

WELCOME TO THE PEDIATRIC SURGERY SERVICE

For ALL RESIDENTS: GENERAL SURGERY, PEDIATRICS, UROLOGY, PLASTICS, ANESTHESIOLOGY

We're happy to welcome you to the Pediatric Surgery team. 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. We work with 3 Administrative Assistants (Denise, Renee and Jessica), a Nurse Practitioner (Julia Pond), a Research Assistant (Henrietta Blinder) and MPSRC Research Coordinator (Bethany Easterbrook).

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.

Our goal is to be recognized by residents as one of the best educational rotations in the Department of Surgery. To achieve this, we aim to: a. Encourage graduated responsibility, with more autonomy for senior level residents; b. Maintain a balance between service and learning and c. Develop a model competency-based rotation. Each resident will be assigned a **Faculty Mentor** for the rotation.

Learning Resources: In addition to the **Pediatric Surgery Resident Manual (online)**, we suggest you read the **pediatric surgery chapter** from Sabiston. The **computer in 4E10** has several .ppt presentations in folder "Pediatric Surgery Educational ..". Ask the fellow to review "**Tubes and Lines**" with you during your rotation. There is also a good **online handbook** at: <http://home.cogui.net/titolugo/handbook.htm>.

Assessment: Residents are expected to maintain an **Educational Portfolio** during their rotation. The true purpose of these assessments is not to stress you or overburden you, but to provide formative feedback to help you identify your own strengths, gaps, and learning objectives. Our goal is to help you achieve them.

Ask your department to send your webeval In-Training Evaluation Report (ITER) to your Mentor to complete. You should meet with your Mentor for orientation, again after the first week, and for a mid-rotation assessment after the first month if your rotation is longer than a month. You must arrange a meeting with your Mentor to complete your final evaluation.

Included in your Orientation Package are:

1. Resident Orientation handout with link to Pediatric Surgery Manual
2. Your specific specialty objectives and assessment forms.
3. Credit Valley Hospital Forms to complete to join a surgeon on a day-trip to CVH (clinic and day-surgery).
4. Guidelines for presenting Pediatric Surgery Rounds (with .ppt slide guidelines and CanMEDS roles)
5. Orientation to LapSim modules.

Have a great rotation!

Brian Cameron MD, CTU Director Pediatric Surgery

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Resident Orientation to The Pediatric General Surgery Unit At McMaster Children’s Hospital, Hamilton

See Resident Manual at: http://fhs.mcmaster.ca/pediatricsurgery/resident_portal.html

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
AM	8:00 Tutorial 4E10* * <i>Confirm</i> 09:00 – 12:00 2Q clinic (Dr. Flageole)	8 - 3 OR	9 – 3 OR	8:00 SRP Rounds or Skills Sessions CSBL* 9:00 – 12:00 Case review and Teaching Rounds (4E10)	8 – 3 OR 09:00 – 12:00 2Q clinic (Dr. Fitzgerald)
PM	12:00 – 13:00 Pediatric Surgery Rounds (4E20) 13:00 – 16:00 2Q Clinic (Dr. Cameron)	8 – 3 OR 13:00 – 16:00 2Q Clinic (Dr. Walton)	9 – 3 OR	13:00 – 16:00 2Q Clinic (Dr. Bailey)	8 – 3 OR

Pediatric Surgery Team

Dr. Karen Bailey

Dr. Peter Fitzgerald

Renee Welsh (Admin Asst)

Dr. Mark Walton

Dr. Helene. Flageole

Denise Allen (Admin Asst)

Dr. Brian Cameron

Jessica Boyd (Admin Asst)

Phone (or call paging x76443)

905-869-0428

289-237-8050

905-512-9039

905-906-2084

289-925-6991

Office

75230

75227

73550

75228

73552

75244

75222

75231

Important Phone numbers :

3B	=	72980	2Q Clinic	=	75094 / 73457 / 75772
3CN	=	76345/76344	Short Stay Unit	=	75564 / 75565
3CS	=	76971/76972	Julia Yole	=	75545 / 73618
ER	=	75020	Radiology	=	75279
OR	=	75645	Ultrasound	=	75316
PICU	=	72610	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

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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.

CENTRICITY – get and use your own password .

Daily Work:

1) Rounds

- a. Start at 0630-0700 hrs 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. Start times for Elective MUMC OR days are Tuesdays/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 0750.**
- 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 desk area.

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 the Fellow.
 - iii. Use current cases and clinical examples, and gear towards medical students, and Residents (Surgery/Pediatrics) - *guidelines appended.*
- b. Thursday 9:00am –12:00pm
 - i. Review patients with staff and team, present cases and be prepared to answer questions! Bring a relevant reference and educate us.
 - ii. Each week either chapter review, journal club, or M&M rounds.
 - iii. 8:00am once a month is the SRP Rounds (Surgery, Radiology, Pathology)

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 the Administrative Assistants (listed above).

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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).

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- 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, anesthesia resident 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 - proceed immediately.

The TTL (trauma team leader) is either the Pediatric Intensivist or the Pediatric 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 technique of the CT scan). Whether you have done the ATLS course or not you will have timely backup from the pediatric surgeon as well as the pediatric surgery fellow. Please assign a pediatric trauma score and Glasgow coma score in your assessment note.