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## PROGRAM PERSONNEL AND CONTACT INFORMATION

### PROGRAM LEADERSHIP

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
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<tbody>
<tr>
<td>Program Director</td>
<td>Stacy McConkey, MD, FAAP</td>
<td>407-303-5908</td>
<td><a href="mailto:Stacy.McConkey.MD@flhosp.org">Stacy.McConkey.MD@flhosp.org</a></td>
</tr>
<tr>
<td>Associate Program Director</td>
<td>Tiffany Tamse, MD</td>
<td>561-543-2252</td>
<td><a href="mailto:Tiffany.Tamse.MD@flhosp.org">Tiffany.Tamse.MD@flhosp.org</a></td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>Simona Milosevska</td>
<td>407-303-2888</td>
<td><a href="mailto:Simona.Milosevska@flhosp.org">Simona.Milosevska@flhosp.org</a></td>
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### PROGRAM FACULTY

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Specialty</th>
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<tbody>
<tr>
<td>Hospitalist</td>
<td>Samantha Carroll, MD</td>
<td></td>
</tr>
<tr>
<td>Pediatric, Focus: Adolescent Medicine</td>
<td>Heather Elizondo Vega, MD</td>
<td></td>
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<tr>
<td>Pediatric, Focus: Community and Acute Care</td>
<td>Anita Moorjani, MD</td>
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<tr>
<td>Pediatric</td>
<td>Catherine Loe, MD</td>
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### ROTATION DIRECTORS

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<thead>
<tr>
<th>Role</th>
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<th>Specialty</th>
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<tbody>
<tr>
<td>Acute Care</td>
<td>Anita Moorjani, MD</td>
<td></td>
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<tr>
<td>Adolescent Medicine</td>
<td>Heather Elizondo Vega, MD</td>
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<tr>
<td>Advocacy</td>
<td>Stacy McConkey, MD</td>
<td></td>
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<tr>
<td>Allergy/Immunology</td>
<td>Steve Rosenberg, MD</td>
<td></td>
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<tr>
<td>Pulmonology</td>
<td>Akinyemi Ajayi, MD</td>
<td></td>
</tr>
<tr>
<td>Pulmonology (In-patient)</td>
<td>Maggie Sifain, MD</td>
<td></td>
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<tr>
<td>Cardiology</td>
<td>Matthew Zussman, MD</td>
<td></td>
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<tr>
<td>Community Pediatrics</td>
<td>Anita Moorjani, MD</td>
<td></td>
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<tr>
<td>Dermatology</td>
<td>Monique Kumar, MD</td>
<td></td>
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<tr>
<td>Developmental/Behavioral</td>
<td>Emily Forrest, MD</td>
<td></td>
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<tr>
<td>Emergency Medicine</td>
<td>Yaron Ivan, MD</td>
<td></td>
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<tr>
<td>Gastroenterology</td>
<td>Lina Hernandez, MD</td>
<td></td>
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<tr>
<td>Gastroenterology</td>
<td>Sangeeta Bhargava, MD</td>
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<tr>
<td>Gastroenterology</td>
<td>Sanjay Khubchandani, MD</td>
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<tr>
<td>Gastroenterology</td>
<td>Sridhar Goli, MD</td>
<td></td>
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<tr>
<td>GEM (Endocrine)</td>
<td>Konda Reddy, MD</td>
<td></td>
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<tr>
<td>GEM (Genetics)</td>
<td>Aditi Dagli, MD</td>
<td></td>
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<tr>
<td>Hospitalist</td>
<td>Samantha Carroll, MD</td>
<td></td>
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<tr>
<td>Hematology/Oncology</td>
<td>Fouad Hajjar, MD</td>
<td></td>
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<tr>
<td>Infectious Disease</td>
<td>Alejandro Jordan-Villegas, MD</td>
<td></td>
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<tr>
<td>Infectious Disease</td>
<td>Federico Laham, MD</td>
<td></td>
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<tr>
<td>Intensive Care, Simulation, Research</td>
<td>Ramin Nazari, MD</td>
<td></td>
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<tr>
<td>Nephrology</td>
<td>Deogracias Pena, MD</td>
<td></td>
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<tr>
<td>Neurology, Epilepsy</td>
<td>Kihyeong Lee, MD</td>
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<tr>
<td>Neurology, Epilepsy</td>
<td>Satish Agadi, MD</td>
<td></td>
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<tr>
<td>Newborn (Family Medicine)</td>
<td>Bob Quigley, MD</td>
<td></td>
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<tr>
<td>Newborn (Family Medicine)</td>
<td>Sabiha Siddiqui, MD</td>
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<tr>
<td>Neonatology</td>
<td>Angel Luciano, MD</td>
<td></td>
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<tr>
<td>Sports Medicine</td>
<td>Katerina Backus, MD</td>
<td></td>
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<tr>
<td>Radiology</td>
<td>Laura Varich, MD</td>
<td></td>
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<tr>
<td>Surgery</td>
<td>Raleigh Thompson, MD</td>
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<tr>
<td>Urology</td>
<td>Michael Keating, MD</td>
<td></td>
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<tr>
<td>Weight and Wellness</td>
<td>Angela Fals, MD</td>
<td></td>
</tr>
</tbody>
</table>
### ADDRESSES/PHONE NUMBERS

**Center for Pediatric & Adolescent Medicine (CPAM)**  
15502 Stoneybrook West Parkway  
Suite 112  
Winter Garden, Florida 34787  
Ph 407-656-0042  
Fax 407-656-0633

**Residency Office**  
2501 North Orange Avenue  
Suite 301  
Orlando, Florida 32804  
Ph 407-303-2888  
Fax 407-303-2869

**Graduate Medical Education**  
2501 North Orange Avenue  
Suite 235, Mailbox 38  
Orlando, Florida 32804  
Ph 407-303-7133  
Fax 407-303-7323

### PROGRAM MANUAL STATEMENT

The training program complies with Accreditation Council for Graduate Medical Education (ACGME) and AdventHealth Graduate Medical Education (GME) policies, procedures and processes that are available on the GME website/manual.

### CURRENT RESIDENTS

**Class of 2019**  
- Jillian Green, MD  
  University of Central Florida, College of Medicine  
- Emy Jean-Marie, MD  
  Windsor University School of Medicine  
- Lyndsey van der Laan, MD  
  St. George’s University School of Medicine  
- Ashley Muszynski, MD  
  University of Toledo  
- Binh Vu, DO  
  William Carey University College of Osteopathic Medicine

**Class of 2020**  
- Fatima Ajmal, MD  
  University of Birmingham COM & DS GBR  
- Heather Cross, MD  
  Florida State University  
- Paola Pare, DO  
  Kansas City University of Medicine and Biosciences  
- Brett Pierce, MD  
  Central Michigan University COM  
- Genevieve Price, MD  
  St. Matthews University SOM  
- Courtney Rozbitsky, MD  
  Tulane University SOM

**Class of 2021**  
- Abigail Adair-Dimmick, MD  
  Florida State University College of Medicine  
- Carlos Carmona, DO  
  AT Still University of Health Sciences-Kirksville  
- Adriana Delgado, DO  
  Edward Via College of Osteopathic Medicine  
- Matthew Goldstein, DO  
  New York Institute of Technology College of Osteopathic Medicine  
- Sara Porter, MD  
  University of Mississippi School of Medicine  
- Rafaela Uwaibi, MD  
  University of Florida College of Medicine

### ALUMNI

**Class of 2018**  
- Wendla Sensing, DO  
  Hospitalist  
  Ohio  
- Sasha Wee, MD  
  Hospitalist Fellow, Medical University of SC  
  South Carolina  
- Prema D souza, MD  
  Urgent Care  
  Missouri  
- Jordan Schneider, MD  
  ICU Fellow, Children’s Hospital of Michigan  
  Michigan  
- Sophie Thibault, MD  
  Pediatrician  
  Florida  
- Kary Vega, MD  
  Pediatrician  
  Texas

**Class of 2017**  
- Jennifer Arble, DO  
  Pediatrician  
  Colorado  
- Shannon Bogan, MD  
  Locums Hospitalist  
  Pennsylvania  
- Marcos Colon, MD  
  Current DB Fellow, Vanderbilt University  
  Tennessee  
- Christian Chaban, MD  
  Pediatrician  
  Florida  
- Hafid Mantilla, MD  
  Hospitalist  
  Idaho  
- Mark Stephens, MD  
  Current Neonatal Fellow, University of Kentucky  
  Kentucky

**Class of 2016**  
- Saif Al Haque, MD  
  Pediatrician  
  Florida  
- Suneeta Brito, MD  
  Pediatrician  
  Florida  
- Catherine Loe, MD  
  Pediatrician  
  Florida
Curriculum

Per ACGME, an educational unit should be a block (four weeks or one month).

### PGY-1
- General Pediatrics Days: 2
- General Pediatrics Nights: 2
- Newborn Nursery: 1
- NICU: 1
- Emergency Medicine: 1
- Developmental Behavior: 1
- Advocacy: 1
- Acute Care: 1
- Neurology: 1
- Elective: 1
- Pediatric Potpourri: 1

### PGY-2
- General Pediatrics Days: 1
- General Pediatrics Nights: 1
- PICU: 1
- NICU: 1
- Emergency Medicine: 1
- Adolescent Medicine: 1
- Community Pediatrics: 1
- Allergy / Pulmonary: 1
- Cardiology: 1
- Acute Care: 1
- Elective: 2

### PGY-3
- General Pediatric Days: 1
- General Pediatric Nights: 1
- PICU: 2
- NICU: 1
- Acute Care: 1
- Genetics, Endocrinology and Metabolism: 1
- Hematology and Oncology: 1
- Emergency Medicine: 1
- Subspecialty: 1
- Elective: 2
- Pediatric Potpourri: 1

Resident can take a total of six electives over three years. Two of those rotations must come from the core list above. The other four are up to you. Choices of electives should be reflective of your plans for a career; you should be able to tell the PD why a rotation will help you in the future. We have an extensive list of possible electives, or you can create your own elective. Subspecialty rotations can be repeated once, but should have revised Goals and Objectives to reflect what the resident would like to learn by taking the rotation again. It will also be possible to take extra rotations in the NICU, PICU or EM without violating requirements—please talk with the PD about how to rewrite the G&O and to set up those rotations. There are a few electives not available in the PGY1 year, such as International Health rotations, and a maximum of three research electives over the three years.

Medical Library

The AdventHealth Medical Library offers comprehensive information resources to medical staff, hospital employees, students, patients, and the community. Journal articles and books can be viewed at: [https://drupal01.floridahospital.org/medicallibrary/](https://drupal01.floridahospital.org/medicallibrary/)

Articles/books can be requested most easily by emailing the library at: [medicallibrary@flhosp.org](mailto:medicallibrary@flhosp.org)

It typically takes 24 hours to obtain an article. If the library must pay for the article, it can take up to 7 days.

Committees

The Residents are required to participate in at least one committee and attend all meetings. If you are unable to make it, please coordinate with another resident to attend in your absence. It is your responsibility to let all the other residents know what was discussed in these meetings (unless it is confidential to the committee members only).

<table>
<thead>
<tr>
<th>AAP Delegates</th>
<th>PGY-1</th>
<th>PGY-2</th>
<th>PGY-3</th>
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<tbody>
<tr>
<td>Sarah Porter</td>
<td>Heather Cross</td>
<td>Jillian Green</td>
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<thead>
<tr>
<th>Education Committee</th>
<th>PGY-1</th>
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<tr>
<td>Rafaela Uwaibi</td>
<td>Paola Pare</td>
<td>Ashley Myszynski</td>
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<tr>
<td>Matthew Goldstein</td>
<td>Courtney Rozbtsky</td>
<td>Lyndsey van der Laan</td>
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<th>PGY-1</th>
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<td>Fatima Ajmal</td>
<td>Lyndsey van der Laan</td>
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<tr>
<td>-</td>
<td>Fatima Ajmal</td>
<td>Binh Vu</td>
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<th>PGY-1</th>
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<tbody>
<tr>
<td>Carlos Carmona</td>
<td>Genevieve McKinley</td>
<td>Ashley Myszynski</td>
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<tr>
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<td>Abby Adair-Dimmick</td>
<td>Paola Pare</td>
<td>Binh Vu</td>
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<tr>
<td></td>
<td></td>
<td>Courtney Rozbtsky</td>
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See GME Manual for most recent policies regarding reimbursement and payment. *It is your responsibility to stay up to date with policies.*

All expense receipts and paperwork must be submitted to Program Coordinator no later than 30 days from date that charge is paid. It is best practice to submit items immediately following payment. Expense report submission to Coordinators after the 30-day deadline may delay processing and submission to Payroll, resulting in missing the 60-day Payroll submission deadline.

