**Intern Survival Guide**



**2024-2025**

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## **Being Good to Yourself and Others**

**Taking care of others requires taking care of #1 first…YOU!**

* Getting into residency is a valuable reward after a long road in medical school, but residency can be very hard work with little rest or routine. The schedule of intern year especially can be exhausting, tiring, and stressful but remember, each year gets better and better!
* We all know the schedule is difficult. There will be many days that seem stressful, so it is important to take things a day at a time, and when you have a hard day find effective and efficient ways to get back up and keep going when you return.
* *You work hard. So, Eat when you can. Sleep when you can (Use the restroom when you can). PLEASE TAKE TIME TO GET FOOD AND DRINK WATER.*
* Remember, all of your seniors have gone through this, and your fellow interns are going through it with you. Reach out to others, share some humor, check in on how others are handling things or take a moment to vent during a hard day.
* Eli and Rebecca are your chief residents, and they ARE HERE FOR YOU! The chief office number is **6-3686** and you can always contact them if you just need a confidential space to let things out or have specific concerns in or out of the hospital.
* Take a short break every day to relax. Many times, it can be hard to leave work behind even when you have physically left the hospital. This can make it harder to rest effectively, be fully “present” at home if you need to be, or to perform other tasks you need to do after you leave. To counter this, create a “transition” habit. When you leave the hospital after a long day or night, listen to music or the news, make a phone call to someone close to you, watch something on TV, go workout, or do something else short, interesting, enjoyable and distracting to help your mind “transition” away from the hospital.
* Keep in touch with the things that you value and enjoy. Try to maintain hobbies and activities that you find stress relieving. Spending time with family and friends, religious or spiritual affiliation, exercise, painting, music, knitting, reading or whatever it may be!
* Remember that your stress relief and wellness can look completely different from someone else’s.
* Work life balance is important. Find a way to designate a portion of your weekend to go out and do something fun. For example, some people make a point to go out on the night before their day off no matter how tired they are. It ensures you get out and enjoy life after a hard week.
* Get enough sleep. Mental alertness and problem-solving capacity are greatly reduced with sleep deprivation. Set an appropriate bedtime and set alarms – even backup alarms. If you have a long night shift and do not feel safe driving home, nap in the call room until you are ready to safely drive home.
* Try to schedule routine Doctor/Dentist appointments when you have electives, Behavior/Development, or ED when you will have more flexibility in your schedule. Otherwise, give the chiefs as much notice as you can of upcoming schedule conflicts, and they will try to work things out on a case-by-case basis. Your health is important too!
* If you are ever unable to work a scheduled shift due to an illness or other emergency, page the pediatric chief on-call to notify them. Give as much advance notice to the extent possible. There is a back-up system in place for this reason. Life happens.
* If you need any mental health services, Stony Brook hospital has two wonderful Psychiatrists Dr. Pecoraro, who sees SB residents as patients free of charge (everything of course, is kept confidential per HIPAA). Dr. Pecoraro’s email is Philip.Pecoraro@stonybrookmedicine.edu You can also call 631-632-3145 if unable to get in contact with Dr. Karant directly. If you have any pressing mental health needs requiring urgent same-day attention, please notify your chief-on-call right away so that we can implement back-up that day while you take care of yourself.
* *doctors are human too.*

***So… “Be Kind to One Another.” ~Ellen Degeneres***

## **Being a Team Player!**

* Throughout the course of the year, you will be working, speaking, and consulting with nurses, phlebotomists, social workers, clerks, administrators, laboratory workers, child life specialists, pharmacists, residents and attendings. While there will be many different personalities to deal with, remember that you are working for your patient, so maintaining professional relationships is very important.
  + Always speak to others with *respect*. Everyone has gone through training to work in their position. Everyone has attributes and skills that are useful and valuable in the care of your patients, and no one can take care of a patient completely by themselves. *It takes a village.*
  + Make sure you are on the same page. When speaking with other services, let it be known what your concerns are, what your specific questions are, and how you would like them to help. Be sure to mention time sensitive aspects of care or other factors that may influence priority or preparation (e.g. patient will need sedation for procedure, requires NPO status, has significant co-morbidities, will need parental consent, or has social or protection issues pending). If you have questions or aren’t sure of your specific question, ask someone for help!
  + Get people involved early when applicable. Avoid the situation where the disposition of your patient is held up by other services and is out of your control. If you anticipate home care needs, insurance issues, or are concerned about social issues, do not hesitate to voice those concerns with our social worker. A potential consult is better served if you call them early in the day rather than around sign-out time, or earlier in the week rather than Friday afternoon. If you need help sending reference labs or have a question on dosing, try to call the respective departments before they close or the pediatric-experienced members leave.
  + Keep people updated (this applies more with nursing and social work) whenever something changes with the plan, especially if it differs from what was discussed on rounds. Of course, you will be informing your nurse of any new labs or procedures required, changes in monitoring. Confirm specialty suggestions with the nurse once the attending approves.
* Of course, if you are facing difficulty or resistance regarding patient care or communication, do not hesitate to escalate the level of involvement.
  + When calling hospital services, especially if confirming/scheduling time-specific events, *always write down the name and extension of the person with whom you have spoken*. Also ask for any supervisor's name and number should things change.
  + If you are paging an resident in another department on specialty and are not getting a response within reasonable time and number of attempts, page the next listed resident/ fellow Let your own senior resident know about your difficulty in reaching the service.
* If you have a concern about patient care, let your senior resident know so they can help. That’s what they are there for.
* There will be times where you will disagree and not fully get along with your co-residents.
  + We are human beings, and we all have opinions that are not always going to be on the same page. Keeping an open mind to others’ opinions *is a skill* however it helps us learn to collaborate ideas, compromise and come to solution that works best for everyone. If there is a ever a question about patient care and a decision cannot be made, reach out to your senior residents/ attending to help come to a conclusion.
  + As an intern, you do have a voice and your opinion matters! If you ever feel like a wrong decision is being made, speak up! It is better to run the idea by a senior or attending and have them confirm that what Is being done is correct.

***“Teamwork truly does make the dream work.”***

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## **Continuity Clinic (aka Resident Continuity Practice (RCP)**

On a weekly basis, each resident is assigned to either a full or half day of outpatient general pediatric clinic, with the exception of certain rotations (NICU, Night Intern).

