McMaster Children’s Hospital NICU

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Welcome to the NICU! We are a regional perinatal and tertiary referral center providing level III neonatal diagnostic and supportive care including mechanical ventilation, high frequency ventilation, nitric oxide therapy and pediatric surgery (excluding ECMO). In addition, we offer a regional NICU Developmental Follow-Up Clinic.

INTRODUCTION FOR RESIDENTS

I. Goals of the resident neonatal rotation and resident evaluation
II. Geography and the interprofessional teams
III. Resident responsibilities
IV. NICU information – for your day-to-day work
V. Education in the NICU
VI. Completing your rotation
I. GOALS OF RESIDENT ROTATION

A. Overall Goals and objectives of the neonatal rotation:
   1. Understand normal newborn physiology and examination findings;
   2. Understand pathophysiology and treatment of common newborn diseases;
   3. Identify high-risk antenatal/postnatal factors, recognize clinical and laboratory signs of a sick newborn, and develop appropriate treatment plans;
   4. Develop procedural skills in newborn resuscitation and emergency intervention;

B. Royal College of Physician and Surgeons Objectives in Neonatology
Adapted From---RCPSC document “Objectives of training in Pediatrics”, 2008
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OBJECTIVES RELATED TO MEDICAL EXPERT ROLE
1. To understand and apply knowledge of pathophysiology, generate differential diagnoses, and approach investigations and management of common newborn urgencies/emergencies including:
   a. Respiratory distress
   b. Sepsis
   c. Hypoglycemia
   d. Shock
   e. Bilirubin emergencies
2. To gather, integrate, and report information about the patient
3. To perform comprehensive examinations of the newborn
4. To make informed diagnostic and therapeutic decisions, and develop and carry out management plans

OBJECTIVES RELATED TO COMMUNICATOR AND COLLABORATOR ROLES
1. To provide transfer of care that ensures safety and optimizes patient care
2. To present cases and prepare documentation that is accurate, organized, and timely
3. To establish therapeutic relationships with families
4. To establish good professional relationships with peers and members of the interprofessional team

OBJECTIVES RELATED TO MANAGER ROLE
1. To set priorities and manage time effectively in order to optimize patient care and own learning
2. To make effective use of information technology
3. To demonstrate leadership skills, delegate tasks, and provide supervision

OBJECTIVES RELATED TO HEALTH ADVOCATE ROLE
1. To advocate for, provide health teaching, and anticipatory guidance to families, regarding policies that promotes health in infants ex. breastfeeding, cessation of smoking, SIDS prevention, immunizations, parent bonding, and strategies against infections disease
OBJECTIVES RELATED TO PROFESSIONAL ROLE
1. To provide care and communication that is culturally/spiritually supportive and respectful
2. To demonstrate a sense of duty and accountability to patients, families, and the professional team
3. To gain an appreciation of the principles of medical ethics and their application to neonatal practice
4. To recognize one’s own limitations, seek help/advice when required and integrate into practice

OBJECTIVES RELATED TO SCHOLAR ROLE
1. To develop and implement an ongoing and effective personal learning strategy
2. To critically appraise and integrate medical information and evidence into practice
3. To participate in the education of families, students, and other health professionals

SPECIFIC KNOWLEDGE CONTENT AREAS: From the RCPSC

1. Demonstrates an understanding of the following:
   a) Fetal growth, development and physiology including the role of the placenta
   b) Aspects of pregnancy, labour, and delivery which affect the neonate
   c) Effect of maternal systemic disease on the fetus/newborn
   d) Demographic, medical and psychosocial factors which influence mortality and morbidity “the high risk pregnancy”
   e) Process of neonatal adaptation to extra-uterine life
   f) General principles of care of the newborn: skin, warmth, feeding Neonatal growth, nutrition, metabolic problems, feeding problems
   g) Aspects of drug therapy unique to the newborn including the management of pain
   h) Newborn screening
   i) Neonatal imaging, including X-ray, Ultrasound, CT, and MRI scanning
   j) Pharmacology related to breastfeeding
   k) Principles of neonatal transport
   l) Problems encountered in the follow-up of the high-risk neonate

2. Demonstrates experience in:
   a) Initial assessment of the newborn, including APGAR score and gestational age
   b) Recognition of the seriously ill newborn
   c) Neonatal resuscitation and stabilization of critically ill newborn including Neonatal Resuscitation Program certification
   d) Umbilical venous and umbilical arterial line catheterization
   e) Umbilical catheter removal
   f) Management of conventional ventilation and its complications
   g) Blood drawing
   h) Intravenous catheter insertion (peripheral)
i) Peripheral arterial puncture  
j) Endotracheal intubation in the newborn  
k) Thoracentesis and chest tube placement (in vivo or simulation)  
l) Lumbar puncture  
m) Gastric tube placement  
n) Use of vasoactive drugs  
o) General principles of exchange transfusion  