Employee must sign the finished expense report before submission to the GME office. Program Coordinators will collect expense reports, review documents for completeness and accuracy, and submit to GME Director for signature and submission to payroll.

Expense reports received by the Payroll Department after 60 days will require Senior Vice President approval, and must be submitted with a letter detailing why the submission deadline was not met. **Reimbursement cannot be guaranteed for late submissions.**

Pediatrics Educational Allowance:
- PGY-1: $500
- PGY-2: $800
- PGY-3: $1300

The following are appropriate use of education allowance funds:
- Academic textbooks and journal subscriptions
- Professional society membership dues
- Educational software, such as U World, Med Study
- Personal digital assistant (PDA) capable devices such as cellphones, etables, and lap tops
- Multiple cell phones, laptops, or tablets will not be approved in the same 24-month period.
- Board review courses and materials
- Medical equipment such as stethoscopes
- Educational courses
- Uniforms
- License verification services

Payment:
- Allow 4-6 weeks, after submission to payroll, for payment.
- Employees will receive payment on their regular AH paycheck/direct deposit. Note that reimbursements will be taxed per applicable Florida and federal laws.
- Residents, Faculty, and Staff are responsible for tracking their own expenses and reimbursements, including review of AdventHealth employee earnings statement for payment.

Department benefits:
- Membership to the AAP - ILP, Pedialink, Pediatrics in Review, PREP & Challenger
- Training license and renewal of TRN
- BLS, PALS, NRP certification
SUPERVISION & PROGRESSIVE RESPONSIBILITY IN ENTRUSTABLE PROFESSIONAL ACTIVITIES POLICY

Supervision
In the clinical learning environment, each patient has an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as approved by each Review Committee) who is ultimately responsible for that patient’s care. This information is available to residents, faculty members, and patients. Residents and faculty members will inform patients of their respective roles in each patient’s care.

The clinical activities of all residents are supervised by teaching staff and/or more advanced house staff members in such a way as to ensure that residents assume progressively increasing responsibility according to each resident’s level of education, ability and experience. The teaching staff determines the level of responsibility accorded to each resident. Schedules for teaching staff and more advanced house staff members are structured to ensure supervision is readily available to those on duty.

The following guidelines have been established to assure the appropriate supervision of house staff:

- **Inpatient Pediatric Service:** All patients admitted to a pediatric inpatient service are assigned an attending general or subspecialty pediatrician. The assignment to this pediatrician is made at the time of admission, regardless of the time of day. The house staff is instructed to notify the attending pediatrician of every admission to the service and make the attending physician aware of the condition of all seriously ill children on the service. Attending pediatricians are notified of the admission of stable patients soon after the residents develop a working diagnosis and treatment plan to encourage the residents’ independent diagnostic and management plans. The timeliness of the notification of the attending depends upon the unit and the urgency of the problem. Daily attending rounds are made by the faculty who remains actively involved in directing patient care. The residents are given progressively increasing responsibility, while continuously maintained under faculty supervision. The first-year resident typically carries several in-patients, a minimum of 5 as suggested by the Pediatric RRC, and the supervising resident typically does not exceed the 30 patients also suggested by the RRC. Residents transition over to this supervisory capacity, with 1 such month in the second year, on the day shift and one month on the night shift, and 2 months in the third year (one during the night and one during the day) on the General Pediatric Inpatient units. There is an attending general pediatrician available 24 hours a day for consultation and is physically present when required. The resident on call for a particular service knows exactly which general pediatrician is on call for that service via the Operator and can contact them at any time via phone.

- **Outpatient Pediatric Service:** Faculty members from the General Pediatrics Division are assigned to staff the pediatric outpatient clinic on a daily basis. Scheduled patients or walk-ins seen in the pediatric clinic are evaluated initially by pediatric residents and then are staffed by the faculty from the General Pediatrics Division. The subspecialty clinics function in the same manner with every patient being seen in consultation with a faculty member. Each resident is assigned a panel of patients that he or she follows in a continuity fashion for well-child care (Continuity Clinic) for one to two half-days a week for their 3 years of training.

- **Pediatric Emergency Medicine Rotations:** Each level of Pediatric resident has a rotation through the Emergency Treatment Center (ETC) at the AdventHealth, The evaluation and treatment of trauma patients in the ETC is directly supervised by the Pediatric Emergency Medicine faculty.

Adequate supervision is in place for all residents who care for patients. Supervision will be exercised through a variety of methods. Some activities require the physical presence of the supervising faculty member. For many aspects of patient care, the supervising physician may be a more advanced resident. Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member or resident physician, either in the institution, or by means of telephonic and/or electronic modalities.

In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback as to the appropriateness of that care.

To ensure oversight of resident supervision and graded authority and responsibility, the program will use the following level classifications of supervision:

- **Direct Supervision** – the supervising physician is physically present with the resident and patient.
- **Indirect Supervision:**
  - With direct supervision immediately available – the supervising physician is physically within the hospital or other site of patient care, and is immediately available to provide Direct 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.
Oversight – The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

**Assignment of Progressive responsibility**

The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident will be assigned by the program director and faculty members in the Clinical Competency Committee.

The program director must evaluate each resident’s abilities based on specific criteria. The Pediatric Milestones, as developed by the APPD, will be the basis of the evaluation system used at AdventHealth Pediatrics Residency program.

**Clinical Responsibilities**

The clinical responsibilities for each resident will be based on PGY-level, patient safety, resident education, severity and complexity of patient illness/condition and available support services.

The program director and the Clinical Competency Committee will have the authority and responsibility to set appropriate clinical responsibilities for each resident.

Residents will be responsible for an appropriate patient load.

Insufficient patient experiences do not meet educational needs; an excessive patient load suggests an inappropriate reliance on residents for service obligations, which may jeopardize the educational experience.

**Teamwork**

Residents will care for patients in an environment that maximizes effective communication.

This will include the opportunity to work as members of effective inter professional teams that are appropriate to the delivery of care in the specialty.

Faculty members functioning as supervising physicians will delegate portions of care to residents, based on the needs of the patient and the skills of the residents.

Senior residents will serve in a supervisory role of junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident.

The Program has set guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty members, such as the transfer of a patient to an intensive care unit, or end-of-life decisions.

Each resident will know the limits of his/her scope of authority, and the circumstances under which he/she is permitted to act with conditional independence. PGY-1 residents will be supervised either directly or indirectly with direct supervision immediately available.

Faculty supervision assignments will be of sufficient duration to assess the knowledge and skills of each resident and delegate to him/her the appropriate level of patient care authority and responsibility.

The Pediatric Residency program will demonstrate that the appropriate level of supervision is in place for all patients cared for by all residents. Every pediatric resident has an attending pediatrician assigned who is responsible to assure the excellence of medical care and to supervise and teach pediatric house staff involved in the care of that patient. Each clinical service is continuously covered by a faculty member who is accessible at any time by phone.

PGY-1 residents are supervised either directly or indirectly with direct supervision immediately available while they acquire basic knowledge and skills specific to the specialty. Activities of PGY-2 residents and above are supervised by faculty as appropriate to the patient situation and resident capability. Supervision does not equate merely to the presence of more senior physicians nor with the absence of independent decision making on the part of residents. These supervision standards encompass the concepts of graded authority, responsibility and conditional independence that are the foundation of delegation of authority to more senior house staff members. Should a resident ever need further assistance or information, they can contact the senior resident or faculty on call.

During pediatric residency training at AdventHealth, residents will be evaluated in a 360-degree manner. Evaluations will take place during every rotation they complete by faculty. We will be utilizing a milestones-based evaluation system with the Dreyfus model electronically on New Innovations system. Residents are also evaluated in the system by their peers (both junior and senior residents), nursing and patients. The outcome of these evaluations will be tracked, and the residents progress will be monitored by the Clinical Competence Committee (CCC) to determine whether the resident will be allowed to progress to the next level of responsibility. *Revised 8/21/17*
Staffing of patients/Admissions

All patients admitted to pediatric units (General pediatrics, PICU or NICU) must be staffed with the attending physician after the patient is evaluated and a plan for care is made.

Attending will notify residents of admission prior to the patient arriving on the floor, junior and senior residents will evaluate the patient, come up with a plan of care and then call the attending physician to review the patient’s history and plan of care. Staffing should be done primarily by the junior resident, with the senior resident performing the role when needed.

Faculty should be notified in the following circumstances:
- Change in patient status- worsening state or transfer to higher level of care
- Death of patient
- Unexpected admission
- Patient leaving unexpectedly or AMA
- Complaints from patients or parents
- Repeated concerns or questions from nursing

Outpatient

ER: All patients must be staffed with faculty

Clinic

All patients must be staffed with faculty prior to the patient leaving. Faculty will repeat selected parts of the history and exam based on the level of the resident and complexity of the patients. Faculty should see all patients in person prior to the patient leaving.

Escalation of concerns

If issues arise during a shift, residents should consider escalating concerns up to supervisors or administration.

For nursing issues: Including failure of nursing to complete tasks, continued disagreement between nursing and physicians, or patient complaints regarding nursing, contact the nursing supervisor for the shift.

For issues regarding physicians or medical care: Contact the faculty physician on call, or for immediate assistance, call the PICU in house physician. If you are unable to reach the in house or faculty physician, contact Chief Resident or Program director.

For issues regarding the hospital: Contact the children’s hospital administrator on call.

Revised 8/21/17
RESIDENT WELLNESS/ FATIGUE MITIGATION POLICY

From ACGME Common Program Requirements Section VI.C. Well-Being:

VI.C.1.a) [This responsibility must include:]
efforts to enhance the meaning that each resident finds in the experience of being a physician, including protecting time with patients, minimizing non-physician obligations, providing administrative support, promoting progressive autonomy and flexibility, and enhancing professional relationships

VI.C.1.b) [This responsibility must include:]
attention to scheduling, work intensity, and work compression that impacts resident well-being

VI.C.1.c) [This responsibility must include:]
evaluating workplace safety data and addressing the safety of residents and faculty members;

VI.C.1.d) [This responsibility must include:]
policies and programs that encourage optimal resident and faculty member well-being; and

VI.C.1.d.(1) Residents must be given the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.

VI.C.1.e) [This responsibility must include:]
attention to resident and faculty member burnout, depression, and substance abuse. The program, in partnership with its Sponsoring Institution, must educate faculty members and residents in identification of the symptoms of burnout, depression, and substance abuse, including means to assist those who experience these conditions. Residents and faculty members must also be educated to recognize those symptoms in themselves and how to seek appropriate care. The program, in partnership with its Sponsoring Institution, must:

VI.C.1.e).(1) [The program, in partnership with its Sponsoring Institution, must:] encourage residents and faculty members to alert the program director or other designated personnel or programs when they are concerned that another resident, fellow, or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence

VI.C.1.e).(2) [The program, in partnership with its Sponsoring Institution, must:] provide access to appropriate tools for self-screening; and,

VI.C.1.e).(3) [The program, in partnership with its Sponsoring Institution, must:] provide access to confidential, affordable mental health assessment, counseling, and treatment, including access to urgent and emergent care 24 hours a day, seven days a week.

VI.C.2.

There are circumstances in which residents may be unable to attend work, including but not limited to fatigue, illness, and family emergencies. Each program must have policies and procedures in place that ensure coverage of patient care in the event that a resident may be unable to perform their patient care responsibilities. These policies must be implemented without fear of negative consequences for the resident who is unable to provide the clinical work

To meet the well-being needs of the residents, the Pediatric Residency will implement and maintain the following processes:

1. Residents will receive didactic and interactive sessions on the following topics:
   a. Burnout- recognition in self and others
   b. Self-Care- mindfulness and personal care
   c. Creation Health- specific to AdventHealth system
   d. Work Life Balance
   e. Life after residency
   f. Leadership

2. Residents will have an initial meeting with Physician Support Services as an introduction to services available to residents during the first quarter of their PGY1 year. Services are free of charge to residents and available 24 hours per day, 7 days per week.
3. Residents will fill out a Pro Qual survey during their PGY1 year, reviewing results with the Physician Support service staff at their annual retreat. Self-Surveys will also be discussed at that time and made available for residents through New Innovations.