### **General Clinic Day Scheduling:**

* You will find out your clinic assignment prior to orientation. You will remain at this clinic throughout your residency.
* The clinic schedule is emailed out monthly by the chiefs for all of the Stony Brook pediatric clinics. There are rarely changes to your clinic day, but it is important to check as it can happen.
* *Rotations without clinic sessions:* NICU, Night intern
* *Full day clinic:* Electives, ED, Development
* *Half day clinic:* Wards, Heme/Onc, Newborn Nursery
* Before leaving for clinic from an inpatient setting, sign out your patients to another team member (i.e. intern or senior), finish your notes, and prep discharges. Team members will cover each other’s patients on clinic days.
  + Ensure you leave at 12 noon to give yourself enough time to grab lunch and account for traffic/driving time.
* You may occasionally be assigned to alternate clinic sites/days depending on the schedules of other team members to minimize understaffing. Check your email frequently for these updates.
* When someone else has clinic on the Ward, the other intern(s) on their team need to cover for that person. Pay attention in AM sign out and during rounds so you are well equipped to manage your co- intern’s patient that day.
* Clinic days consist of two types of visits: GPV = Well Child Visit (General Patient Visit) vs. ACV = Sick Visit (Acute Patient Visit)

### **Ambulatory EMR:**

* All outpatient SB clinic sites utilize EMR.
* For GPV (Well Child Visits): document with **Powernotes**:
  + Add Documentation —> Powernote —> Precompleted: search for “well child” and you will find multiple well child note templates that are pre-completed with necessary information for each age group (developmental milestones, anticipatory guidance, etc.)
    - Save them all to your favorites for easy access!
* For ACV (Sick Visits): document with **Dynamic** **Documentation**:
  + Add Documentation —> Dynamic Documentation: “Office Visit Note”
* Using “**Quick Orders**”: All orders, prescriptions, and follow-up visits need to be scheduled through the EMR so “Quick Orders” is the easy way to access it all
  + There are multiple “Quick Orders” view, select the **Pediatric Primary Care** tab for clinic
    - This will show common in office procedures, ambulatory labs, pediatric immunizations power plans (which contain all the necessary charges and orders for each well check), referrals, medications
    - This prevents you from having to search for procedures, meds, labs, etc.
* **Patient Keeper:** You are also responsible for patient billing, which is completed through the EMR. You will receive detailed billing instructions during orientation, which is too lengthy to describe here, but always remember to bill each of your visits.
  + When the attending also sees your patient, enter modifier “GC” while billing (think of C for attending Came in).
  + If the attending does not see the patient which can occur after the first six months of intern year, enter modifier “GE” while billing (think of E for Empty room).
* You can save auto texts for several clinical scenarios you may encounter. It becomes useful for template layouts for well visits and certain common sick visits. To do so, highlight the text you want and right click it to save it as auto text. TAKE ADVANTAGE OF THIS! It will make note writing much shorter. You can make auto texts for anything that you commonly through into notes (i.e. developmental milestones for different ages during a GPV or your typical supportive care speech for your standard URI)
* You can also save Macros which may help you with notes. Ex Negative Review of Systems, Normal Physical Exam.

### **Clinic duties:**

1. **Seeing patients:** For the first six months of intern year, you present all patients to the attending, who also sees the patient.
   * After that, you will be able to see patients on your own - you still always need to present to your attending, but the attending does not necessarily have to personally examine the patient.
   * Never hesitate if you are unsure about the diagnosis of a patient; your attending is ALWAYS available and willing to see the patient.
2. **Message Pools:** In addition to the patients on your schedule, you will have messages in the “Pool” (resident pool and physician pool, not lab pool) that you and the other residents at clinic will have to reply to. You can right click, assign the message to you and work on it before seeing patients, while waiting to present to the attending or while waiting for your next clinic patient to arrive. This can be nerve-wracking, but it is great practice for health calls, which you will do in second and third year. The messages need to be done by the end of the clinic session so just remember – teamwork!
   1. You will need to add your clinic’s pool messages
   2. Click message center -> Pools tab (on righthand side) -> Manage -> Search for your clinic’s pool i.e “Stony Brook Children’s 4 Tech Physician Pool” “Stony Brook Children’s 4 Tech Resident Lab Pool”
3. **Forms:** There is a basket of school physicals, medication refill forms, etc. that accrue. You are responsible for checking this basket and filling out as many forms as you can.

### **Establishing continuity:**

* Try to schedule your patients for follow ups on your clinic days to maintain continuity. We also encourage you to assign yourself to specific patients you mesh well with. Schedule follow-up appointments with you!
  + During COVID this has been difficult given residents are working off attending schedules and do not have a schedule of their own but you can offer patients to come back on your clinic day under the attending you will be working with that day (you get your entire month’s clinic schedule so you know who you’ll be working with over the next few weeks!)
* Recruit infants from the Newborn Nursery or during your inpatient rotations. If a family doesn’t have a primary pediatrician, offer your card and recruit them to your clinic to build your continuity population. Always carry a few cards in your wallet/bag!

### **RCP Curriculum:**

* Once a month, there is RCP Curriculum Week, where a topic is reviewed for ~30 minutes before the start of your afternoon clinic session.
  + Readings/articles/modules/worksheets are sent out in advance.
  + You should prepare for Curriculum Week by completing all assigned readings and questions and come to clinic prepared to discuss the topic.
  + If your name is bolded for that week, you are leading the discussion!

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## **Development/Behavioral**

**So, You’re Starting Your Development Block…**

* Your Development/Behavioral rotation will incorporate a number of outpatient experiences geared to expand your understanding of normal vs. abnormal child development and behavior, and the management of common developmental issues.
* Bring reading materials to clinic as there may be *downtime*.
  + **This is a good block to use to study for your boards** (Level 3/Step 3), so have a device where you can access a question bank/flashcard during the downtime in clinic
* Required book chapters are accessible in E-book format through the Stony Brook libraries website using links provided in the reading list that is given to you at the beginning of the rotation. It looks like a long reading list, but each chapter is only 3 pages long, and each topic is high yield for the Pediatric boards.
  + All the required and supplemental readings are located on the curriculum website as well with links.
* Be engaged and ask questions. Remember that many of the chronic care patients that come through the peds acute floor have needs in this area, and the more you understand them, the better care you will provide.
* By the end of this rotation your goal should be to have a better grasp on developmental milestones, diagnosing, and managing common developmental disorders such as:
  + ADHD, Autism, Language and Speech disorders, Sleep disorders, Cerebral Palsy, Genetic disorders such as Down syndrome and Turner Syndrome

**Scheduling:**

* **Dr. Danielle Macina** (danielle.macina@stonybrookmedicine.edu) will send you your schedule prior to your Development block.
  + Reach out to her if you do not receive it in a timely fashion.
  + This also will include when, where, and who to report to.
* You will be scheduled for a variety of outpatient experiences, such as development clinic, high risk clinic, genetics clinic, ADOS and neurodevelopmental testing, observations in school, etc.
* If you are sick, also notify the attending you were supposed to be with so that she can contact the appropriate person for where you were scheduled for the day.

