00 Lunch
13:00-15:00 Patient care
- Wrap up discussion of new and outstanding issues with attending/SPR
- Write progress notes, arrange investigations and consults, follow-up labs, multidisciplinary rounds, etc
- Complete daily progress notes and discharge summaries
- Resident-led teaching sessions and bedside teaching
- Discharges for the next day planned and arranged with specific criteria

15:00-16:00 Teaching – see Teaching schedule for topic and location
16:00 Update Team Lists for evening handover, check labs etc.
16:30 Handover

Call and Post-Call

- Will do call at McMaster
- Will see consults from ER, in-patient services or transfers to Level 2 Nursery
- Will update patient lists before morning handover
- Will attend morning handover and teaching post-call (will leave at approximately 09:00 on post-call days)
- Will hand their patients over to a team member (Junior resident or Senior Pediatric Residents) prior to going home post call
- Will cover the patients of fellow residents when they are post-call

Vacation

- Residents may take 1 week of vacation per month on inpatient CTU rotations.
- Senior Pediatric Residents and Junior Pediatric Residents may not take vacation at the same time.
- All requests need to be approved by the CTU administrator and chief residents on Medportal prior to starting the rotation.

Discharge Planning

- Each morning patients ready for discharge will be discharged early by the resident if discharge criteria are met.
- Discharge planning begins at the time of admission and is an ongoing process.