3. Develops an approach to the management of neonatal conditions including:  
a) Respiratory distress  
b) Prematurity  
c) Cyanosis  
d) Bronchopulmonary dysplasia  
e) Jaundice  
f) Retinopathy of prematurity  
g) Intrauterine growth restriction / small for gestational age infants  
h) Feeding difficulties, vomiting  
i) Metabolic abnormalities including: hypoglycemia, hypo/hypernatremia, hypo/hypercalcemia, acidosis  
j) Intraventricular and other intracranial/extracranial hemorrhage  
k) Seizures  
l) Perinatal depression, asphyxia, hypoxic ischemic encephalopathy  
m) Sepsis  
n) Apnea  
o) Surgical problems of the newborn  
p) Anemia, polycythemia, thrombocytopenia  
q) Bleeding, hypovolemia  
r) Drug withdrawal  
s) Congenital anomalies  
t) Floppy infant  

C. Resident evaluation  
1. On the first day of your rotation, you should fill out your learning contract with the Consult attending during your orientation.  
2. Rotation specific ITER will be completed by the resident’s direct supervisor or as a composite evaluation by the ERP if resident works with multiple supervisors (p.5)  
3. Procedural log (specific procedures in NICU should be document by the resident as per Pediatric residency program guidelines)  
4. Mini-MAS, weekly milestone-based assessments (as per Pediatrics program guidelines) – residents are free to approach supervising ‘Team’ attending or Consult attending to complete these  
5. **Resident tracking tool**: please submit at the end of the rotation to facilitate the completion of the rotation evaluation (p. 7)
Rotation specific ITER
Part 1 Acute care management in neonatology
For the following topics, did you observe the resident do all of the following?
   a) Display an understanding of the pathophysiology and generate a differential diagnosis
   b) Recognize risk factors in practice and investigate using sound clinical judgement
   c) Initiate appropriate management and monitor effectiveness

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<thead>
<tr>
<th>Topics</th>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>Newborn delayed transition (NRP)</td>
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<td>Respiratory distress</td>
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<td>Sepsis / at risk for sepsis</td>
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<td>Hypoglycemia</td>
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<td>Hyperbilirubinemia</td>
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<td>Newborn shock</td>
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Part 2 CanMEDS role competencies in Neonatology

MEDICAL EXPERT
1. Gathers, integrates, and reports essential and accurate information about the patient
2. Performs complete and accurate physical examinations of the newborn
3. Makes informed diagnostic and therapeutic decisions based on sound clinical judgment
4. Develops and carries out management plans

COMMUNICATOR / COLLABORATOR / MANAGER
1. Provides transfer of care that ensures seamless transitions, including regular updating of handover documents and patient ‘pink sheets’ / summaries
2. Communicates and interacts effectively with physicians and other health professionals; recognizing their roles and expertise
3. Counsels families about the particulars of the medical condition and communicates effectively
4. Maintains comprehensive and timely medical records including: admission pathways, discharge summaries, daily notes reflecting their own medical assessments and ongoing management plans
5. Organizes and prioritizes responsibilities (attendance at deliveries, attendance at teaching sessions) to provide patient care that is safe and efficient
6. Is adequately prepared for daily rounds in order to contribute to medical assessments and develop management plans
## PROFESSIONAL / HEALTH ADVOCATE

1. Shows respect for patients, families, and members of the interprofessional team
2. Recognizes the policies that promote health in infants, i.e. breastfeeding, cessation of smoking, SIDS prevention, immunizations, parent bonding, and strategies against infections disease
3. Provides anticipatory guidance to families regarding at risk newborns related to the above
4. Demonstrates a sense of duty and accountability to patients and the profession (on time for rounds, takes ownership of their patients, dependable, ‘follows-through’)
5. Provides appropriate role modeling and supervision
6. Demonstrates sensitivity and responsiveness to a diverse patient population
7. Identifies own limitations in knowledge and experience and seeks help/advice when required
8. Accepts feedback and integrates into practice

## SCHOLAR

1. Sets rotation specific learning goals and implements strategies for achieving these
2. Able to locate and critically evaluate current medical evidence; and assimilate into management discussions and practice
3. Participates in the education of families, students, and other health professionals in the unit
4. Uses information technology to optimize patient care and own learning
**Resident tracking tool**

**Purpose:**
We recognize during your neonatal rotation you will work with multiple supervisors (attendings and fellows) and a variety of allied health professionals. In order to provide a comprehensive assessment of your neonatal rotation please complete the following tracking tool and return to **Dr. Connie Williams**, in 4F offices or electronically willico@mcmaster.ca at the end of your rotation. Once this form is returned, your evaluation will be submitted on one45. Please also remember to submit copies of any **Mini-MAS** completed during this rotation.