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## **Documentation Guidelines & EMR Tips**

Stony Brook’s EMR = Cerner PowerChart

Medical documentation is part of a medical-legal record; therefore, it is imperative that all medical documentation be consistently high-quality and up to date!

* Another medical care provider should be able to continue quality medical care at any time based on objective, complete, accurate entries. All notes must be documented ASAP.
* There are certain situations that may prevent you from getting to it in a timely fashion, however you must ensure it is completed by the end of your shift.
* Always avoid using a copy forward function or copying and pasting previous notes into another – this is a huge risk! Remember that your notes, especially your assessment and plan are your opportunity to demonstrate your critical thinking and knowledge of your patients.

**EMR Tips & Tricks:**

You will receive a thorough orientation on how to use Cerner Power Chart, our EMR, during your orientation, but here are some specific tips that your seniors have found practical and helpful:

* **NOTES**:
  + Save common note pathways on your ‘Favorites’ list (Pediatric Admission H&P, Pediatric Progress Note, Pediatric Event Note, etc.)
    - Find these notes under ‘Encounter Pathway’:
      * Each pathway has slightly different fields and comes with some auto-populating information.
      * This is particularly the case when it comes to subspecialties and electives.
    - “Note Type” is simply a label for the note and does not change what it looks like.
  + Be sure to always forward signed notes to the correct attending so they can addend/sign your note.
  + Macros: Developing your own set of macros can be a huge time saver. Be sure to make your own!
    - Insert by clicking the blue M next to a heading
    - Create by filling out the template as you want it, right click on heading and click ‘Save Macro As’
  + Auto-texts: Developing your own set of auto-text can be a huge time saver. Be sure to make your own!
    - Insert by inserting the auto-text phrase you saved it as
    - Access by clicking “Manage Auto Text” anytime you are in a free text part of a note
* **REVIEWING RESULTS**: Always remember to have the appropriate timeframe selected in Power Chart when browsing in your ‘Results’ and ‘Clinical Notes’ sections and adjust as needed
* **ROUNDS LIST**: For any patient list you view or make, you can also view this on a ‘Rounds List’, which can be very helpful when carrying a large load of patients (NICU, Newborn, nights, covering for your co-intern on ward, and eventually overseeing your interns when you are a senior).
  + The rounds list simply displays patients’ names and info, but importantly, has icons that display whenever a new lab, imaging study, or other order (and customizable to display any other result) returns. You can even set the timeframe for which this applies. Having this list open and refreshing can keep you on top of events for your patients without having to open their individual charts. Try it out and see if it helps your workflow!
* **PATIENT LISTS**: You can use default lists based on location to find the list of patients on each unit.
  + You can also make a patient list of your own to use by going to the Patient List tab and then clicking on the picture of the wrench icon (‘List Maintenance’)
    - Create a name for your patient list, this is not a list that will show up on anyone else’s EMR, this is for you. Click the arrow that points to the right to add it to the lists you want to have shown up on your screen.
    - Once the tab with the personal list shows up, click the picture of the person with the yellow asterisk to add patients to your list. You can remove patients from that list by clicking the picture of the person with the red X.
    - You can scroll through any patient list in the order while performing any function (such as intake/output or labs or MAR) by clicking the forward or backward arrows on the top right of the screen.
      * Tip: alphabetize your list on Newborn Nursery and crank out your intake/output numbers this way.
* **HIPAA**:
  + For patient privacy and safety purposes, NEVER leave your computer console on with the EMR logged in when you need to step away.
  + EMR is a great tool but there are still ways to make errors, and there are glitches to work out, so always check and double check your notes and orders.
  + Always make sure you are documenting on the correct patient!
* **HELP DESK:** Call 631-444-4357 for the IT Help Desk if you are ever having trouble with the EMR.
* **Auto Text Utility Tool:** Can view any one’s dot phrases! Take time to make your own and tweak things along the way. It saves time.

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## **Emergency Department (ED)**

**So, You’re Starting the ED…Or you have a short call…**

* The Pediatric ED is located on the 4th floor of the main hospital building, please be sure to find your way there before your first ED rotation or short call –it can be confusing to get there.
* You may wear scrubs for your ED rotation and short calls.
* During your ED rotation, you may work 8am – 8pm, 3pm - 3am, or 9pm – 9am, although most of the shifts you will work as an intern will be either 8am-8pm or 3pm-3am.
* Shifts are 12 hours with the intention o**f using the last hour to write notes and finish discharging/admitting your final few patients.** If it is very busy, this may not always be the case, but do your best to leave at the 12-hour mark (or at least be done with patients so you can just work on notes). The attendings and your fellow residents are aware of this suggestion and generally do not push you to take patients during your final hour.
* During electives, you will occasionally be scheduled for a Thursday short call “backup”. For the weekday short calls, you will be called in by the ED attending if it is busy. You are expected to call the Peds ED (631-638-3500) between 5-5:30pm to confirm whether you should come into your short call shift. If you do not get called in, you do not have to go to this shift, but you should be available in case you are needed. Keep your work phone by you!
* The team consists of a PEM attending, a pediatrician, and residents (number depends on the shift). There is also sometimes an NP
* You may work with other Peds or ED residents.
* **TIP:** These are long and late shifts, be safe going home! If you need to sleep or even just finish, remember that you can always go to the call room or NICU call room to work or rest.