4. The Pediatric residency program strives to maintain a reasonable work load for residents on all in and outpatient services. There are caps set on inpatient and outpatient services for numbers of patients rounded on per day, numbers of admission per shift and numbers of patients seen in a half day clinic for all levels of residents with a goal of protecting time with patients, avoiding work compression and keeping the intensity of work appropriate for each individual resident.

5. Resident schedules are created with resident well-being in mind. Our program avoids frequent 24 hour shifts (never more than 1 in 7) and does not require significant at home call. We encourage our residents to complete their documentation work in a timely manner, but will allow them to work on documentation from home, as long as the time is included in the 80-hour week and does not preclude rest.

6. Disney Onboarding: all residents who are new to the program (and all AH employees working in AHFC) are sent to Onboarding training designed by the Disney institute. During orientation, the importance of Family Centered Care, Patient satisfaction, and the concept of On and Off Stage, service recovery and teamwork.

From ACGME Common Program Requirements Section VI.D. Fatigue Mitigation:

VI.D.1.a) [Programs must:] educate all faculty members and residents to recognize the signs of fatigue and sleep deprivation;

VI.D.1.b) [Programs must:] educate all faculty members and residents in alertness management and fatigue mitigation processes; and,

VI.D.1.c) [Programs must:] encourage residents to use fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

VI.D.2. Each program must ensure continuity of patient care, consistent with the program’s policies and procedures referenced in VI.C.2, in the event that a resident may be unable to perform their patient care responsibilities due to excessive fatigue.

VI.D.3. The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home.

VI.E.1. Clinical Responsibilities

The clinical responsibilities for each resident must be based on PGY level, patient safety, resident ability, severity and complexity of patient illness/condition, and available support services.

VI.E.2. Teamwork

Residents must care for patients in an environment that maximizes communication. This must include the opportunity to work as a member of effective interprofessional teams that are appropriate to the delivery of care in the specialty and larger health system.

To meet the Fatigue mitigation needs of the residents, the Pediatric residency will implement and maintain the following processes:

1. Residents and faculty will receive annual education on recognition of fatigue, sleep deprivation, fatigue management, fatigue mitigation and strategic napping.

2. Call rooms are available in a secure location for residents to utilize when needed, and are available 24/7 if the resident is too fatigued to safely drive home.

3. Residents are encouraged to hand over to a senior resident or faculty if they become too fatigued to safely care for patients.

4. AdventHealth Pediatric residency does not routinely utilize 24 hour shifts in our program, and encourage residents to be conscious of how they use their time off from the program.

5. If residents are unable to work due to fatigue there is continuity of care provided by senior residents, faculty or advance practice providers. The residency program also utilizes a backup system for residents overnight if there is an unexpected need or increased demands for patient care. Revised 8/21/17
In the new requirements, the terms “clinical experience and education,” “clinical and educational work,” and “clinical and educational work hours” replace the terms “duty hours,” “duty periods,” and “duty.”

Specific duty hour requirements are as follows:

1. **Maximum Hours of Work Per Week:** The duty hours of any resident must be limited to 80 hours per week (or other applicable limit as specified by the appropriate Residency Review Committee (RRC), when averaged over a 4-week period, inclusive of all in-house call activities and any moonlighting activities. Any time spent at AdventHealth or at another institution for clinical and academic purposes, related to the residency program, both inpatient and outpatient, counts toward the weekly maximum. Additionally, the weekly maximum includes time spent for administrative duties related to patient care, including documentation in the EHR, the transfer of patient care, scheduled academic activities such as conferences, research related to the program, any time spent answering phone calls from patients while on call, and any time the resident spends on-site after being called in to the hospital. Not included in the weekly maximum is time spent outside of AH (or outside another institution related to the program’s academic purposes) for academic preparation, reading, and studying.

2. **Maximum Duty Period Length:**
   - PGY 1, 2 and 3 residents: no schedule exceeds a maximum of 24 hours of continuous duty in the hospital, with no more than 4 additional hours used for any transitional activities (i.e. maintaining continuity of medical and surgical care, transferring patient care, or attending educational sessions).
   - In no event does the PGY 2 or above resident accept a new patient (any patient for whom the resident has not previously provided care) during this 4-hour extension period.
   - Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty, and must have 14 hours off after a 24-hour shift.
   - 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. Residents must appropriately hand over the care of all other patients to the team responsible for their continuing care. (utilize form for Extension of duty hours to document)
   - Any resident exceeding maximum duty period lengths will document their justification in the institution’s resident management system (i.e. New Innovations).
   - The Pediatric residency program has minimized the number of handoffs, and has created an EMR hand off template to ensure the best possible patient care.

3. **Maximum Frequency of Over-Night In-House On-Call Duties:** In-house call must not be scheduled more frequently than every third night when averaged over a 4-week period

4. **Frequency of In-House Night Float:** Residents must not be scheduled for more than six consecutive nights of night float or as specified further by the program’s RRC, as applicable.

5. **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). This day off does not include home call nor is the resident required to carry a pager or phone. A day is defined as 24 consecutive hours.

6. **Minimum Time Off Between Scheduled Duty Periods:** Based on the level of the resident, there are identified levels of time off between scheduled duty periods.
   - PGY 1 residents – should have 8 hours free of duty between scheduled duty periods, and must have 14 hours free of duty after a 24-hour shift.
   - Intermediate level residents (as defined by the program’s RRC) – should have 8 hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 continuous hours of in-house duty.
   - Final year residents (as defined by the program’s RRC) – can participate in transition to practice activities when they are preparing to care for patients over irregular or extended periods. It is still desirable that these residents have 8 hours free of duty between scheduled duty periods, but there may be circumstances where residents must stay on duty to care for their patients or return to the hospital after shorter intervals.
   - The Program Director monitors time off between scheduled duty periods.

7. **Home Call:** Residents returning to the hospital from home call must count their time spent in the hospital towards the 80-hour maximum weekly hour limit. The frequency of home call is not subject to the every-third-night limitation but must satisfy the requirement for 1 day in 7 free of duty, when averaged over 4 weeks.
   - Home call activities must not be so frequent as to preclude rest and reasonable personal time for each resident.
   - Residents are permitted to return to the hospital while on 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.”

8. **Moonlighting:** is only permitted during the PGY3 year, with permission from the Program Director, and the DIO. Residents must be shown to have excellent progress towards the goals of the residency program with ITE scores above the national
average, good evaluations, no performance improvement plans, and be in good standing in all areas of the ACGME competencies. The resident desiring to moonlight must have their permanent Florida License, proof of adequate malpractice insurance, and complete all paperwork required for Moonlighting activity by the GME office. All hours worked will be recorded in New Innovations, and must comply with the 80 hour work week rules. Moonlighting hours will be reviewed monthly by the Program Director. If a resident shows signs of excessive fatigue or decline in performance while moonlighting, permission will be rescinded.

Transitions in Care
It is essential for patient safety and resident education that effective transitions in care occur. Residents will be allowed to remain on-site in order to accomplish these tasks; however, this period of time will be no longer than an additional four hours. Residents will not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.

Care of Patients beyond work hours
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 humanitarian attention to the needs of a patient or family.

Under those circumstances, the resident must:
1. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
2. Document the reasons (using the form for Duty Hours Extension form) for remaining to care for the patient in question and submit that documentation in every circumstance to the program director.
3. The program director will review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

***Circumstances of return-to-hospital activities with fewer than eight hours away from the hospital by residents in their final years of education must be monitored by the program director. ***

There are no circumstances under which residents may stay on duty without eight hours off.

The Pediatric Residency program meets the requirements of this policy as well as any applicable standard set by the ACGME, the appropriate RRC, or other accrediting or certifying body. This policy is distributed by the GME Office to all GME contract holders. The Pediatric Residency also distributes this policy at the time of interview and orientation. The Pediatric Residency Program monitors resident Clinical and Educational Work Hours with a frequency sufficient to ensure compliance with this policy and the ACGME/RRC/other accrediting or certifying body’s rules. Revised 8/21/17

**STRATEGIC NAPPING POLICY**

If you are working a 24-hour shift, you may be able to find some time to lay down. Trying to nap should never affect patient care.

You are allowed to lay down under the following conditions and stipulations:

- You are never allowed to sleep or lay down in places visible to patients or their families. This includes, but is not limited to, lobbies, desks on the floor, patient/treatment rooms with the doors/windows open.
- You must tell the charge nurse, HUC, and other residents that you are going to lay down. You must tell them explicitly which phone you have and which physical location you will be in (e.g., Family Med DO call room, empty room 7312, 6S treatment room, etc.). If you are not taking one of the service phones, you must either give your cell phone number to the HUC or take a Spectralink that you can be reached on.
- You must answer calls and wireless texts in a reasonable amount of time (<5 minutes). This means you must ensure that you get adequate phone reception wherever you are going to be laying down.
- If a nurse/RT/resident requests that you examine a patient or speak to a parent, you are required to do so in a reasonable amount of time, just as if you were working any regular 12-hour shift.
- There should be no delay in seeing new admissions because you are laying down
- There should be no delay in staffing patients with the senior resident because the senior resident is laying down
- There should be no delay in the senior resident seeing new patients after they have staffed with the intern
- Annoyed or disparaging attitudes towards HUCs, nursing staff, or other residents for waking you up will not be tolerated. All members of the medical team should feel and know that you are fully accessible at all times.

Being able to sleep during a shift is a privilege, not a right. If you abuse this privilege or do not follow the conditions as described above, your privilege to leave the floor and lay down will be revoked. If you are fatigued to the point where you are unable to provide safe and effective patient care, please see the section on “Strategic Napping” for instructions on how to handle that situation.
From ACGME Common Program Requirements Section VI.A. Patient Safety:

VI.A.1. Patient Safety

All physicians share responsibility for promoting patient safety and enhancing quality of patient care. Graduate medical education must prepare residents to provide the highest level of clinical care with continuous focus on the safety, individual needs, and humanity of their patients. It is the right of each patient to be cared for by residents who are appropriately supervised; possess the requisite knowledge, skills, and abilities; understand the limits of their knowledge and experience; and seek assistance as required to provide optimal patient care.

Residents must demonstrate the ability to analyze the care they provide, understand their roles within health care teams, and play an active role in system improvement processes. Graduating residents will apply these skills to critique their future unsupervised practice and effect quality improvement measures. It is necessary for residents and faculty members to consistently work in a well-coordinated manner with other health care professionals to achieve organizational patient safety goals.

VI.A.1.a) Patient Safety

VI.A.1.a).(1) - Culture of Safety

A culture of safety requires continuous identification of vulnerabilities and a willingness to transparently deal with them. An effective organization has formal mechanisms to assess the knowledge, skills, and attitudes of its personnel toward safety in order to identify areas for improvement.

VI.A.1.a).(1).(a) The program, its faculty, residents, and fellows must actively participate in patient safety systems and contribute to a culture of safety. (Core)

VI.A.1.a).(1).(b) The program must have a structure that promotes safe, interprofessional, team-based care.

VI.A.1.a).(2) - Education on Patient Safety

Programs must provide formal educational activities that promote patient safety-related goals, tools, and techniques. Optimal patient safety occurs in the setting of a coordinated interprofessional learning and working environment.

VI.A.1.a).(3) - Patient Safety Events

Reporting, investigation, and follow-up of adverse events, near misses, and unsafe conditions are pivotal mechanisms for improving patient safety, and are essential for the success of any patient safety program. Feedback and experiential learning are essential to developing true competence in the ability to identify causes and institute sustainable systems-based changes to ameliorate patient safety vulnerabilities.

VI.A.1.a).(3).(a) Residents, fellows, faculty members, and other clinical staff members must:

VI.A.1.a).(3).(a).(i) know their responsibilities in reporting patient safety events at the clinical site; VI.A.1.a).(3).(a).(ii) know how to report patient safety events, including near misses, at the clinical site; and,

VI.A.1.a).(3).(a).(iii) be provided with summary information of their institution’s patient safety reports.

VI.A.1.a).(3).(b) Residents must participate as team members in real and/or simulated interprofessional clinical patient safety activities, such as root cause analyses or other activities that include analysis, as well as formulation and implementation of actions.