A. **Supervisor tracking tool:**
Please indicate which clinical supervisors and which allied health members (for multisource feedback) you worked with:

<table>
<thead>
<tr>
<th>Neonatal attending</th>
<th>Number of shifts (days/nights)</th>
<th>Number of patients reviewed</th>
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<thead>
<tr>
<th>Neonatal fellow (program or clinical fellow)</th>
<th>Number of shifts (days/nights)</th>
<th>Number of patients reviewed</th>
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<th>Allied health members</th>
<th>Number of shifts (days/nights)</th>
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B. **Learning tracking tool for attendance at deliveries and neonatal consultations**

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<tr>
<th>Indication for consult</th>
<th>Date</th>
<th>What I learned...</th>
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<tr>
<td>Ex. Meconium</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Skill: intubation and suctioning below the cords</td>
</tr>
<tr>
<td>Ex. Hypoglycemia</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Knowledge: learned hypoglycemia protocol for at risk newborn (CPS)</td>
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<tr>
<td>Ex. 26 weeker</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>Skill: inserted UAC/UVC both successful!</td>
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II. INTRODUCING THE REST OF THE INTERPROFESSIONAL TEAM

Clinical geography of teams:
The patients are divided onto three clinical teams, consisting of members of all the professions listed below.

**Team 1:** mixture of acute/critical patients and patients of moderate acuity  
Located in Pod A and C

**Team 2:** mixture of acute/critical patients and patients of moderate acuity  
Located in Pod B and E

**Team 3:** mixture of acute/critical patients and patients of moderate acuity  
Located in Pod D and E

**Team 4:** level II nursery, mixture of short stay (jaundice, R/O sepsis, hypoglycemia, late preterm) and chronic complex patients  
Located at the L&D entrance of the Unit footprint (down the hall from Level III)

A. Neonatologist and Program Fellow
In general, both the fellow and attending will make daily rounds on every patient. On occasion, rounds will be under the direction of the fellow. No significant change in plans made during rounds should be made without consultation with the fellow or attending. The on-call fellow or attending should be notified of all admissions. The fellow is available for supervision of all procedures during both day and night.

B. Neonatal Nurse Practitioners
Neonatal nurse practitioners are nurses with advanced education/training and certification in neonatal resuscitation and stabilization. They function as care providers in collaboration with staff physicians. They are skilled at NICU invasive procedures. They are present on each team during the day and will assist you in attending deliveries, providing daily patient care, and performing procedures as needed.

C. Charge nurses and admission nurses
The charge nurse decides where the infants will be placed in the NICU and makes the assignments for RN staffing of the unit. The charge nurses are the “go-between” for staff RNs and the providers. Charge nurses are extremely valuable in making sure the day-to-day operations run smoothly. The admission nurses attend deliveries when NICU presence is requested. She/he will update the L&D team on pending deliveries and new antenatal consultations. She/he is also a member of the neonatal resuscitation team.

D. Bedside nurses
Nurses are at the front line of care, taking ownership of and advocating for their patients. They are a valuable source of ‘daily updates’ regarding the state of the babies. With new models of developmental care, there will be handle times for babies, so seek them out in the morning to find out when is a good time to examine your babies.
E. Respiratory Therapists
RTs are skilled in airway management, non-invasive, and invasive ventilation. There is one RT assigned to each NICU team, and one responsible for labour and delivery. They will attend deliveries with resident in order to support airway management.

E. Social Workers
Social workers provide support to families while their babies are hospitalized in the NICU. In general, this includes emotional support as families adjust to having an ill or premature baby, assisting with finding resources in the hospital or community, and helping the families understand communications with the medical team. NICU social workers are also committed to supporting staff members, realizing that families’ experience is directly affected by the resiliency of those caring for their baby.