**Scheduling:**

* Each week in the ED you may work up to 5 days and have 2 days off, though these may be post call days.
* **TIP:** Remember you have 2 DAYS OFF during the week, so keep that in mind when making scheduling requests during this rotation.
* One of these days will be a full day in Continuity clinic, so it is only a day off from the ED.
* You are expected to attend lectures on Wednesdays if you are working the 8-8 shift

**Cerner Firstnet:**

* First-Net is the ED EMR. The first thing you should do when you arrive is set yourself up as a provider. When you log in it should come up immediately and ask you, “Would you like to be checked in as an available provider?” Click “yes”.
  + Pick a nice nickname for yourself and a representative color
  + You are now checked in as a provider; when you pick up a patient, make sure to assign yourself to them by right clicking in the mid-level column
* When writing notes on First-Net, be sure to save the document type as “ED Physician Note” and choose a reason for visit (i.e., abdominal pain, fever, chest pain, etc.). All ED notes have a template. Most ED physicians prefer if you fill out those templates as it helps with billing.
* If you start a note with one provider and your patient does not leave when they do, sign the note to them and then start an addendum with the next provider using the “ED Addendum” template.
* If another resident is signing a patient out to you, make sure you also write an addendum for the note using the “ED Addendum” template.
* For both addendums, it is not necessary to fill out the entire H&P again; you may simply write “see previous resident’s note full history and physical exam – in short, this is a X-year old X here for ---“etc.).

**Charts:**

* There are clipboards located on the side of the nurse’s station for each patient. They contain patient stickers and a “triage sheet” which explains the reason for their visit and has vitals listed. The clipboards chart in the slot of the appropriate room/hall number on the left. This keeps the clipboards organized for the nurses and providers.

**Supplies:**

* Green supply carts are in each patient room – ask a nurse or resident for things you cannot find. On your first day, be sure to ask for the code # from the nurses, clerk, or attendings/co-residents. The code is the same for all of the carts in the ED.
  + Each of these carts contains basic supplies you may need: ear loops, gauze, lubricant, syringes, needles, butterfly catheters, saline, hydrogen peroxide, blood tubes, etc.
  + At the bottom of each cart are diapers, occasionally the family will ask.
* There are cabinets behind where the residents sit. On the far side of the wall (closest to where the nurses sit), the cabinets contain supplies for the patients, including ortho casts and formula.
* Cabinets in each room contain chucks, pillows, towels, blankets, urine/emesis basins, 4x4 gauze, bottles of sterile saline and water.
* Each room has boxes of gloves. Gowns/masks are stored in a tan box mounted on the wall in one of the hallways.
* There are more specific supply carts in the ED as well, including: ortho/casting cart, suture cart, blood/IV/urine supplies, ENT cart
* Behind the nursing desk is a portable ophthalmoscope/otoscope to use for patients who are roomed in the hallway
* When in doubt, ask someone for the supplies you need!

**WORKSTATIONS:**

* Behind the clerk sits a very long desk with 6 computers. The two on the far left are for the attendings, but you can work at the others. There are lockers where you can stash your things behind the long desk.
* Here is where you will present to attendings and can find portable otoscopes/ophthalmoscopes if needed.
* There are cubbies behind the computers, you can place personal belongings there.

**When things Happen:**

* The ED is pretty straightforward in that you come in when your shift starts, see patients, and sign-out when your shift ends.
* Be aware of Pediatric traumas or rapid responses that are called in the ED or on the 4th floor (in radiology) as you may have to run to those as well
* Patient Arrival:
  + When patients arrive in the ED, they are seen by triage, assigned a level of acuity, vitaled, and sent to the Pediatric Emergency Room with their chart.
  + When they are ready to be seen, their name and room location will pop up on the electronic board and their chart will be placed in the new patient rack. Grab a chart and try to see patients as they arrive because they can stack up quickly.
  + As soon as you take a chart, be sure to assign yourself to that patient so that your attendings and co-residents are aware that someone is seeing that patient.

**Procedures:**

* The ED is a great place to get Lumbar Punctures, Sutures, I&Ds, bladder catheterizations, throat cultures, and venipuncture/IVs.
* The ED residents will also need procedures, make sure to be proactive when signing up for patients and advocate for yourself if there is something you need!
* Let the nurses know you would like to learn how to put in an IV or do venipuncture (also how to remove an IV!). They do this all day/every day and are very good and usually willing to teach you!
* You cannot log procedures supervised only by a nurse; however, you may ask an attending or senior resident if they would be willing to oversee you doing an IV or venipuncture with a nurse and sign off on it!
* Try to get all of your venipunctures and IVs done during your ED shift. Usually by the time patients come to the floor for admissions, the IVs are already in and there is not as much of an opportunity to get these procedures.
* Make sure to log all your procedures in New Innovations at the end of each shift. It can be easy to forget to do so, but you don’t want to be scrounging for procedures to log at the end of your year.
* To log a procedure, you will need the patient’s MRN, the date of the procedure, and the certified person (senior resident or attending) who is signing off on the procedure log.
* You should do as many procedures as possible during your rotation. Practice makes perfect!

**Contents of an ED Chart:**

**Triage Form:**

* Can be seen by clicking the “T” next to a patient’s name on First-Net
* Level of acuity (assigned by nurse in triage), dependent on patient age, chief complaint, initial VS. Determines how quickly the patient is seen. Always see the higher acuity patients first.
* On each clipboard is a sheet w/ the patient’s chief complaint and vital signs, as well as patient stickers. You may write on the vital sheet, but it is recommended to take notes on a separate paper as you have to replace the clipboard once you have seen and presented the patient.

**Orders:**

* Use Power Orders through Firstnet
* In the ED, all orders are “STAT” and “x1” in frequency.
* Images (XR, CT, MRI) can be ordered through the “Emergency Department” →” ED Radiology” to get images not only STAT but with most of the order information filled out for you
* Discuss all orders with the attending before placing them

**Consults:**

* Consults are arranged via Firstnet. A physician-to-physician consult order MUST be placed.
* Page the consult service through the pager system but always place the order in the chart as well
* *Never call a* *consult without attending approval* *and never initiate a plan proposed by a consultant without attending approval.*

**Admissions:**

* If a patient needs to be admitted, you first must determine who the admitting physician/service will be.
  + A patient with a private attending who admits to the hospital will be admitted under that PVT attending (see Appendix). A list of private attendings with admitting privileges is posted on the wall on the right side of the last computer on the right in the workstation.
  + A patient with no PMD or a PMD without admitting privileges will be admitted under the hospitalist service (SVC).
  + A patient going to a subspecialty/surgical service will get admitted under their on-call attending.
* Page the admitting physician and discuss/formulate a plan (from 6PM to 6AM, you will admit directly to the overnight senior resident). Make sure they accept the admission/patient and let your ED attending know they have accepted.
  + Always discuss plan for admission with the ED attending prior to paging the attending/overnight resident.
  + Some consult services (surgery, neuro, endo, etc.) will tell you to admit to their own service.
  + Always call the PICU/PONC/6W and sign out the patient to the senior resident; please relay to them the plan that was discussed between yourself and the accepting attending!
* After the attending has accepted the patient, page the senior resident on the floor to let them know about the admission
* If you are admitting a surgery patient, still page the floor senior to let them know the patient is being admitted – they are still responsible for rapids when the patient is on the floor, and if they are unaware of the patient, there can be lapses in care!
* Place the admission orders. Type in “ED Bridge” to the search box in orders and fill in the required fields (you will need to know the name of the resident you spoke with and the name of the attending who accepted the admission).
* DO NOT place admission orders until you have spoken to the attending/overnight resident and they have accepted the admission!