VI.A.1.a).(4) Resident Education and Experience in Disclosure of Adverse Events

Patient-centered care requires patients, and when appropriate families, to be apprised of clinical situations that affect them, including adverse events. This is an important skill for faculty physicians to model, and for residents to develop and apply.

VI.A.1.a).(4).(a) All residents must receive training in how to disclose adverse events to patients and families.

VI.A.1.a).(4).(b) Residents should have the opportunity to participate in the disclosure of patient safety events, real or simulated.

Based on these recommendations from the ACGME, the Pediatric Residency program will provide the following education and experiences via real life or simulated scenarios for the residents:

Education:

1. Residents will receive didactic education about AdventHealth, and specifically AdventHealth for Children’s safety priorities.
2. residents will receive education on how to file a Risk Master report for issues involving patient, staff or hospital safety and near miss reports.
a. Residents will be expected to demonstrate the ability to file a report for a faculty member on a test patient
b. Residents will be expected to file at least one Risk Master report per year per resident. Numbers of risk master reports filed will be followed and reported to residents

3. Residents will receive education regarding the monthly reporting format and it’s interpretation from the Patient Safety representative from AdventHealth for Children (AHFC)
   a. They will then receive monthly updates at House Staff lunch via email or in the minutes of the meeting, which are available on the H drive
   b. Residents will choose a safety project to champion- either one that currently exists, or one of their choosing with the support of the Patient Safety and Quality Committee for AHFC
   c. Chief residents will be the sitting member of the PSQC and will bring reports on progress of the safety project and the meeting proceeds back to the residents at HSL

4. Residents will receive education on how to deliver news of an adverse event or error via didactic teaching, and practice skills gained in a simulated patient scenario during their simulation week activities.

5. Residents will participate in a real or Simulated Root Cause Analysis with an interpersonal team once per year during their Simulation week activities.

6. Residents will all present a Morbidity/Mortality and Improvement conference during their residency.

Quality Improvement / Patient Care Improvement

From ACGME Common Program Requirements Section VI.A.1b: Quality Improvement
   VI.A.1.b).(1).(a)
   Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.
   VI.A.1.b).(2).(a)
   Residents and faculty members must receive data on quality metrics and benchmarks related to their patient populations.
   VI.A.1.b).(3).(a)
   Residents must have the opportunity to participate in interprofessional quality improvement activities.
   VI.A.1.b).(3).(a).(i)
   This should include activities aimed at reducing health care disparities.

To meet the QI requirements, the Pediatric residency will implement and maintain the following processes:
1. Residents will receive education regarding Quality Improvement, PDSA /DMAIC principals and Healthcare disparities via didactic lectures annually.
2. Residents will all participate in interdisciplinary QI projects within the AHFC inpatient or CPAM outpatient setting annually. Projects will have a faculty mentor, follow the PDSA principals and will be reported on annually to the PSQC and via poster or oral presentation to the GME annual research and QI day
3. Chief residents will attend the PSQC meetings and bring back monthly reports to the residents at House Staff Lunch regarding AHFC Quality initiatives.
4. Residents will present their QI projects that are based at AHFC at the PSQC meeting.
5. Residents will participate in QI / LEAN /six sigma training and daily huddle boards at Center for Pediatrics and Adolescent Medicine for clinic designated projects.
6. Residents will work to include Healthcare Disparity Issues for our patient population in resident driven QI projects.
7. Residents will receive feedback on their quality indicators for their designated patient populations in clinic via Athena dashboards and through self-improvement studies completed biannually for their Continuity Clinic population.

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Admissions
Pediatric residents are not allowed to accept or decline patients from outside facilities or the Emergency Room. All decisions regarding appropriateness of admissions are made by faculty only. If a patient is admitted, and is stable, complete the initial evaluation of the patient prior to calling the Attending Physician. If the patient is not stable, notify the attending physician immediately for further instruction and work to stabilize the patient medically.

Transfers
Patients admitted to the Pediatric service cannot be transferred out without first discussing the transfer with the attending staff. It is the Pediatrics resident responsibility to write orders and a transfer note summarizing the PICU or floor stay and plans on all such patients. It is often necessary for transfers from the PICU to occur early in the day to open up beds for admissions. If you anticipate your patient being transferred it may be time saving to work on orders and a transfer note prior to rounds, as long as it is understood that the patient cannot leave until cleared by the attending. Additionally, the accepting resident and attending must be notified prior to the transfer. For patients admitted primarily to a surgical service they may transfer patients to the floor on their service prior to the patient being seen that day by the Pediatrics staff. If you have concerns about the appropriateness of such a transfer, please alert the attending staff prior to the patient leaving.

Consultations
The decision to consult other services is made through discussions with the attending staff. All requests for consults should be telephoned by you to the resident or staff physician on the consulting service. This should be done as early in the day as possible. Please let them know the reason you are requesting their help, and whether the request is urgent or routine. A consultation order must be placed in the EMR with pertinent patient information, clearly stating what question you would like answered by the consultant.

Discharges
On rare occasions, a patient is discharged to home from the PICU, but it will occur typically from the floor. PICU discharges occur with some complex patients who are best known by the PICU team or frequently with kids admitted with ingestion who have no psychiatric issues or fracture care. If Pediatrics was the admitting service, then it is the resident responsibility to write the discharge orders and instructions, and to complete a discharge summary within 24 hours of the discharge. If a surgical service has admitted and is discharging the patient, it is their responsibility to complete the discharge. Please be sure the attending staff is aware of all such discharges to facilitate the appropriate assignment of the discharging service for documentation purposes. On the floors, the pediatrics staff must see the patient prior to discharge and approve the plan. Do Not allow patients to leave prior to being seen by the staff.

Deaths
The attending staff must be notified of any death or any event requiring cardiopulmonary resuscitation. The primary care attending and all consulting physicians should also be notified. While some deaths are unanticipated, many are anticipated and there are often multiple conversations with the family in anticipation of the death of their child. We recognize that this may be your first experience with the death of a patient. Learning how to approach families in this situation is a skill that can be difficult to master. While these discussions will typically be led by the attending staff, we encourage you to be present. Social work staff should be notified of all impending and actual deaths in the unit as well. Information regarding organ donation is available and you are strongly encouraged to read this material early in your rotation.

Following the death of a patient, the mortician is notified, typically by the unit secretary. The mortician will facilitate all the necessary paper work. You may be asked by the mortician if the family has been approached about autopsy. It is unlikely that this responsibility will fall to you, and all questions should be referred to the attending.

It is the Pediatrics resident responsibility to complete a discharge summary (discharge summary of a deceased patient template) within 48 hours of death. Please route the completed summary to the appropriate attending staff.

Procedures
Invasive procedures are not uncommon in the PICU, and do occur on the floor as well. We will try to allow everyone the opportunity to perform procedures. All invasive procedures must be supervised by the attending. A procedure note is to be done in the EMR immediately following the completion of the procedure. The attending staff must be listed as the ‘final reviewer’ on all procedure notes. Informed consent should be obtained whenever possible, but is not necessary if the family is not yet present and the procedure is indicated in the management of the patient. Procedures to be documented include
intubation, arterial catheterization, central venous catheterization, lumbar puncture, thoracentesis, pericardiocentesis, Swan-Ganz catheterization, conscious sedation, and intraosseous access.

A special note regarding intubations. Unfortunately, not all intubations are planned! If an emergent intubation is necessary and the attending staff is not present, RT and attending staff MUST be notified. You must be able to concisely and clearly relay the needed information about the patient for to proceed safely with the intubation. While awaiting their arrival you should be managing the airway, and gathering the supplies needed for intubation. The medications to be used for intubation should be discussed with the attending. If the patient has been stabilized with bag-valve-mask ventilation, you may request that anesthesia supervise your attempt at intubation. One last note is in regard to extubations. Unfortunately, not all extubations are planned as well!! But for those that are planned (ideally all extubations!) the attending staff MUST be present! If an unplanned extubation does occur, the attending should be notified immediately of the event.

Administration of blood products
Transfusion of blood products requires informed consent whenever possible. This is particularly important for first-time exposure to blood products. Please document specific consent to transfuse. If you feel transfusion of blood products is indicated for a patient on a surgery service, please discuss indications for transfusion with that service prior to the administration of blood products.

Examples of things to run by senior residents or faculty (consider writing an event note):
- Changes in oxygen requirement
- Increased respiratory effort
- Labs that are significantly different than expected
- Parents concerns about plan or major questions or worries about their child
- Nursing disagreements
- Issues with other services
- Admissions that are coming in planned or not
- Poor tolerance of feeding, or stopping feeds
- Temp spikes
- Transfusions
- Change in antibiotic choice or addition of meds other than simple drugs like Tylenol
- Fluid Boluses

Never hesitate to notify faculty or senior residents of any condition, particularly if you are not comfortable with management, or are being questioned about management by other clinical staff such as Respiratory therapy or nursing.

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Transitions of Patient care are a critical aspect of Medicine and significant attention should be paid to its performance. Due to the advent of ACGME work hour’s rules, there are more frequent transitions of care than previously utilized. At AdventHealth for Children, we have designed the work shifts to eliminate excessive handoffs and create a safe and efficient process for the residents to exchange information at shift change.

**Inpatient General Pediatrics**

Resident shifts are 12-24 hours in length with a minimum of 30 minutes of overlap to allow for adequate handoff. Shift length is limited to 12 or 24 hours to allow enough time to handoff patients and not violate work hours rules. Residents are trained to utilize both a written and verbal handoff, in a quiet environment with minimal interruptions. Both supervising and junior residents attend the same handoff, as do medical students participating in sub interns and the Hospitalist faculty.

AHFC pediatric residents use the IPASS handoff system designed by Boston Children’s Hospital. Cerner, which is the inpatient EMR has been programmed to create the written portion of the handoff, which consists of patient identifiers, room numbers, medications, allergies, weight, diagnosis and various labs which are the most recent. It allows room for residents to take notes, and create "to do lists". For patients on the resident teaching service, Patients are presented by the junior level residents or supervising residents if the junior level resident is not available. The residents present the history of the patient, current issues, lists of concerns or things to follow up, and a series of “if this then that” scenarios, followed by time for questions from the receiving team (consisting of the junior residents and supervising residents) who are on the Night shift. Day shift residents then update the team on pending admissions and patients that have not yet been seen.

The night team then repeats the process in the morning to the day team, including those patients who might be ready for discharge that morning, those who were admitted overnight on the resident teaching team and the hospitalist team and a listing of admissions that are pending or have not yet been seen. Hand off occurs at 0630 and 1830. Residents stop doing complete admissions at 0600 and 1800 to allow for time to prepare for handoff. Faculty or supervising residents will quickly evaluate patients that come in during that time for urgent needs, and the complete basic orders for admission.

Supervising night residents receive handoff on patients for Patients on 6S, 6T, and 5 T, supervising night residents relieve handoff on patients from the night shift hospitalist faculty prior to their leaving for the night, and will give handoff verbally at 0700 to report any acute changes between 2400 and 0700.

For patients admitted from the AHFC and outside ETCs, residents will receive a brief handoff from the general pediatric Hospitalist faculty, who have received handoff from ETC physicians. Residents will then see the patient upon arrival, and call the Hospitalist faculty to staff the patient and review the plan of care. Transfers from the PICU to the floor will be preceded by a call from the Hospitalist or ICU faculty to handoff patient care, and any urgent transfers from the floors to the PICU will be preceded by a verbal handoff from the resident, and notification of the Hospitalist faculty.

**NICU handoff**

NICU handoff involves residents, nurse practitioners and NICU faculty two times per day at 7:00am and 4:00pm. Cerner generates a NICU specific handoff with similar information to the handoff used on the general pediatrics inpatient unit. Verbal handoff is used in addition to the written handoff. At 7am the night nurse practitioners give verbal handoff to the faculty, residents and other nurse practitioners on their respective patients. They give them back the NICU handoff sheet that was printed from the night prior with notes written from the events of the night. The nurse practitioners will also write event notes in Cerner on the babies to be referenced on major events. Faculty will also do a separate faculty to faculty sign out at this time. At 4pm the residents and day nurse practitioners sign out to the night nurse practitioner with a newly printed NICU handoff sheet for each of their patients and a list of things to follow up. Faculty will also do a separate faculty to faculty sign out at this time. Residents will remain in the NICU until 5 pm for procedures and delivery attendance.