F. Allied health team
Neonatal dieticians are active members of the interprofessional team who will guide the parenteral and enteral nutrition and growth for our patients. They will support you in writing TPN orders, advancing feeding, and monitoring growth. Occupational therapists are experts in developmental care for babies, oral feeding assessments and safety, and guiding therapy programs for babies at risk. Lactation consultants support mothers and babies in the unit and on the post-partum floor to initiate and promote breastfeeding.

G. Flow coordinator
Care managers coordinate the pre-discharge, discharge and follow-up experience for the NICU patients. They also coordinate transfers back to referral hospitals when medically appropriate. A meeting occurs each morning to discuss patient flow (within and across hospitals).

F. Colleagues / partners providing Level I newborn care
Level I / well-baby care is provided by Family Physicians at McMaster. For a baby on the ward (4C) with respiratory or critical issues, or level II issues (ex. Hypoglycemia) requiring potential nursery admission, neonatology will become involved. For medical issues not requiring intensive/intermediate care, the McMaster general pediatrician group will provide consultation. When you are attending deliveries, babies may be transferred from L&D to 3 locations – the well-baby nursery (with Mom on 4C), Level II nursery (managed by the Team 4 neonatal team) or Level III if there are intensive care / airway management issues under neonatology teams 1-3. This decision should be made in discussion with the ‘Consult Neonatologist’ during the daytime or with the on call fellow / neonatologist at night time.
III. RESIDENT RESPONSIBILITIES

Resident workload
Team and patient assignments are aimed to optimize learning at the level of training of the resident. Residents are encouraged to provide consistent coverage by following the same patients throughout their NICU week. You will be provided with a work schedule at least two weeks before the start of your rotation. Vacation requests will be accommodated as per PAIRO guidelines. Once the schedule is released, individual requests may still be granted providing there is safe and adequate clinical coverage.

Daily schedule
0800: Handover in 4D23
1000: Bedside Rounds
1700: Evening handover

General expectations
- Residents rotating through the NICU should be accessible by their pager from 8 am till 6pm (till handover has been completed). Please give the business clerk your pager number on your first day.
- Please ensure you have completed the electronic documentation learning PRIOR to the start of your NICU rotation. This includes access to the NICU handover list, the Neonatal admission document, and your 4 digit PIN for electronic signatures. Detailed instructions on how to acquire access are provided in the NICU orientation package (emailed in advance by Jessica Okis).
- Please bring a pair of scrubs with you, as you will be required to wear then in the unit. “Green hospital” scrubs are the only ones permitted in the OR.

Parent communication
- Parents should be notified of any consults, major test results, or significant changes in their infant’s condition. Out of courtesy, and medico-legally, all parents should be informed of any procedures that are happening to their baby. Some specific procedures (ex. Blood transfusion, lumbar puncture etc...) require specific consent discussions and written consent.

Clinical responsibilities on NICU Teams 1 - 4
As residents on the team, you will have the following clinical responsibilities:
- Frontline provision of medical care for assigned inpatients
  - Airway/ventilation management
  - Nutrition orders and monitoring
  - Daily orders to be written re: investigations and treatments
  - Daily progress notes outline your medical assessment and management plan
  - Ongoing completion of interim discharge summaries
  - Family counseling, meetings, case conferences with consultant services
Clinical responsibilities on Level II / L&D week
A new role is under development in this transitional year in NICU which allows an educational and clinical opportunity for residents during their NICU rotation or during their NICU IP time. The “L&D / Level 2 resident role” involves:
- Picking up the Frontline L&D pager at morning handover or 9am (Tuesday/Thursday) after resident teaching
- Attending the daily interprofessional “L&D huddle” (9:15am 4D23) where the cases of the day are discussed with assignment of resuscitation roles
- Attending deliveries with the RN/RT team, independently or ‘buddied’ with the L&D fellow depending of level of risk of delivery and level of resident training
- Attending high risk deliveries with the L&D fellow, attending and team; actively taking part in neonatal stabilization and related procedures
- Participating in daily patient care and rounds on Neo Team 4 (Level 2) when not involved in above; senior residents will have opportunity for a higher level of autonomy / independence in patient management.
- Consultations in L&D for antenatally or postnatally identified issues

Residents will be directly coached by the L&D fellow and will work closely with the 4th attending both in Level 2 and in the Stabilization room. Residents will keep a tracking log during their week of cases seen / learning points / and attempted/completed procedures.
We recognize that residents will arrive to their NICU rotation with varied experience in antenatal/neonatal consultation and resuscitation/transition at delivery. You should always feel comfortable to request ‘back-up’ when attending consults or deliveries. The algorithms on p. 12 and 13, illustrate the process for learners’ attendance at deliveries (day/night shifts). The consult attending will review all of your clinical encounters, providing both supervision and education around cases.