**Discharges:**

* To discharge a patient, in your ED note, select a diagnosis, order prescriptions, and select patient education and provide follow up recommendations. These are all clickable sections within the ED templates.
* You may also fill these sections out within the “Depart”.
* **TIP**: “Form for School/Work Excuse” can be added on in the patient education section and completed to give the patient a note for school or work
* Follow-up is generally with their PMD in 1-2 days, if needed. Also list any specialty services the patient should follow up with.
* Once the discharge is prepped and printed, placed discharge orders by searching for “ED Discharge Orders to Home”. Have the attending sign the discharge form. The forms can then be attached to the patient clipboard and placed in the rack for discharge.
* You may discharge patients yourself. This can be particularly helpful if the ED is busy. Go back to the patient and have the parent sign the form and then sign it with your ID number. DO NOT GIVE THE FAMILIES THE SIGNED PAPER; THIS BELONGS TO THE HOSPITAL. The rest of the packet can be handed to the families.

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## **Electives**

**So, You’re Starting an Elective…**

Electives are available in a number of subspecialty fields. The day-to-day schedule will vary based on the elective but can consist of both outpatient subspecialty clinics and inpatient consults. They may also include procedure days, depending on the schedule.

Subspecialty Clinics:

* These clinics function more or less like your continuity clinic.
* You will see patients first, then present to the attending. You are expected to write the note unless they tell you otherwise.
* Depending on the rotation, always be proactive and ask the attending what is expected of the resident when seeing the patient first:
  + Ex: Should resident wait for attending to perform rectal exam (GI rotation), should resident wait for attending to perform puberty exam (endo rotation), etc.
  + Ask attending which note template to use, as different subspecialties have different pre-completed notes/templates with focused questions that can help you know what questions to ask during your H&P

Inpatient Consults:

* Exact flow will depend on rotation but most of the time, the resident is expected to see the patient first, then present to the attending/rest of the team, and document a consult note
* Always clarify what the expectations are with your attending/fellow when starting a rotation

Rotation Preparation:

* You’re not expected to know everything on Day 1 of your elective. But the Curriculum Website is a great resource for reading materials. Much of the material that you need to know is there.

**Schedule:**

* A week before your elective, contact the attending on service to find out where you should be on your first day. This is very important, so that you know where and when to go and who to report to!
  + If you’re not sure who to contact, ask the chiefs
* Ideally, the specialty will provide you with a full schedule prior to starting the rotation, but sometimes they will let you know where to go day-to-day.

**Didactics:**

* Depending on the rotation and if your schedule permits, you are expected to attend afternoon case conference (Monday & Friday from 12:30-1pm)
* You are required to attend Wednesday Grand Rounds and Lectures while on electives

**Calls:**

* While on your elective rotation, you will also be required to work short calls in either the ED (weekend 5 hours shifts) or the Newborn Nursery (weekends)
* Make sure you get orientation in the Newborn Nursery before your first short call if you haven’t had your Nursery rotation yet.

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## **Heme-Onc (aka PONC)**

**So, You’re Starting Pediatric Heme/Onc…**

* The Heme/Onc ward is located on 6W3, adjacent to acute pediatric floor.
* The team will consist of 1-2 medical students, 1 intern and 1 senior.
* You and your medical student will be responsible for all of the patients on the floor. You are responsible for finishing all progress notes in the morning, prior to rounds (at 9:30 am). The census will be smaller than peds acute floor, but patients will likely be more complicated, so be prepared to have a heavy workload. It is very important to pay attention to details!
  + Some things to know about your patients prior to rounds are: their labs that were drawn in the morning (to see who may need a transfusion or if your patient is still severely neutropenic), what chemo protocol they are on and what day of the protocol they are on, where in the stages of their chemo they are on (induction/consolidation/maintenance)
* The Peds Heme/Onc NPs are helpful! They have an office located on 6W3.
* Because there is no formal AM signout for Heme/Onc, sign-out is first come first serve with the floor team, so if you do not want to be stuck waiting until floor sign-out is done, arrive early/on time!
* ***There is a separate heme/onc ward office handbook —> ask the chiefs/seniors for this document if you have not received it!!!***

**Scheduling:**

* As the Heme/Onc intern, your work hours are from 6:30am– 6pm.
* Because there are only two residents on the rotation at a time, you will end up doing 4 weekend calls (either Saturday or Sunday each week). Despite what the schedule technically reads, the weekend call schedule will be determined by you and your senior resident.
* **The chiefs need to know who will be on if it is different from the printed schedule.** If you are schedule-shuffling, send the chiefs an email with your final decision and cc your senior. This formalizes the process and decreases scheduling memory lapses.