**PICU handoff**
PICU handoff involves residents and nurse practitioners and occurs at 2 times per day. The night PICU resident signs out the patients to the day resident and nurse practitioners verbally and using the printed pediatric provider handoff. The day resident will stop seeing new admits at 6:00 to prepare for sign out but will triage the patient and make sure baseline admission orders are entered for the patient. The day resident signs out to the night resident verbally and using the pediatric provider handoff at 6:30 pm for all of their patients. Again they will be using the I-PASS system as above. They will also hand off the information about new admissions that are pending. For patients admitted from the AHFC and outside ETCs, residents will receive a brief handoff from the PICU faculty, who have received handoff from ETC physicians. Residents will then see the patient upon arrival, and call the PICU faculty to staff the patient and review the plan of care. Any urgent transfers from the floors to the PICU will be preceded by a verbal handoff from the resident, and notification of the Hospitalist faculty.

**Newborn**

Newborn sign out occurs twice daily at 6:30-7am and 5:30-6pm between the day pediatric and family medicine newborn interns and the family medicine OB night resident. Hand off is given verbally and using a Patient list from Cerner. The newborn phone is also handed off at this time. The night resident will answer the pager and enter baseline admission orders for the patients and will sign out the H&P to the day residents to complete.

Evaluations of handoff are completed by inpatient faculty using the handoff evaluation form for all residents in their PGY 1 year, immediate feedback is provided by faculty who are attending handoffs.

If a resident is fatigued during a shift, and unable to safely care for patients, they must alert their senior resident or faculty and give a handoff of current patient load, and following a strategic nap, receive updated handoff from faculty or senior resident upon return.

*Revised 8.21.17*
The Clinical Competency Committee (CCC) for AdventHealth for Children’s Pediatric Residency program will have the following tasks:

1. Review all resident evaluations semi annually
2. Prepare and assure the reporting of Milestones evaluations of each resident semi annually to ACGME
3. Advise the program director regarding resident progress, including promotion, remediation and dismissal.
4. The Program Director will appoint the committee

The CCC membership will consist of the following individuals:

1. The Associate Program Director will Chair the Committee, ensuring that the evaluation of the residents is free of bias.
2. The Resident Liaison: only if the Resident Liaison is not a resident themselves
3. Interested members of the core faculty or teaching faculty with extensive contact with the residents
4. Other health professionals (nursing or advanced practitioners) with extensive contact with the residents

Meetings will be held twice a year: December and June

During meetings:

1. All residents’ progress will be evaluated, via a summary of rotation evaluations, milestone achievements on evaluations, ILP goals progress, professionalism expectations, ITE scores, and progress on any Performance Improvement Plan that is in place.
2. The CCC will review the average scores for milestones that the residents have received over the past 6 months on their rotation evaluations, and these will be added to the ADS system by the Program director and coordinator
3. If there are any concerns requiring remediation for residents, failure to progress in the recorded milestones, or disciplinary concerns, including dismissal from the program, these issues will be discussed amongst the group at CCC
4. A Performance Improvement Plan will then be devised by the program director or appointee (such as the resident mentor) and subsequently reviewed and approved by the CCC after the meeting
5. PIP progress will be reviewed at each CCC meeting, and failure to fulfill the PIP may result in probation, remediation of the resident, which will be reported to the ABP, or dismissal from the program
6. Each meeting’s minutes will be documented, and the comments specific about each resident will be added to their NI portfolio, which is summarized two times per year and sent to the resident for review and feedback purposes.
7. During the December meeting, all PGY3’s will be assessed for possible readiness to graduate, and sit for the boards, PGY2’s on their progress as a supervising resident, PGY1’s on their performance in the program thus far. In the June meeting, the CCC will decide on whether the PGY3’s will be graduated, the PGY2’s performance and readiness to lead teams, as well as the PGY2’s ability to supervise residents while on night shift.

Performance Improvement Plan:

- If a resident has been judged deficient in any milestone area by any faculty member, the clinical competency committee, or the Program Director (PD) a Performance Improvement Plan (PIP) will be instituted.

- After a complaint or concern is reported the PD, or mentor of the resident will decide which of the milestones best fits the reported area of concern.

Reviewed SM 8/23/17
Members:
Faculty involved in resident education, or those with an interest in GME. AH Children's Hospital administration, GME faculty, Program Director (PD), Associate Program Director (APD), Residency Coordinator, Chief Resident, 2 Representatives from each class of Residents.

Meeting Frequency: Biannually, or more frequently as needed

Purpose of the Committee: Advise the Program Director on the direction of the educational program for residents in Pediatrics.

- Planning, developing, implementing, and evaluating educational activities of the program.
- Review and make recommendations for the revision of competency-based curriculum goals and objectives.
- Address areas of non-compliance with ACGME standards, and review program annually using evaluations of faculty, residents, and others.
- Reviewing the program annually using evaluations of the faculty, residents and others.
- Assist the program director in setting annual goals, and review of progress on the goals set in the past year.

The PEC must document a formal, systematic evaluation of the program curriculum annually, and the program director will use that to render a written annual program evaluation (APE) which will be submitted to AH GME in September.

The annual program evaluation will be based on all of the following information:

- Resident performance
- Faculty development
- Graduates performance, including performance on ABP certificate examinations
- Annual GME program evaluations from residents and faculty
- ACGME program survey results from residents and faculty
- ITE scores for current residents
- Review of the curriculum, goals and objectives, rotation content
- Review of resident and faculty QI projects, and Scholarly productivity
- Review of faculty and rotation evaluation summaries
- Annual review of policies and procedures in the residency program

Fall Session
- Citation Review (if applicable)
- Recruitment Review
- Program Stability
- Review of Goals and Objectives for rotations
- Didactic Curriculum
- ITE scores
- Boards Pass (Grad performance)
- Resident Case Logs

Spring Session
- Faculty / Resident Evaluations – Program & ACGME
- ACGME Program Requirements
- Policy Review
- Rotation Evaluations
- Duty Hour Violations
- Scholarly Activity / Products
- QI Projects

Meeting Minutes:
Attendance will be documented, and meeting minutes will be kept by the Program Coordinator.
Residents will provide their own cell phones, which should have adequate service anywhere inside the hospital. The hospital will provide a phone stipend each month. If residents do not want to use their personal phone number for hospital work, they can consider alternative phone numbers (Google numbers), or a separate phone. During work hours or while a resident is on a shift, you must have your phone with you, and answer it promptly. Text messages from other care providers should be answered similarly.

**Expectations of residents in timeliness of communication and patient care:**

- Assure that all newly admitted or transferred patients undergo initial evaluation within one hour of admission or transfer.
- Assure that all new patient orders are entered within one hour of admission or transfer.
- Staff all new admissions and transfers with attending hospitalist within two hours of admission.
- Complete patient record documentation in a timely fashion utilizing established documentation templates.
- All patient admit notes and patient progress notes must be completed prior to the end of resident shift.
- All discharge notes must be completed by the end of the resident shift – no later than 24 hours of discharge.
- Answer pages/texts promptly.
- Emergent and urgent pages are answered immediately. These texts/pages should be identified by following the message with 911
- Pages from attending physician are answered within 15 minutes.
- Non-urgent pages/ texts are answered within 30 minutes
- Admissions that arrive on the floor at 0600 or 1800: ensure that patient is stable, greet family and put Starter* orders in computer, the next resident or physician extender will complete the work up- these patients will be checked out to the next provider
- *Starter orders: definition: Orders to get nursing started in the admission process: may be written prior to staffing with the faculty. Includes, admit orders, vital signs, diet orders, pain management, condition, activity, oxygen requirements, IV fluid orders.

**Considerations:** There have been delays noted in the time texts or calls are sent and when they are received by the phone- there are dead spaces to phones in our hospital. If you are uncertain as to whether the resident received a text, please confirm with a call.

**Hospital phones:**

- iPhones are used for the following services:
  - Inpatient senior- handed off between residents serving as senior residents
  - Inpatient junior- held by resident who is in house all day, or alternated between residents at night
  - These two phones should be held by a resident 24 hours/day
  - NICU phone: held by resident able to attend deliveries, or performing procedures, Spectra Link phone will be held by the second resident when there are two residents on service.
  - PICU phone: held by resident on service in the PICU. Is this being used?
  - Mommy call phone: held by the senior resident from 5pm- 8 am Mon-Friday, all day Saturday and Sunday and Holidays when clinic is closed. The senior resident is responsible for forwarded mommy calls from CCK and CPAM. Residents can call the office phone number to transfer calls to one of the other phones if needed. See SOP for Mommy Calls/CCK calls from CPAM for details
  - Care of phones: residents are responsible for keeping the phones charged, utilizing the extra battery packs or plugging the phones in when checking out.
  - If there are problems with the phones, please contact the program coordinator or MIS

**Email**

The residency program will only use AdventHealth email addresses. You are required to check your e-mail daily and answer any requests. It is recommended that you utilize outlook calendars to include your call schedule from NI (Please contact residency coordinator for more information.). Email can be securely obtained on cell phones. Do not include HIPPA sensitive information in the content portions of emails or texts.

If you have had e-mail via another network provider (i.e. gmail, hotmail, AOL, Yahoo etc) you may keep this as your personal email but all patient or program related correspondence will be managed by AdventHealth email system. You are expected to check your email regularly. The format of your new email address will be as follows:
For example: john.doe.md@flhosp.org is the alias which is created by MIS and it is often your formal first name.last name.md.

If you have any questions regarding this issue please call: AIT Help Desk at 407-303-8000

Staff are reminded that certain uses of electronic mail are forbidden, including:
1. Sending of harassing, threatening, or obscene messages, jokes or materials.
2. Distribution of chain letters or similar solicitations.
3. Participation in non-business-related list servers such as "Laugh of the Day" or "Joke of the Day" services.
4. If patient information is included in the email, it should not be in the subject line.
5. You are expected to check your email daily to ensure timely receipt of important information from the Residency Program.

Violations of this policy will be investigated and may result in disciplinary action. Electronic mail can be an important productivity tool, and staff are encouraged to use it in any way which achieves that goal. Inappropriate use consumes computer resources needed for legitimate hospital functions. Please use the system responsibly.

Internet
- AdventHealth has very specific policies regarding use of Internet during work hours on hospital computers. Your internet history is monitored by your sign-on and is policed. Please be sensitive to those around you and do not leave sensitive internet sites (political or personal) up on computers in work areas.
- Do not utilize AH email to forward insensitive material or “Joke of the day” emails.
- Exercise caution on social networking sites: never mention patients, even those without identifiers, or patient care situations that may be identified by patients or family members. Medical careers have been ended by posting on social networks due to HIPPA violations. It is better to not post than lose your career!

EMR
- You are responsible for checking your Cerner and epic in-box daily. Take responsibility for follow up of labs, X-ray and culture results for your patients. There are now multiple "culture books" in which you can check out a lab to your co-workers if you are not going to be available to check it yourself, and your inboxes can be redirected to co-workers if you are going to be gone.
- Also remember to check for phone calls and patient messages in Athena- you are responsible for managing anything that comes to your inbox for your patients. You should be checking and responding to anything in your Athena box within 48 hours, and you are expected to check your inbox on Monday, Wednesday and Friday each week. If you are on vacation, you must arrange for a fellow resident to assume care for your inbox. Please document who will be watching your box while you are on vacation or out of town on the sign-up sheet at CPAM.

Clinic folders at CPAM:
- Nursing staff will leave paperwork that needs to be completed on your patients in a file with your name on it. It is placed on the counter near the back door- you should check it weekly when you come to clinic.

CONFERENCE POLICY

The Pediatric Residency program at AdventHealth for Children will use a variety of modalities for education of the residents and rotating off service residents.

The Educational Conference Curriculum in Pediatrics will contain the following:
1. Didactic lecture series: lectures will be utilized for topics not amenable for case based conferences or discussion. These will be given by faculty from the Children’s Hospital and invited lecturers.
2. Morning Report: cases admitted to the hospital will be presented by residents and medical students, with discussion revolving around differential diagnosis and management. Faculty who are on service will be asked to attend for their cases and other faculty invited for discussion of cases. Residents assigned to Nights, PICU will have times assigned by the chief residents.
3. Case based conferences: Residents will present cases or topics from a variety of rotations, including Advocacy, Continuity Clinic, Adolescent Medicine, Acute Care
4. **Journal Club**: occurring every other month, residents will be expected to present a recent article for review with their colleagues and a selected faculty member for the quality of the article and application to daily practice.