Pager Codes
- ‘33’ is labour and delivery. Please call back 76147 and you will be informed about the delivery location.
- “11” is for team huddle. The morning huddle usually takes place in 4D23. Subsequently ‘huddles ‘ take place in the DI room

USEFUL NICU GUIDELINES / PROTOCOLS
The macpeds website, neonatology page will have a copy of the following frequently encountered in neonatology. They can also be found on the HHS Policy Library through citrix.
1. GBS algorithm. 5. Infant at risk of Hepatitis B
2. Hypoglycemia protocol 6. Algorithm for approach to neonatal alloimmune thrombocytopenia
3. Neonatal abstinence syndrome
4. Infant at risk of HIV
Process for learners’ attendance at delivery, supervision, education, documentation
Daytime coverage: 8am – 6pm (till handover complete)

**Ongoing consults (i.e. to be followed) should be added to Level II handover list**
Process for learners’ attendance at delivery, supervision, education, documentation
Nighttime coverage: 5/6pm – 8am

**Next morning – Level II attending reviews list of consults from overnight at handover)**

**Ongoing consults (i.e. to be followed) should be added to Level II handover list**
IV. NICU INFORMATION FOR DAILY WORK

- So terminology is standard, we consider the birth date = day of life 1
- Orders are written daily on babies’, even if it is only “same feeds, no bloodwork”
- Drug dosing should be reported as mg/kg/day
- Intake should be reported as “XX” ml/kg/day and “XX” calories/kg/day
- Urine output should be reported as “XX” ml/kg/hr

Daily Patient Assessment and Evaluation:
- This includes a clinical exam, intake / output status, assessment of fluids, feeds, laboratory results, and imaging in the last 24 hours
- Details of intake / output charts and daily weights are found on the nursing paper flow sheet (white, at the bedside).
- Please use the visual flow sheet on Meditech to review the vital signs, nursing notes, and notes from allied health (dietician, social work, and OT).
- In addition oxygen Histograms may be printed at the bedside to assess respiratory status.
- Medication details are found on the MAR (paper, at the bedside).
- The yellow nursing record “cardex” (at the bedside) is a useful record of timelines and interventions such as duration of non-invasive respiratory support, central lines, etc.
- “Special Forms” ex. CCAC, genetics testing, prescriptions... are in a cart at the South Desk.

TPN and feeds
- Please schedule a session with Lori Chessel or Christine Kalata (dieticians) to learn how to order TPN.
- TPN orders should be written by 2 pm, feeding orders should be written by Noon daily.
- TPN order sheets and Echocardiogram requisitions are found online under Order sets (through citrix).
- There are standard and slow feeding guidelines for infants < 1500 gms based on their birth weight. These pre-printed order sheets are in a binder at the south desk, they are to be placed at the front of the baby’s chart.
- All medications, fluids, and feeds are initially calculated on the birth weight. Once the baby crosses birth weight then the new weight is used for calculations unless there are special circumstances (as determined by the medical team on rounds).
- Weight charts are plotted every other day (on a table in the baby’s chart) and weekly (on the growth chart, paper, in baby’s chart). Head circumference and weight measurements are found under the’ Nutrition’ tab of the visual flow sheet. ‘Mondays’ are ‘Measure’ day. Weekly weight gain is calculated as gm/kg/day over the week.

Medications and infusions
- Medications that are given as infusions have to be ordered daily. Please check the online Neonatal Pharmacy (through citrix) specifically for Dopamine infusions. Instructions to calculate infusions are available on the Neonatal Pharmacy. Please contact the team fellow/pharmacist if there are any questions.
INFECTION CONTROL
1. Wash hands thoroughly upon entering the NICU each day
2. Think about your moments for hand hygiene (see Fig. 1 below)
3. No rings, watches, bracelets, or long sleeves in the NICU: “Bare below the elbows” policy.
4. Dress in the NICU: frontline staff including nurses, nurse practitioners, residents, fellows and attendings all wear scrubs.

Figure 1: Moments of hand hygiene – when in doubt – sanitize hands!
DOCUMENTATION

Medical documentation in the NICU is electronic. Access in meditech is through the Provider Workload Management. (**Ensure you follow instructions sent by Jessica prior to your rotation start or you will not have access to patient charting or handover sheets).

