

## **Some Practical Tips on Being a Senior Pediatric Resident at McMaster**

*This document is meant to provide practical information to help transition junior pediatric resident to the senior pediatric resident role. Challenges special to the SPR role include delegating and supervising junior residents and clinical clerks. As a manager and collaborating with ER and PICU staff, the SPR facilitates getting patients where they need to go. Being a medical expert is an important role as an SPR, but specific patient management is not the focus of this discussion. You will develop your own style as an SPR with experience, but there some guideline that every SPR should live by to, above all, keep patients safe. No rules apply for every scenario, but some general trends arise that are described here.*

### **Consults to ER**

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

Make sure you get the patients name (with exact spelling so you can look up on meditech) and location (you would be surprised how difficult the patient is to find sometimes), the name of ER physician. Ask for vitals, general appearance, investigation and treatment done by the ER physician (e.g. back to back to back ventolins). You can also ask the emergency physician: “What are you most concerned about?” If the patient may be unstable and you cannot go to the ER immediately, you can ask ER physician if they can watch the patient for 20 minutes and/or order some labs.

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

You really should not refuse any consult, no matter how simplistic it seems. If you think a consult is inappropriate or can be seen on an out patient basis in the resident clinic, run the referral by your staff person. However, some things require urgent management by another service (e.g. testis torsion) and needs to be redirected appropriately.

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

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

If something seems sketchy or if you’re not sure, ask your staff.

The SPR should not take outside parent or physician calls, redirect any such calls to your staff.

*How do I deal with ER consults?*

You must at least “eyeball” every patient. This entails assessing general appearance, vitals and treatment to date. If there is any uncertainty regarding the patients stability, take whatever action is necessary immediately (call your staff if not 100% sure of your management, and if the patient

seems like they may crash, page PICU 1000). If the patient is clearly stable, delegate the consult to a clerk, junior resident, family medicine or BCT resident, and advise him or her how long it should take (e.g. 1 hour is reasonable for most consults), and maybe give a few tips on how to approach the history, physical, what to look for, when to call you back (e.g. deterioration). It is helpful to ask a clerk or junior something like, "Have you seen many kids with bronchiolitis?" to get an idea of how much direction they need before sending them into action. It also helps learners know that you are in touch with their learning needs. Triage patients appropriately, it is not a good learning experience to have the clinic clerk see the complex chronic patient.

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

"Take the info from the consult, check the vitals and see the child for yourself. ALWAYS check vitals and then recheck HR and RR yourself. If the child is in any distress - you must stabilize them yourself (i.e. get the insulin, fluids and labs ordered in DKA, check neuro status and- if you're happy- get someone to do the whole consult while you keep an eye on them intermittently). If the child is not clearly well (nor acutely sick), ask some pointed questions to determine the acuity of the situation.

Then decide who is most appropriate to see the consult (ie. peds jr for more acute stuff and clerk for consults that can take an hour and it doesn't matter). Do all the consults you get. It's not our role to filter them (unless its a life threatening mistake i.e. bowel perforation and surgery hasn't been called, then consider calling surgery yourself and offer to do the consult anyway). If there are recurrent inappropriate consults from the same person, mention it to staff - it's their role to discuss staff-staff. It is our role to keep the patients safe. We shouldn't get mixed up in consult politics.

If a patient is crashing (or might), call peds 1000 without delay. If they are stable, but have a bad story that makes you worry they might crash, call your senior/staff or peds 1000... unless you are truly fully comfortable and know what to do. This is not the time to prove yourself or be a hero. What is best for the patient always comes first. While you wait for help. Stay calm and remember your A, B, C's, fluid boluses are good (unless they're obviously cardiac or fluid overloaded), think about STAT labs (CBC, cx, lytes, urea, Cr, glu, gas, lactate +/- more) and whether they need STAT meds (lorazepam, antibiotics, steroid, ventolin, epi). Remember that help is on the way and you are not alone.

Consider asking nursing to call peds 1000 while you stabilize. Delegate tasks to others, so you can concentrate on decision making."

*When do I call a code (5555)?*

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

*When do I consider paging PICU (1000)?*

If you think a patient needs to go to the ICU, the initiation of the consult has to be done staff to staff. If you need back-up with a very sick patient, call your staff (or have them called).

An unofficial, non evidence based, SPR opinion of when a patient needs ICU:

- FiO<sub>2</sub> greater than 40%
- two doses of lorazepam and still possible seizing
- more than 2 boluses of 20cc/kg crystalloid with no obvious improvement

Remember the other people in house: PICU resident (+/- fellow, staff), PACE...

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

Generally don't wait until cases pile up to review- call the staff early and ask them what they want you to do. They may say to wait to review several cases in some cases- but this is staff decision.

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

You can send the patient to the senior resident clinic as follow up (fill out a normal green consult form and have it faxed to Skye 905 521 4981, then call Yvonne or Lyn at the 2Q clinic and leave a message Ext. 75774, the patient will get in at the earliest in 10 days). Alternatively, the pediatrician you are working with at that moment may arrange to see the patient either in their outpatient office or in the hospital if they're on service.

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

A "trauma fan out" is called by the ER physician in the case of trauma of sufficient severity to require the trauma team. The PICU resident, the trauma team leader (a staff, not necessarily PICU staff), the general surgery resident, and the anesthesia resident get paged. The SPR does not get paged for a trauma. The person who arrives first will assume the role of trauma leader and can choose to delegate this role to someone more senior when they arrive.

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

*How should I provide positive feedback to clerks and juniors?*

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

*How should I provide negative feedback to clerks and juniors?*

Being medical people and having a tendency toward perfectionism, it can be difficult to face criticism. It can be beneficial to acknowledge openly to clerks and juniors that many situations are new for them and it's OK not to know everything, as obvious as it seems to us that clerks shouldn't feel they have to know everything! Try to fill in the gaps in the history, physical and encourage any attempts to formulate a differential and plan.

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

A useful teaching session can take place in 5 minutes and you don't need to be an expert to execute one. It can be helpful to ask a clerk or junior a question like, "Do you know the risk

factors for sepsis in a neonate?” especially when it relates to a case in front of you. If they already knew the answer, it helps their morale, and if they didn’t, it’s a digestible learning point. It’s also good for the senior to review, and you often learn something new, or identify gaps in your knowledge when the junior turns the tables on you...

*How should I debrief encounters with clerks and juniors?*

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

For sad cases, for example, shaken baby syndrome, it may be useful to acknowledge this out loud to the clerk or junior (when away from the patient and family, of course) to facilitate being able to emotionally deal with the badness we see.

## **Handover**

*What do I need to do during handover?*

- Identify your team (juniors, clerks), write down their names and pager numbers, and clarify which teams they are on. Ask them how their day/ rotation is going.
- Get an updated patient list. Ask the juniors (and the outgoing senior), “Who is sick? Who needs to be seen? Has everyone updated the patient list (is every patient on the list?)”
- Have a fresh sheet of paper (or the back of the team lists) ready for the ER consults (that may be in various stages of waiting to be seen, being seen by a junior/clerk, or waiting for a bed). Many residents use check boxes to make sure you they don’t forget everything (e.g. to make sure every consult in ER has been seen, labs checked, etc.)
- Get hem/onc handover from resident or staff on hem/onc (this may occur later- you can always call the staff on call for handover).
- Subspecialty handover (GI, endocrine, etc.): these services may or may not have inpatients, so the staff may give you handover. If you haven’t received handover on weekends, and the nurse calls you about a patient, you can tell the nurse to call the subspecialty staff.

*What should I do before handing over in the morning?*

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