5. **Morbidity and Mortality conference**: each resident will be required to present a Morbidity and Mortality conference utilizing the ACGME’s 6 competencies. During the presentation, they will present what went well within and what could be improved upon, with a review of the literature surrounding the case, which will include suggestions for improvements. To be attended by faculty, residents, and all AHFC staff.

6. **Resident Wellness Series**: monthly conference series which will include topics such as ethical case discussion, debriefings of recent traumatic or difficult patient situations, the impaired physician, death and dying, personal/professional balance, and every other month Schwartz rounds.

7. **Grand Rounds**: bi-weekly conference with presentations to be chosen by different departments, updates on new research, invited presentations, and topics of interest.

In addition, the residents will be assigned question banks (such as the AAP’s PREP series), and review articles chosen by various subspecialty rotations to review while on that specific rotation. Supplementary online education modules will be developed by faculty or assigned for use out of online curriculum such as the Johns Hopkins online curriculum for Continuity Clinics or the Challenger series. Residents on night shift rotations will have an online series of modules to utilize during their shift based on the APPD’s night shift curriculum.

They will be released from duties while on inpatient and outpatient duties, with patient care duties covered by the attending physicians to attend morning and afternoon conferences. They will not be required to attend while on night shift rotations (violates ACGME work hours rules), on vacation, on leave or when they are post call or at certain offsite rotations. Attendance will be taken at each conference and recorded in the New Innovations data base. It is important that residents remember to sign in. If you are at Winter Garden, please ensure that someone sign you in on the list.

**Residents will be required to attend conferences while they are onsite at the AdventHealth Campus for at least 70% of the total number of conferences they are eligible for considering vacation, and rotations where they are excused. You will be marked tardy at 12:35pm** (every 3 tardy conferences per block will be counted as a missed lecture).

**Excused from AM conferences when on these rotations:**
- Community Pediatrics (while you are at community sites only) *
- Adolescent Medicine (while you are at community sites only) *
- Emergency Medicine (unless working night shift) *
- Newborn
- NICU Day
- PICU

**Excused from PM conferences when on these rotations:**
- Advocacy (while you are at KidsHouse only) *
- Community Pediatrics (while you are at community sites only) *
- PICU Nights
- Inpatient Nights
- Allergy (two weeks of rotation only) *
- GEM (when not inpatient rounding) *
- Emergency Medicine (unless working midday shift) *

*If you can’t attend these conferences, please send an email to the Chief Residents stating which conference you will miss and why. The request to be excused can be grouped into a weekly email. Otherwise, if you can attend conference and will not violate work hours rules, please attend all lectures to reach 70% compliance.

**If a resident is on an away/offsite rotation and attends a conference at that site then they must show proof of the conference attendance to count towards their 70% attendance.

This data base will be updated quarterly and available for resident viewing online. If residents fall below the expected attendance rate, they will be informed via email, and will meet with the Program Director to review the expectations of the program. Continued failure to attend will result in a period of remediation in which they will be expected to attend 100% of
If the resident is below the 70% requirement they will be asked to make up the deficiency with a presentation of their own. For every 3 missed conferences over the 70% they will be required to give 1 presentation. Continued failure to attend will result in a period of remediation in which they will be expected to attend 100% of lectures.

CQI PROJECTS POLICY

Resident participation in CQI projects is mandated by the ACGME as well as being a part of the Certification process for the American Board of Pediatrics. The process of CQI will be introduced in a lecture format presented in the orientation series during the summer. Following the lecture, we will ask for proposals for QI projects that will be completed over the course of the Academic year. By October 1st, residents will choose which QI project they will work on, and report it in their ILP.

The projects should be in one of 2 areas: Resident education, evaluation or satisfaction; or Patient care, education or satisfaction. The projects should take place within the hospital and not mandate IRB protocols. Project approval will be given by Dr McConkey and the groups’ advisor (faculty physician) after review of the proposal.

Groups and their advisors will meet as needed to plan the projects and monitor progress of the cycles. Groups should have 2 co-leaders to facilitate the group. A monthly email summary (meeting minutes) should be sent around to the group and kept in a file for review by Dr. McConkey. Faculty advisors will have a prominent role within the groups and will be asked to assist in keeping the cycles small and doable.

Prior to approval of the projects, groups should do a literature search about their topic to see what is available about the topic in Evidence-Based Medicine literature.

Projects will be required to report to the QI/QA committee one time per year at one of their scheduled meetings. The projects will also be monitored by the hospital QI department.

Evaluation / Points will be assigned at 4 different times as follows
1. November: Project topics, group co-leaders need to be named, EBM search summary completed, approval of faculty advisor for the project and location of the project. Project registered with the GME database in NI
2. January: Project update with summary of pre-change data, and proposed change documented with approval from faculty advisor
3. March: Project update given to QI committee, summary of what change was made, plans made for follow up data made with approval of faculty advisor
4. May (or date of GME Research Day): Residents will submit a poster for each project to GME Research Day, and at least one member of each team will be required to be present for questions during the Poster Session. One project per year may be chosen for an oral presentation, and will not need a poster. Posters will be judged by a panel of Faculty, with prizes for the best projects. Faculty attending will be asked to make recommendations/comments about projects for feedback to residents.

Each follow up time is worth 10 points. Points will be assigned by Dr. McConkey and the Faculty advisor based on individual participation and quality of the work. Projects may run year-to-year if the issue is ongoing.

DOCUMENTATION POLICY

All Inpatient documentation is completed in Cerner, utilizing appropriate templates.

General Pediatrics and Newborn Nursery:
Timing: admission notes should be completed within 24 hours or prior to leaving at the end of your shift.
Daily progress notes should be completed prior to 1400 daily.

Discharge paperwork: clinical summaries should be completed within 24 hours, ideally prior to leaving the hospital at the end of a shift.

If a patient is planned to be discharged early the next day or during the next shift, paperwork should be completed as much as possible prior to leaving your shift, with the clinical summary filled in and prescriptions for home filled out and sent to the pharmacy.
Medical student notes: on the inpatient unit, M3 students should be encouraged to write daily notes and H and P's to be reviewed by the senior resident or faculty. M4 students should also write notes daily, with review by the senior residents. Hospitalist faculty are responsible for daily notes and final admission and clinical summaries for M4s on their service. Residents or faculty should never give a medical student their sign on and have them write notes for them.

Overnight shifts: any major changes in the patient’s exam, condition or plan should have an addendum note place on the daily progress note.

NICU: utilize proffered templates for admission and daily progress notes, updating clinical summaries weekly

PICU: admission notes must be completed by the end of the shift, with daily notes completed by 1400. Discharge Summaries (when applicable) should be finished within 24 hours.

Outpatient:
ER: complete all paperwork prior to completing your shift

Clinic: complete all charting in Athena, utilizing preferred templates.

CPAM student notes should be completed in the message function in Athena, and sent to the attending physician. Faculty staffing medical students are ultimately responsible for completion of notes.

Well child and AC notes: should be completed prior to leaving clinic for the day, at most within 24 hours.

Athena: background information should be completed wherever possible, ensuring that problem lists and diagnosis lists are updated regularly. In Athena, please be sure to utilize the EMR to its full potential by utilizing the Patient information and patient clinical education sections. Complete all medication reconciliation yourself with every visit.

Phone calls: If you take a Mommy Call from a CCK or CPAM patient, be sure to document the advice given in a phone note in Athena.

Pulling notes forward/Copy and Paste of daily notes: the practice of pulling notes forward or cutting and pasting previous notes is dangerous and puts physicians and the hospital at risk for fraud or safety issues. If you are pulling any note forward, the note must be updated and changed daily to represent the current state of the patient. It is best to initiate a new note daily and put the proper thought and accurate documentation into the note.

All notes of residents will need to be consigned by faculty physicians.

PROCEDURE POLICY

Pediatric Residents 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 applicable results. Residents must demonstrate procedural competence by performing the following procedures:

- Bag-mask ventilation
- Bladder catheterization
- Giving immunizations
- Incision and drainage of abscess
- Lumbar puncture
- Reduction of simple dislocation
- Simple laceration repair
- Simple removal of foreign body
- Temporary splinting of fracture
- umbilical venous catheter placement
- Venipuncture
Must complete training and maintain certification in Pediatric Advanced Life Support, including simulated placement of an intraosseous line, and Neonatal Resuscitation, including the simulated placement of an umbilical catheter.

To accomplish the training of pediatric residents, AdventHealth Pediatrics Residency Program will utilize the following techniques:

1. During the orientation month of July in the PL1 year, residents will be required to attend and become certified in Basic CPR training, PALS training and NRP training.
2. The residency program will provide Procedural simulation training during June (for PGY1s) and during the Potpourri month (block 7) for all levels of residents.
3. Procedures to be covered during this training will include simulated models of the following:
   a. Bag-mask ventilation
   b. Umbilical venous catheter placement, UAC placement
   c. Intraosseous line placement
   d. Lumbar puncture
   e. Venipuncture
   f. Intubation, LMA
   g. IV placement
   h. Needle decompression of a pneumothorax/chest tube placement
   i. Basic defibrillator use
   j. Bladder catheterizations
   k. Giving immunizations
   l. I & D of abscess, removal of foreign body
   m. Reduction of simple dislocation and temporary splinting
   n. Simple laceration repair
   o. Changing tracheostomies
   p. Changing G tubes
   q. Arterial blood draws

Supervised training for the procedures will also occur on the following rotations:
   - General Pediatrics clinic: giving immunizations, simple foreign body removal, reduction of simple dislocation, I & D of abscess, circumcision
   - Emergency Medicine: simple foreign body removal, reduction of simple dislocation, IV placement, venipuncture, I & D of abscess, lumbar puncture, temporary splinting of fractures, intubation
   - General Pediatrics Inpatient: IVs, Urinary catheterizations, LPs, Changing G tubes, Changing Tracheostomies, I & D of abscess, Bag and mask
   - NICU and PICU: intubation, bag and mask ventilations arterial line placement, arterial puncture, chest tube placement, thoracentesis, UVC, UAC, LP, central lines

“Mock codes” will take place while residents are rotating through the following rotations:
   - Emergency Medicine, General Pediatrics Inpatient, PICU, NICU
     a. During mock codes residents will be evaluated on communication, leadership, medical knowledge, team work and professionalism.

**EVALUATION POLICY**

AdventHealth Pediatric Residency utilizes 360-degrees, milestone based evaluations through New Innovations (NI) software. Residents should receive evaluations from every block, and are requested to give their evaluations of every block.

Types of evaluations:
   - **Faculty of Resident (Monthly):**
     Residents will be evaluated by faculty after each block. You may receive more than one evaluation per block.
Family/Patient (Quarterly):
Residents should receive evaluations by patients and families from clinics in CPAM. Numbers will be based on return rates, but will be requested of families quarterly. Residents will also receive summaries of their Press Ganey scores as available.

Peer to Peer (Per specific schedules):
In rotations where there are situations with a senior and junior resident working together, the senior will evaluate the junior residents and vice versa- these will be kept anonymous.

AH GME Summative Evaluation of Resident (Final):
Program Director will complete summative evaluation at the end of training.

Resident of Faculty (Monthly):
Residents will be mandated to evaluate at least one faculty per block, these evaluations will be kept anonymous by batching the evaluations bi-annually for the faculty.

Resident of Rotation (Monthly):
Residents will be mandated to evaluate every rotation block, which will be kept anonymous

Resident of Nursing (Quarterly):
Residents will evaluate GP, NB, NICU and PICU nursing staff they worked with during these specific rotations.

Resident of Continuity Clinic (Bi-Annually):
Residents will provide feedback about their continuity clinic setting.

Nursing Evaluation of Residents (Per specific schedule):
Residents will be evaluated by nursing staff on inpatient and clinic rotations.

Resident & Faculty - Evaluation of Program:
Residents will complete the annual ACGME program evaluation online, as well as a confidential program evaluation once per year which will be used to evaluate the program strengths and weaknesses to plan goals for the next academic year.

Residents will have bi-annual feedback sessions with their mentors and receive formal feedback from the Program Director (PD) through new innovations twice per year.