**Preparation for the Rotation:**

1. As with the wards, before you start, familiarize yourself with where everything is.
2. The day before you start, the Heme/Onc intern will sign out the patients to you. Make sure that you know everything about each one of those patients: take notes during the verbal sign-out, comb the chart for pertinent information (H&P and off-service notes are key, if the latter is applicable) and go through the computer for current chemo protocol, orders, latest labs and current medications. Ask questions about anything you are unsure of or that seems confusing – there can be a lot of medications and labs on these patients, and you are responsible for them!
3. READ about the diagnosis and management.
   1. **Make sure you know the side effects and mechanism of action of any chemotherapeutic medications the patient is on —> attendings love to ask about side-effects during rounds, so be prepared!**

**Where Things Are:**

**Charts:**

* Red Charts are usually found in the chart rack, which contain patient stickers, ED and outside records, **chemotherapy orders.**

**Chemotherapy Binder:**

1. In the chemo binder, you will find the paper orders for chemotherapy that the nurses will fax to pharmacy. **You are never responsible for any IV chemotherapy orders or fluids required for prehydration,** but you should review the orders before and after they are entered into PowerChart. We have a chemopharmacist that will place these orders into the computer just prior to the patient being admitted to the unit.
2. There is always a copy of the chemotherapy protocol in the chart during the admission. Have this copy available at all times because besides actual chemotherapy medications, the packet lists what labs to obtain at what times (you will be monitoring certain serum and urine values while on certain regimens) as well as what to do if labs are not ideal! We have all found this to be extremely helpful throughout our rotation.
3. **You are responsible for fluid order adjustments (which you should keep an eye on, as they can change with each stage or day of chemotherapy), restarting home medications (including PO chemo), and daily labs.**
   1. **Of note, if a patient is coming in for IV chemo, then chemopharmacy will also order their home PO chemo regimen. It is always a good idea to double-check these orders!**

**When Things Happen:**

Daily:

1. 6:30 - 7am: Obtain sign-out from night team
2. 7am – 8:30am: Pre-Rounding (obtain data, see patients, finish/sign notes)
3. 9am – Midmorning: Rounds with attending (keep in mind, you and med student are responsible for presentations)
4. Midmorning – 5pm: Reviewing orders for the day/night, doing admissions and consults, checking in with patients. Can have one of the rounds as described below.
5. There is a heme/onc clinic in the cancer center (attached to the children’s hospital) in the afternoon that one-member intern/senior should attend from Mon-Thurs, you guys can alternate days.
6. 5pm: There are no formal “evening rounds,” however you should check-in on patients one final time to let them know any changes/plan for the night. You should also check in with nurses to make sure they are aware of contingency plans and they would be able to voice their concerns at that time.
7. 6pm: PM Signout in the MART conference room.

Weekly:

1. Heme/Onc Clinics: Daily in the afternoons, starting at 1pm. You and your senior must each attend once a week.
2. Tumor Board: Every other Monday at 4pm.
3. Radiology Rounds: Thursdays at 11am
4. Interdisciplinary Meeting: Every Tuesday at 12pm in the Signout room.
5. You and your senior will also have your usual half day of continuity clinic each week

Weekend:

1. Rounding on weekends for heme/onc tends to be quick, and mostly “table rounds” (sitting at a computer with the attending, reviewing labs and overnight events, then quickly checking on all patients at the end). The attendings may arrive for rounds anywhere between 7:30/8 and 9 AM. If they arrive early, they do note care whether or not notes are completed before rounds!
2. Once rounds are complete and you’ve finished your tasks for the day, checked in with nurses, placed necessary orders, etc., you are free to leave and sign out your patients to the acute pediatric floor weekend day team (they cover heme/onc over the weekend once the heme/onc residents sign out).
3. The above bullet brings up a very important topic: PLEASE make sure all tasks for the day are completed, nurses are comfortable with contingency plans, and families are comfortable with the plan for the day – there is nothing worse than the heme/onc resident leaving the acute pediatric floor day team to tie up loose ends, especially when the peds floor census is crazy)! Your attention to detail will be much appreciated.

**Pre-Rounding:**

1. Ask the nurses about overnight events (that you should know about from the night team already, but you never know).
2. Review vitals (including **ALL ranges**), ins and outs (report UOP in cc/kg/day), new labs or films, etc.
3. Check the MAR to note the time of chemotherapy, PRN pain medicine, etc.
4. See as many kids as possible if they’re awake. If the patient is sleeping, let them sleep as much as possible.
5. Finish notes before rounds, if possible, but can be completed immediately following rounds

**Attending Rounds:**

1. Attending rounds are bedside and family-centered with presentations outside of the patient’s room.
2. For established patients, presentations should be short: brief introduction to the patient (if chemo, include protocol and day of treatment), overnight events, ROS by system, VS, pertinent PE findings, new labs, assessment and plan for the day.
   1. Tip: When presenting vitals, include ranges and UOP in cc/kg/day.
   2. Tip: When presenting labs, include pertinent indices (i.e., corrected reticulocyte count in sickle cell patients or ANC in chemotherapy patients).
3. If the patient is a new patient, you will have to present the entire H&P.
4. You should defer all presentations to your medical students if they are following a patient. Make sure to go over with them the correct format and help them in their areas of weakness.
5. On Wednesdays, everyone goes to Grand Rounds, then one resident (you or your senior) will stay for rounds and man the ward while the other goes to lecture. This should switch off every week.

**Admissions:**

1. Admissions are the same as on the acute pediatric floor. H&Ps are due ASAP. Patients who are admitted will need a complete history and physical written on PowerChart, growth chart and BMI, admission orders, PMD notification (if necessary) and **medication reconciliation.** 
   1. **TIP:** Use past notes/labs from PowerChart to fill in as much history as possible before the patient arrives on the floor.
   2. Unlike patients on peds acute floor, patients on Heme/Onc are “frequent flyers” (they have chronic diseases and have been in/out of the hospital multiple times). This is why information gathering prior to their admission is crucial; it’s not the best practice to ask them to regurgitate their child’s long, complex history to you when they were most likely just here within the past month. Going in with a baseline of knowledge and asking only pertinent questions (see below, “Frequently Encountered”) will be much appreciated by the parents.
   3. A note about medication reconciliations: we cannot stress enough how important this is! These patients are on a lot of medications, make sure you are reviewing dosing and timing of all medications they are on so that you can order them if necessary on admission, and also so that at time of discharge, your depart medication rec is much easier!

**Heme/Onc Consults:**

1. Other services will frequently consult the Heme/Onc service for Hematology and Oncology issues.
2. Either you or your senior will be responsible for doing a complete H&P for consulted patients as well as formulating your own assessment and plan. The patient H&P/plan will of course be reviewed with the attending prior to the end of that day.
3. Keep track of them during their admission and write notes daily, unless the attending specifies otherwise. After heme/onc unit rounds, you will usually go with the attending to check-in on consult patients for the day.