Types of documentation:

1. Admission pathway
   - Fill in the blank antenatal / perinatal / postnatal history, assessment, and management plan
   - In addition to the birth record, details of maternal history are found under the’ Obstetrical history ‘ tab of the mom’s flow sheet
   - Please review RT/ RN charting for resuscitation details to ensure consistency. This is found under ‘Patient care notes’
   - Centiles for birth weight, length and head circumference need to be completed. The charts for these are available in the patients’ physical chart.

2. Daily Progress Note
   - Daily notes are written on patients that review therapeutic goals, problem lists, clinical assessments and plans

3. Event Note
   Used to document reassessments, changes in clinical status or in management plans (including laboratory results / imaging and rationale).

4. Procedure Note
   All procedures including insertion and removal of lines, changes in airway / ventilation status (ex. Intubation / extubation), etc... must be documented.

5. Discharge summary
   All infants that leave the NICU (transfer to level II, in or out of building, or transfer home) require a written discharge summary at the time of exit. (Typed summary can accompany patient, however, discharge summary must be ‘dictated’ into the meditech system within 24 hours. Due to the high volume and changing acuity, Interim summaries must be kept ready and stored on the NICU Shared drive. There is a ‘template’ found in the shared drive.

6. Handover Sheets
   Team handover sheets are also stored in the NICU shared drive.
   You must submit your HHS username (for signing into Citrix) along with your start date to Monica Maude maudem@hhsc.ca (at least 1 week in advance) who will give you access to the network NICU$ drive. (Jessica can also facilitate this – it is in the email!)
   You will need to map this drive (instructions attached) in your Citrix explorer in order to access the Neonatal folder and the Neonatal handover file.
   Handover sheets are updated and printed before each shift.
V. EDUCATION IN THE NICU

A. Bedside team rounds
Neonatal ward rounds are being reorganized making them more consistent and multidisciplinary. Important management concepts will continue to be brought up, discussed and reinforced during these rounds. The teaching component within these rounds will be focused on management PERLS and identifying areas for further reading and discussion during case presentations.
Rounds will be conducted over 90 minutes. Different members of the health care team will present their opinion on a neonate. The resident will be encouraged to integrate this information and develop management plans for their own patients.

Objectives:
• Develop a common understanding of issues and management plans for patients.
• To develop a shared plan of care
• Structured and effective sharing of information in a multidisciplinary team
• Learn clinical aspects of neonatology that includes integrating history taking, clinical findings and management of common neonatal conditions (ex. RDS, asphyxia)
• Interpretation of common investigations (ex. CBC, CXR)
• Integrating in practice both interprofessional and family-centred care
CanMEDS roles: medical expert, communicator, collaborator, advocate

B. Procedures
Residents in the NICU are trained in neonatal procedures by either nurse practitioners, fellows, or attendings. Endotracheal intubation has been one particular procedure for which increased numbers of personnel compete. This along with the unpredictability of its occurrence makes it a tricky procedure to master. All residents will have access to mannequins on which they can practice intubations. The greatest opportunity for procedures is often during the residents’ night on-call shifts.
CanMEDS role: medical expert

C. Psychosocial rounds, parent meetings and Antenatal consults
Residents will accompany neonatologists to various rounds and meetings. The neonatologist will inform the resident of meetings that could provide an educational opportunity. Residents can observe and where appropriate participate actively in these activities.
CanMEDS roles: Communicator, collaborator, professional, health advocate

D. Formal teaching sessions: Journal club and Neonatal Seminars
In the past, residents have sought out the opportunity to present a scholarly neonatal topic at one Friday morning seminar during their rotation, or present and critically appraise a scholarly article during the neonatal journal club. Depending on the length of the rotation, residents will be provided with this opportunity when possible. Otherwise, both these sessions are protected time for residents as learners.
CanMEDS: Scholar, communicator
F. Reading around your cases
Reading around your patients’ problems regularly, in order to understand the pathophysiology and management of common newborn problems is the best way to learn neonatology. On occasion, attendings will assign topics/cases/problems for reading and informal discussions during team teaching. Residents are encouraged to generate learning cases for discussion.

VI. COMPLETING YOUR ROTATION
Please ensure you have submitted to your resident tracking tool as well as copies of the weekly Mini-MAS you have completed. You should also arrange a time for direct feedback from clinical supervisors prior to the end of your rotation.

Your feedback is important!
** Please ensure you evaluate the neonatal rotation so we can continue to make improvements to the resident program
** Please complete evaluations of staff attendings that you work with, these are important both as feedback to improve our practice and for promotion and tenure

Work hard and have fun on your neonatal rotation!