Resident evaluations are available for viewing any time in New Innovations, or if they have any concerns about specific evaluations they should contact the PD, or Associate Program Director.

AHFC SCHOLARLY PRODUCT POLICY

The ACGME strongly encourages resident and faculty participation in scholarly productivity to enhance the education of residents. Per the ACGME Pediatric RC guidelines

The faculty must establish and maintain an environment of inquiry and scholarship with an active research component. (Core)

II.B.5.a) The faculty must regularly participate in organized clinical discussions, rounds, journal clubs, and conferences. (Detail)

II.B.5.b) Some members of the faculty should also demonstrate scholarship by one or more of the following: peer-reviewed funding; (Detail)

II.B.5.b),(2) publication of original research or review articles in peer reviewed journals, or chapters in textbooks; (Detail)

II.B.5.b),(3) publication or presentation of case reports or clinical series at local, regional, or national professional and scientific society meetings; or, (Detail)

II.B.5.b),(4) participation in national committees or educational organizations. (Detail)

II.B.5.c) Faculty should encourage and support residents in scholarly activities

The Pediatric Residency program at AHFC has a requirement of a scholarly product from every resident prior to graduation. Residents will not be allowed to graduate if their scholarly product is not complete.

1. The product can be completed at any time during residency
2. Qualifying scholarly products:
   a. Case reports- either submitted to a peer reviewed journal or in poster format
   b. Oral presentation of scholarly product – at local, regional or national level
   c. Participation in a research study- required product must be an abstract, IRB proposal, data summary, statistical summary, or written paper which will be submitted to a peer reviewed journal
   d. Write up of a Quality Improvement project for submission to a peer reviewed journal
   e. Book chapter
   f. Review article
   g. Educational curriculum which is submitted to Med Ed portal, APPD share warehouse or equivalent
3. Product must be approved by Program Director, Associate Program Director or Director of Research for AHFC

To assist residents in their research projects the following services/ rotations are available at AH:
1. GME research department: assistance with IRB, ORA, Poster production, statistical analysis, data gathering
2. AHFC research department: similar to GME research dept. specific to AHFC, grant writing, publication editing, study design
3. Consultation with Director of Research AHFC: Dr. William Oh is available to assist in connecting residents with mentors or ongoing research projects hosted by AHFC faculty
4. Research rotations: one research rotation per year is allowed, but a scholarly product is required at the end of each rotation. Rotation plan must be approved by PD or APD and weekly meetings with faculty mentor are required, and must be documented.
1. All residents receive three weeks of vacation per academic year (15 working days and 6 weekend days).
2. Vacation, interview, and sick days count toward PDO time. AdventHealth expects that each employee will maintain a bank of days to be used for sick days, thus we only schedule 3 of the 4 weeks of vacation time allowed. That will supply 4-5 days of PDO for other needs (see # 11). The ABP requires residents to complete 33/36 months inclusive of vacation to be eligible for Boards.
3. Vacation weeks are typically for a seven-day time period: (5 working days plus two weekend days), arranged as Monday through Sunday. Exceptions may be made with Chief and PD discretion.
4. Vacations may not be taken over the Christmas and New Year’s holiday, or during weeks which will have a coverage schedule, including those with the in-training exam, Career Day, Retreats, and the last week of June, for PGY3s
5. Vacations may be taken in 1 or 2-week blocks as indicated on the schedule. If a 2-week block is desired, vacation must be taken the last week of one rotation and the first week of the next rotation, or 2 weeks within a single rotation with special permission required from the Program Director.
6. All requests for changes in vacation must be in writing with a “Change of Vacation Form” (located in the New Innovations Resident Manual under Forms) submitted to and approved by the Program Director.
7. Requests for vacation changes must be made as soon as possible and at least eight weeks in advance to allow for clinic scheduling changes in our patient-centered care system.
8. Vacation time cannot be carried over from year to year; use it or lose it.
9. All residents receive four days off at Christmas or New Year’s, which are not counted towards regular vacation. Each class will determine which half will work Christmas, and which half will work New Year’s, and submit their lists to the Chief Residents when requested in the fall.
10. There is no guarantee that because an individual resident worked the Christmas holiday during one academic year, they will receive the Christmas holiday off the next academic year.
11. The Chief Residents and the Program Director reserve the right to change all published vacation and schedule policies for appropriate educational needs and patient care.
12. Residents may utilize PDO banked “sick days” for the following purposes:
   • Wellness days- doctor or dentist appointments
   • Interview days
   • Taking Step 3
   • Attending conferences- if you are presenting, you will not be charged a PDO day
   • Family emergencies- deaths, births, illness of family members,
   • Maternity / Paternity leave

PL1 Vacation Information
1. Each intern is assigned a schedule that shows which rotations are taken and in what order. It also determines when vacations may be taken.
2. PL-1’s may take vacation during blocks in which they have the following rotations: Elective, Advocacy, Neurology, and Acute Care

PL2 and PL3 Vacation Information
1. Each PL2 and PL3 class determines their schedules and vacations for the next academic year as a group in January.
2. For PL3’s, vacations may be taken during Electives, Heme Onc, or GEM, but not in the last week of June.
3. For PL2’s, vacations are taken from Electives, Community Peds, and Subspecialty rotations.
4. A maximum of three PL2’s and/or PL3’s may be on vacation during a given week.
Procedure for Notification of absence:
Illness that will prevent you from attending work should be reported to the chief resident or program director as soon as possible prior to your shift.

DO NOT just call the clinic or faculty attending to notify them. We will take care of notifying your faculty or rotation of your absence. It is important that we know when you are absent- both for your wellbeing and our accountability for your presence.

- The chief residents will take first call: they will be taking turns when not on inpatient rotations. The schedule will be added to the daily schedule in NI. Please check when you are calling in- sometimes the block will be split up, or it may be the PD or APD if they are both on vacation.

If you have a fever, vomiting or a contagious condition do not come to work. We do not want to make our patients ill – use your discretion when calling in sick. Do not call in for minor illnesses or inconveniences. If it is felt that a resident is abusing the illness policy, we will be forced to request doctor’s notes confirming illnesses. If you have a medical or dental emergency that requires appointments during work hours, please give us as much notice as possible- we will work with you to accommodate appointments.

We encourage you to take care of yourselves- please take the time to schedule an initial wellness evaluation upon getting your insurance both for your medical and dental needs. I would encourage you to use the GME clinics for you and your families care as they are free of copay. If you would like a recommendation for a physician, I would be happy to discuss it with you.

The Pediatric Residency program will allow 2 scheduled “Wellness days” - one occurring in Blocks 1-6, the other one in Blocks 7-13. Residents will request their wellness days by filling out a vacation request form and giving it to the rotation directors for approval. Then will pass the form to the Program and Clinic Director/APD/Chief Residents for review. If all approved, the request will be given to the Program Coordinator for documentation and schedule revision. Residents may not schedule a wellness day while they are on inpatient rotations, during their Continuity Clinic day, or when they are needed for patient care. We reserve the right to deny Wellness days if they interfere with your schedule or patient care needs. Wellness days count toward your PDO time. We will be tracking these days in addition to your scheduled vacation.

Coverage during illnesses: the only positions we intend to cover during resident illnesses are senior supervisory positions at night- primarily Night Shift supervisory residents. You will not be required to repay a fellow resident for coverage, but it would be collegial to offer.

Leaving the hospital during a shift: you must have the permission of your faculty attending to leave the hospital during a shift. This includes any shift, any time of the day or night, even “quick trips” outside the hospital. You have responsibilities to your rotation and patients- it will be considered a significant breach of professionalism if you do not report your absences to your faculty attending.

- **Back up**
  - You will potentially be called in to work if GP night senior calls out sick
  - You MUST be able to get to the hospital within 1 hour
  - You must have your phone with you and have service at all times when you are on back up (I will call, leave a message, text and email you) and you must respond within 15 minutes
  - You may be pulled in to cover even if you have worked all day (yes, this means a possible 24-hour call)
  - If you are called in to cover a night you are excused from your rotation the following day
  - If the GP night senior calls out sick two days in a row, any senior (2nd or 3rd year resident) may be called in for back up coverage. We will give you a day notice that you are the next up to be back up if this is the case.

- **Switching Coverage/Back up**
  - You are responsible for finding the person to switch with you
  - All switches MUST BE approved by the chief resident (as they must comply with duty hours) and will be entered in NI
Journal Club Objectives

1. Learn how to formulate a clinical question
2. Learn techniques on searching the medical literature efficiently
3. Learn how to efficiently read a journal article
4. Critically appraise a variety of journal articles
5. Apply above techniques to everyday practice and to continue lifelong learning
6. Develop skills to apply evidence based medicine acknowledging patient and physician values and preferences
7. Actively participate in the journal club discussion

Journal Club Presentation Guidelines

1. Try to pick an article (preferably a randomized controlled trial if possible) based on a clinical question developed during your residency. Consider using the PICO format in developing your question (Patient, Intervention, Comparison, Outcome).
   - using PubMed clinical queries is a great way to find many articles
   - try to pick a topic that will be of interest to a general pediatrician (remember your audience!)

Types of articles

- **Therapy** – study that is evaluating the use of a certain drug or intervention
  - Discussion points: Absolute risk reduction, relative risk reduction
  - User’s Guide: can be found in MedHub in the Journal club document folder or: http://www.jamaevidence.com/content/3348435

- **Harm** – study that looks at adverse events of a drug or intervention
  - User’s Guide: http://www.jamaevidence.com/content/3346071
  - Discussion points: ARR, RRR, number needed to harm

- **Prognosis** – study that looks at an outcome in a cohort of patients (these are usually cohort studies)
  - User’s Guide: http://www.jamaevidence.com/content/3347447
  - Discussion points: study design

- **Diagnosis** – study evaluating a diagnostic test
  - Discussion points: sensitivity, specificity, positive predictive value, negative predictive value, likelihood ratio, prevalence
  - BMJ Guide: http://www.bmj.com/cgi/content/full/315/7107/540

- **Systematic Overview/meta-analysis** – papers that look at studies and try to synthesis the findings (Cochrane Database, Clinical Evidence articles would be included here);
  - User’s guide: http://www.jamaevidence.com/content/3347535
  - Discussion points: how meta-analysis are performed, grading systems, Forest Plots;

- **Economic Analysis** – studies that review cost of therapy/interventions
  - User’s guide: http://www.jamaevidence.com/content/3349387

- **Screening** – studies that look into screening practices
  - Discussion points: sensitivity, specificity, positive predictive value, negative predictive value, likelihood ratio, screening strategies
  - BMJ Guide: http://www.bmj.com/cgi/content/full/315/7107/540
Clinical Decision/Prediction Rules – studies assessing the formulation or utility of these rules


2. Send the article to the EBM facilitator at least 4 weeks prior to your scheduled journal club to review. You may also ask Dr McConkey or Dr Dabrow to help you find an article in an area of interest.

3. Set up a meeting with the EBM facilitator at least 3 weeks prior to your scheduled journal club to discuss presentation strategies. Your powerpoint presentation should be turned into the Coordinator at least 2 weeks prior to your presentation for CME purposes.

4. Presenting the article – (This is a suggested outline):
   - try to start off with a clinical scenario
   - have the group develop the PICO (patient, intervention, comparison, outcome) question
   - consider discussing search strategies for finding the answer (may consider demonstrating the search live – show different databases)
   - Present background of the paper (go over study design/methods)
   - divide the residents into groups to discuss the worksheet questions relevant to the article.
   - make sure none of the groups are having trouble (especially groups that are doing math)
   - Facilitate the groups answering the questions and discussing positives/negatives about the study.
   - Discuss any teaching points (such as confidence intervals, type 1 and 2 errors, power, etc.) that are relevant to the article.

Resources:
[http://www.cche.net/userrguides/ebm_tips.asp](http://www.cche.net/userrguides/ebm_tips.asp)

Hardin Library: [http://www.lib.uiowa.edu/hardin/](http://www.lib.uiowa.edu/hardin/)
Databases: [http://www.lib.uiowa.edu/hardin/databases.html](http://www.lib.uiowa.edu/hardin/databases.html)


DynaMed (Dynamic Medical Information System) is a quick and easy-to-use medical reference system designed for use at the point of care. DynaMed contains clinically organized summaries of nearly 1,800 topics and is updated daily from review of the research literature. This means that the reference information is always up-to-date and does not require new editions. DynaMed is a useful resource in clinical, educational and research settings.