**Running the List/Updating your senior:**

1. During the course of the day, update your senior (and your patients/families) frequently.
2. Make sure to also update the list frequently, double and triple-checking correct medications and doses.
   1. Don’t let any vital medications (i.e. Antibiotics) fall off the MAR on your watch!
   2. Check your medications orders twice daily
3. You and your senior can take turns staying until 6pm to sign out (of course, if there is a lot going on you both should stay to help each other out).
4. Before evening sign-out, you should have reviewed the most recent vitals (including ranges) for your patients and have a good idea of what the night team should expect overnight.
5. Print copies of the Heme/Onc list for the night team and be ready for sign-out early (~5:45pm) so you can sign-out first! (Just like AM sign-out, don’t want to wait for acute pediatric floor sign-out to finish since their census is longer)!

**PM Signout:**

1. Evening sign-out begins at 6PM. You are signing out to the ward senior/intern team. They cover both acute pediatric floor and Heme/Onc overnight (of course, since most interns have not done PONC in the beginning of the year, the senior is mostly responsible).
2. Confirm which attending will be on call that evening at rounds and whether they would prefer to be contacted via pager or cell/home phone. This is very important information for the night team to have.
3. Presentations to the night team should be brief, but they should also include any and all pertinent information about your patients that would be important to know overnight.
   1. Report by systems, including most recent vitals.
   2. Briefly list important medications and side effects (list chemotherapy side effects on the sign out so night team is aware)
   3. Finish with a summary of night issues/things to look out for or accomplish overnight, as well as labs expected in the AM if there is a value that needs to be watched for.
4. Common Heme/Onc issues to sign out:
   1. ***What to do for a fever:*** What is the temperature cutoff for each patient/what counts as a fever? Do we need a blood culture with fever? To a max of how many/day? Has patient already reached max? Does max restart at midnight? Should we start antibiotics if the patient is febrile? (All of these should be asked during rounds so that you can plan adequately).
   2. ***What to do for abnormal urine dips:*** What are acceptable parameters for urine dips? How should we adjust fluids for abnormal parameters? (Can be found in chemo protocol packet).

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*From “Frequently Encountered H/O PATIENTS” - Dr. Suzanne Van Benthuysen*

**Sickle Cell Disease:** Patients with SCD will often be admitted for pain crises and/or fever.

HPI:

* Normal pain questions: Onset, location, duration, severity (0-10) before and after intervention, quality, what do they have at home and what usually works? Associated sx? Any chest pain, cough or SOB? RUQ pain (think about gallstones)? Febrile at home/in ED?

PMHx:

* What kind of hemoglobin disease is it? (SC, SS, SB-thal). You can look back in the labs on the computer to find out old electrophoresis results if they don't remember.
* Any hospitalizations, surgeries (GB out?), last transfusion, any exchange transfusions or PICU admissions, any acute chest/stroke/ priapism/ osteomyelitis events? (Remember, a lot of these can be found in the chart before speaking to the parents)
* Home meds and compliance? Were they on penicillin until 5 yo?
* Immunizations (pneumococcal vaccines and flu vaccines)
* Look back in the computer and get an idea of their hemoglobin/hematocrit, what are their normal values? What are their normal reticulocyte values?

Orders:

* IVF : Hydrate aggressively → 1.5x maintenance except in cases of acute chest, when fluid overload can be an issue (in that case 1M is sufficient). **Fluids are maintenance and NEVER a bolus**! Bolusing the patient can lead to increased sickling and a worsened crisis.
* Regular diet if tolerated
* Strict Is/Os
* Respiratory:
  + Supplemental O2 as needed to keep oxygen saturation greater than 92%
  + Pulse oximetry protocol (continuous not always necessary!)
  + Incentive spirometer at bedside, encourage frequent use (suggest during commercial breaks if watching TV)
* Pain:
  + Whatever works for them around the clock and PRN for breakthrough (if they don’t know, morphine is usually a good place to start). Attendings will usually weigh in on this before the patient is admitted so you will have an idea.
  + PCA can be started by acute pain service. Call them to come see the patient if you deem it necessary.
  + Motrin or Toradol around the clock always!
* Other Meds:
  + Antibiotics:
    - If febrile, start ceftriaxone ASAP. This is incredibly important in these patients; if they truly have an infection these patients can progress very quickly and antibiotics decrease their mortality! I
    - If you’re also worried about pulmonary involvement, add azithromycin to cover atypicals.
  + Hydroxyurea:
    - Increases hemoglobin F production.
    - If not taking at home, ask why.
  + Folate:
    - Sicklers have inherent folate deficiency because of high RBC turnover.
    - Continue their home dose. If not taking at home – ask why.
  + Pepcid – Prophylaxis for NSAID gastritis
  + Bowel regimen (ex: Miralax) – Constipation from opiates.

Labs:

* Usually get a CBC and differential with reticulocyte count (probably done in ED)
* CXR if any suspicion of pulmonary involvement (probably also done in ED)
* Hb electrophoresis if concerned about compliance.
* Blood culture usually done in ED if patient is febrile.

Hospital Course:

* If patient is febrile, they do not necessarily need to be admitted (but cultures need to be drawn and antibiotics should be administered within one hour of arrival).
* Attendings will decide to admit in cases of poorly compliant patient/family, WBC <5 or >30 or patient is very ill-appearing/there is concern for acute chest syndrome.
* Follow blood cultures:
  + When afebrile and cultures are negative x 48 hrs, patient can go home (if on PO pain meds and not requiring oxygen)
* For pain crises, goal is to get patient off of IV pain meds.
  + Once tolerating PO pain meds, they too can be discharged.
* On discharge, make sure all sickle cell patients have H/O follow-up in clinic, adequate home meds and pain meds.
  + Common home meds: Folate, Hydroxyurea, other maintenance sickle cell patient meds (ex: Exjade for iron chelation)

**Routine Chemotherapy Visit:** Patients coming for chemotherapy have usually been in clinic that day or the day before and have already had their labs drawn. They have probably already answered a bunch of questions about how they were feeling since the last round, but unfortunately, we have to ask them again.

HPI:

1. Make sure to be thorough in ROS: fever/appetite/ energy/pain/rash/bleeding/nausea /vomiting/diarrhea/ constipation/ cough/sniffles/blood in stool or urine/pain on swallowing/pooping/ peeing (all mucous membranes = possible mucositis).
2. Are they neutropenic?