Clinical Evidence: [http://purl.lib.uiowa.edu/ovid/clinevid](http://purl.lib.uiowa.edu/ovid/clinevid)

Clinical Evidence summarizes the current state of knowledge and uncertainty about the prevention and treatment of clinical conditions, based on thorough searches and appraisal of the literature. It is neither a textbook of medicine nor a set of guidelines. It describes the best available evidence from systematic reviews and RCTs, and if there is no good evidence it says so.

ACP PIER: [http://purl.lib.uiowa.edu/ovid/clinevid](http://purl.lib.uiowa.edu/ovid/clinevid)

ACP’s PIER is the American College of Physicians’ peer reviewed EBM resource. Sections on diseases, prevention, CAM and procedures are highly synthesized and designed for point-of-care use. Browse table of contents or search through StatRef.


“The TRIP Database is a clinical search tool designed to allow health professionals to rapidly identify the highest quality clinical evidence for clinical practice.”
Up-to-date: http://www.uptodateol.com/home/index.html

“Up-to-date is an evidence-based, peer-reviewed information resource available via the Web, desktop/laptop computer and mobile device.

With Up-to-date, you can answer questions quickly, increase your clinical knowledge and improve patient care. Independent studies confirm these benefits.

The Up-to-date community includes our faculty of over 4,400 leading physicians, peer reviewers and editors and over 400,000 users. Our faculty writes topic reviews that include a synthesis of the literature, the latest evidence, and specific recommendations for patient care. Our users provide feedback to the editorial group. This community’s combined efforts result in the most trusted, unbiased medical information available.”
**Journal Club Objectives**

1. Learn how to formulate a clinical question
2. Learn techniques on searching the medical literature efficiently
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**Guidelines for Rubric**

1. Pick an article from one of the following types: Therapy, Harm, Prognosis, Diagnosis, Meta-analysis, Economic Analysis, Screening, Clinical decision/Prediction rules = 10 pts
2. Give article to faculty/PD 2 weeks prior to date, meeting with faculty and biostatistician at least 1 week prior to date = 35 pts
3. Present the article- use clinical scenario, create the PICO (Patient, Intervention, Comparison, Outcome) review search strategies = 10 pts
4. Discussion of study- review study design, methods, discuss positives and negatives about the study = 25 pts
5. Discuss teaching points, such as confidence intervals, type 1 and type 2 errors, power, etc that are pertinent to this article. = 20 pts

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Possible Score</th>
<th>Actual Score</th>
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<tbody>
<tr>
<td>Article choice</td>
<td>10 pts</td>
<td></td>
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<tr>
<td>Article and slides to faculty</td>
<td>35 pts</td>
<td></td>
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<tr>
<td>Presenting article</td>
<td>10 pts</td>
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<tr>
<td>Discussion of study design/methods</td>
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<tr>
<td>Teaching points</td>
<td>20 pts</td>
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<td><strong>Total</strong></td>
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>75 % = passing rate
Your goals for this conference are:
The M&M Conference is designed to examine, via case presentations, the successes and failures in our patient care model, with the intent to decrease medical errors, morbidity, mortality, and/or patient dissatisfaction. Presenters and audience members alike will benefit from the information and discussion shared in these sessions.

The presentation should include:
1. A specific patient case – preferably one in which the PL2 played an integral role in patient care. An overview of the medical issues raised in the case - disease etiology, epidemiology, diagnosis, and management.

2. The resident should identify a staff physician (preferably the one involved in the case) to review the case, and to provide feedback prior to the presentation. Ideally, this faculty would also be present during the presentation to provide expertise and further discussion. Please make every effort to give faculty 6-8 weeks’ notice about when your presentation is scheduled, so that they can work around clinic schedules. Inviting several faculty members who were involved in the case will enhance the learning experience significantly.

3. The resident will be evaluated by faculty and residents in attendance, specifically in three areas of competence:
   a. Medical Knowledge – including critical evaluation and application of current medical information
   b. Practice-based Learning and Improvement – including self-analysis of skills and practices, as well as feedback following the case, to improve future patient care
   c. Systems-based Practice – including application and knowledge of the healthcare delivery system and recognition of medical errors within it

The resident will need to include a bibliography of the references used, including review articles and websites used.

M&M Scoring Scale:
1. Present slides/thorough outline to faculty of choice 1 week before presentation = 30 pts
2. 5-10 slides: case summary with HPI, PE, pertinent PMHx, ROS, Social Hx, review of the timeline of events, labs, or pertinent events = 10 pts
3. Review of the disease process/problem involved, with overview of medical pathophysiology = 15pts
4. Analysis of problems within the case = 15pts
5. Discussion of problems identified and suggestions for improvement = 15 pts
6. Literature review for discussion = 15 pts

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<tr>
<td>Presentation (slides)</td>
<td>30 pts</td>
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<tr>
<td>Case Summary</td>
<td>10 pts</td>
<td></td>
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<tr>
<td>Review disease</td>
<td>15 pts</td>
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<tr>
<td>Problem analysis</td>
<td>15 pts</td>
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<tr>
<td>Suggestions for improvement</td>
<td>15 pts</td>
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<tr>
<td>Literature review</td>
<td>15 pts</td>
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>75 % = passing rate
As seniors, you are responsible in creating your own block schedule. You will work with your classmates on creating a schedule that follows the guidelines listed below. Be mindful of rotations you can take vacation in.

**PL-2**

2 blocks – GP Night (1 block in blocks 1-6, 1 block in blocks 8-13) – 6 nights per week
1 block – PICU (must be taken within blocks 1-6) – this is 2 weeks of days and 2 weeks of night
1 block – NICU (must be taken within blocks 1-6) – weekdays + 2 weekends on/2 weekends off
1 block – EM (must be taken within blocks 1-6) – shifts vary
1 block – Adolescent Medicine (must be taken within blocks 3-13, except for block 7) – 5 days per week
1 block – Community Peds* (must be taken within blocks 3-5, and 8-11) (CP is not allowed in Blocks 1, 2, 6, 7, 12, and 13) *(vacation is mandated during this block – has to be 1 full week) – 5 days per week
1 block – Allergy/Pulmonary* – 5 days per week
1 block – Cardiology* – 5 days per week
1 block – Acute Care* (must be taken within blocks 8-13) – 5 days per week
1 block – Elective* – 5 days per week, generally
1 block – Subspecialty* – 5 days per week, generally
Note – only one elective away rotation per year and only one research block per year.
*Vacation is allowed in the blocks marked with an *

**Options for Subspecialty:**

***Note that you may have to arrange your rotations with the preceptors if you change them throughout the year. Rotations marked with an asterisk must be arranged by you ahead of time with the program coordinator and specialty attending.

<table>
<thead>
<tr>
<th>Child Abuse</th>
<th>Nephrology</th>
<th>Ophthalmology*</th>
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<tbody>
<tr>
<td>Medical Genetics*</td>
<td>Neurology</td>
<td>Orthopedic Surgery*</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>Pulmonology</td>
<td>Otolaryngology*</td>
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<tr>
<td>Cardiology</td>
<td>Dentistry*</td>
<td>Rehab Medicine*</td>
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<tr>
<td>Dermatology</td>
<td>Child and Adolescent Psychiatry*</td>
<td>Radiology</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>Hospice and Palliative Medicine*</td>
<td>Surgery*</td>
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<tr>
<td>GI</td>
<td>Neurodevelopmental Disabilities*</td>
<td>Sleep Medicine*</td>
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<tr>
<td>Heme/Onc</td>
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<td>Sports Medicine</td>
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</tbody>
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**Options for Electives:**

Weight and Wellness, Research

*You may take any subspecialty rotation a second time as an elective

***If you are interested in an away elective/international trip you must know where you would like to go 1 year in advance and speak with the Program Director to organize the rotation.

**Specific to PGY-2/PGY-3:** PICU, NICU, CV ICU, International Health

**Back-up/Saturday night call:** Back-up can be scheduled 4 times throughout the year during the following rotations: Acute Care, Adolescent Medicine, Community Peds, Allergy/Pulmonary, Cardiology, and any Subspecialty/Elective. You will be call free for 2 of the rotations.

You will have 1 Saturday 24-hour call per block.

You will have 2 weeks of home back up during these blocks – you must be available to come in to cover for another senior within 30 minutes if needed and available at all times to answer mommy call back up if needed.

**Vacation:** You are required to request 3 weeks of vacation up front along with your preference of Christmas or New Year’s off (we will do our best to oblige your requests). Your 4th week of vacation will be held in reserve. This 4th week is being held for sick time, doctor’s appts, etc. **No more than 2 people per class can be off at the same time.**

You vacation during Community Peds has to be 1 full week – **cannot be split**

No vacation is allowed during the week of the ITE (July 12-19, 2017), during block 7, or the last week of block 13.

Any vacation changes that will affect your clinic day will have to be made 6 months in advance to account for clinic scheduling. If splitting vacation weeks, you must assure that you are not missing more than 3 clinic dates total.

**Maternity/Paternity Leave:** If you are planning on going on Maty/Paty leave, please let us know ASAP (Program Director, Program Coordinator, and Chief Resident).
PLANNING YOUR BLOCK SCHEDULE PL-3

As seniors, you are responsible in creating your own block schedule. You will work with your classmates on creating a schedule that follows the guidelines listed below. Be mindful of rotations you can take vacation in.

PL-3
2 blocks – GP Days (1 block in blocks 1-6, 1 block in blocks 8-13) – 6 days per week
2 blocks - Elective* – 5 days per week, generally
2 blocks – PICU (1 block in blocks 1-6, 1 block in blocks 8-13) – 2 weeks days/night
1 block – NICU (must be taken within blocks 8-13) – weekdays + 2 weekends on/2weekends off
1 block – EM (must be taken within blocks 8-13) – shifts vary
1 block – GEM* – 5 days per week
1 block – Heme/Onc* – 5 days per week
1 block – Acute Care* (must be taken within blocks 1-6) – 5 days per week
1 block – Subspecialty* – 5 days per week, generally

Note – only one elective away rotation per year and only one research block per year.
*Vacation is allowed in the blocks marked with an *

Options for Subspecialty:
***Note that you may have to arrange your rotations with the preceptors if you change them throughout the year. Rotations marked with an asterisk have to be arranged by you ahead of time with the program coordinator and specialty attending.

| Child Abuse | Nephrology | Ophthalmology* |
| Medical Genetics* | Neurology | Orthopaedic Surgery* |
| Allergy/Immunology | Pulmonology | Otolaryngology* |
| Cardiology | Dentistry* | Rehab Medicine* |
| Dermatology | Child and Adolescent Psychiatry* | Radiology |
| Endocrinology | Hospice and Palliative Medicine* | Surgery* |
| GI | Neurodevelopmental Disabilities* | Sleep Medicine* |
| Heme/Onc | ID | Sports Medicine |

Options for Electives: Weight and Wellness, Research
*You may take any subspecialty rotation a second time as an elective
***If you are interested in an away elective/international trip you must know where you would like to go 1 year in advance and speak with the Program Director to organize the rotation.

Specific to PGY-2/PGY-3: PICU, NICU, CV ICU, International Health

Back-up/Saturday day call: Back-up can be scheduled during the following rotations: Acute Care, GEM, Heme/Onc, Elective, and Subspecialty. You will have 1 Saturday 24-hour call per block.

Vacation: You are required to request 3 weeks of vacation up front along with your preference of Christmas or New Year’s off (we will do our best to oblige your requests). Your 4th week of vacation will be held in reserve. This 4th week is being held for sick time, doctor’s appts, etc. No more than 2 people per class can be off at the same time.
No vacation is allowed during the week of the ITE (July 12-19, 2017), during block 7, or the last week of block 13.
Any vacation changes that will affect your clinic day will have to be made 6 months in advance to account for clinic scheduling. If splitting vacation weeks, you must assure that you are not missing more than 3 clinic dates total.

Maternity/Paternity Leave: If you are planning on going on Maty/Paty leave, please let us know ASAP (Program Director, Program Coordinator, and Chief Resident).

Fellowship: If you are accepted into a fellowship, please be mindful of when your contract actually ends. Most fellowships expect you to be there on July 1. Also, please keep in mind when peak interview season is for your specialty and try and schedule an elective during that time.