PMHx:

1. Look up this information in Cerner before they come in; remember, it’s much appreciated by the parents. You will also feel more comfortable if you have a background on the patient before going in the room, and all you have to do is fill in the gaps.
2. When they were diagnosed, how many cycles of chemo/radiation and when was the last one, Past surgical history, home meds and compliance issues, Immunizations

Chemo Orders:

1. You do not have to figure out a structure for a chemo protocol or order chemotherapy yourself. The protocol will be provided to you when a patient is admitted.
   1. Your job is to order anything in the protocol other than the chemotherapy medication itself and prehydration fluids (including adjustment in fluids, medications for nausea, antibiotics, etc.).
   2. As stated above, familiarize yourself with the protocol as well as common side effects!
2. Don’t forget about supportive meds: PCP prophylaxis, mouthwash, etc. These are not always included in the protocol – check with families during your admission med rec what they usually get at home and order these!

Admission Orders:

1. Admission orders should include:
   1. A communication order to the nurse to notify MD for fever > 100.4F.
   2. Also include a communication order with urine parameters (ph., blood, and specific gravity, state “Notify MD when” for any abnormalities). These parameters are found in chemo protocol, as mentioned above.
   3. Diet: Regular pediatric vs. Neutropenic. Write a neutropenic diet for a patients with an ANC<500.
2. Make SURE that you order all labs outlined by the protocol (besides chemo orders)

Hospital Course:

1. Patients will likely get nauseated. Do what you can to keep their appetite stimulated and nausea at a minimum.
2. Most chemo protocols are uncomplicated, and patients finish them and go home uneventfully. (The exception is AML patients – we wait for their counts to drop and recover before they’re allowed to go home due to high risk for developing gram negative bacteremia.)
3. If patients develop a fever and are NOT neutropenic, they are usually cultured and started on a cephalosporin like ceftriaxone until cx are negative 48 hours.
4. If they ARE neutropenic, they have to get started on antibiotics that cover gram positive, negative, and pseudomonas. Cefepime is a standard starting antibiotic and is continued until patient is afebrile, cultures are negative 48 hours, and ANC > 500.
5. In this case we also get daily CBC/diff (to trend ANC, make sure it's starting to go up--you can go home neutropenic, but not febrile and neutropenic, and we want to make sure the ANC is at least trending in a better direction) and blood culture, along with blood cultures with febrile episodes as above.
6. Make sure that on discharge, patients have enough home meds (you may have to write Rx or call in to the pharmacy).

Common Home Meds after Chemo

* **Prophylaxis**:
  + *Prophylaxis for PCP pneumonia:*
    - Bactrim (trimethoprim/sulfamethoxazole): Taken 2-3 days/wk, may cause bone marrow depression
    - Mepron (atovaquone): 2nd line coverage, only comes as liquid, some patients won't tolerate it. Daily drug, less bone marrow depression
    - Dapsone : 3rd line coverage, not as good coverage but less bone marrow depression
    - Pentamidine : 1 IV dose Qmonth, good for sulfa-allergic pts
  + *Prophylactic antiseptic mouth care:*
    - Peridex (chlorhexidine): 1-2 teaspoons (5cc=1tsp) PO TID, swish/spit
  + *Prophylactic Antifungal mouth care:*
    - Nystatin (100,000 units/ml) 1-2 tsp (5-10cc) PO TID, swish/swallow (sw/sw)
    - Mycelex 1 troche PO TID
* **Antiemetics**:
* *Selective 5-HT3 Receptor Antagonist:*
  + Zofran (ondansetron) ODS, pills, or IV
  + Kytril (granisetron) IV only
  + Aloxi (palonosetron) IV only
* *Antihistamine antiemetics:*
  + Benadryl (diphenhydramine) - good antiemetic, IV or PO. Patients can develop addiction to IV push.
  + Atarax -(hyroxyzine)
  + Ativan
  + Emend (aprepitant): antagonizes substance P/neurokinin-1 receptors, usually only given once per protocol on first day as premedication
  + Marinol : active component of marijuana, good appetite stimulant/antiemetic
  + Reglan (metoclopramide)/ Benadryl (addition of antihistamine reduces extrapyramidal side effects)
  + Phenergan (promethazine) phenothiazine derivative, sedating ( use cautiously, don't use in children under age 2 or with seizures)
* **Other Meds**:
  + *Neutrophil stimulators:*
    - GCSF (Neupogen) 5micrograms/kg, SQ qday until ANC adequate (usually 2-week cycle)
    - GCSF (Neulasta) 1 shot SQ usually good for a month, 6mg if >45 kg, 100mcg/kg if <45kg  \*because it LASTS, get it?\* it's easy to mix the two up but neulasta is crazy expensive and neupogen is a bit more affordable. Usually neulasta is given at home (cheaper for the hospital)

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## **Afternoon Case Conference (ACC)**

**So, What Is Afternoon Case Conference…**

ALL House Staff and anyone on electives that are scheduled to attend must attend ACC on Monday and Friday from 1:00-1:30pm. T*his is protected time*. Case conference takes place in person on Tuesdays in 6W Multipurpose Room (the sign out room) and on Fridays in HSC 11-025. There is a virtual link as well that you can join case conference from if you are not in the hospital.

* The goal of ACC is two-fold. First, to focus on resident education, especially high-yield topics, presentation, management/workup, and treatment of various pediatric illnesses. Second, it is an opportunity to hone your presentation skills.
* You may create a PowerPoint with a few slides to show vitals, imaging, and write out your clinical pearls at the end but DO NOT use this as a crutch to read off, this is an *interactive discussion*
* If you are presenting, be prepared to be interactive with the audience and teach about your case. Don’t be afraid to call on people! Ask individuals to interpret vitals, labs, read a CXR, give a differential, etc.
* If you are in the audience, **please** participate in the discussion. It’s no fun speaking to a silent room.
* ACC is facilitated by the chief residents.
  + Senior residents will present cases for the first 6 months.
  + Interns are expected to start presenting cases in December, but keep in mind over the last several years, this has been occurring sooner (as early as October/November).

**Attendance:**

Below is a list of when residents are to attend Afternoon Case Conference based on their rotation:

* **Ward Senior:** Daily
* **Night Senior:** Never, unless presenting
* **Ward Intern:**  Daily
* **Night Intern:** Never
* **Heme/Onc Senior:** Daily
* **Heme/Onc Intern:** Daily
* **PICU/Elective**: Daily (unless on-call or post-call)
* **NICU/Elective:** Only for NICU Afternoon Case Conference
* **Newborn**: Never
* **ED:** Never
* **Backup:** Never, unless presenting
* **Electives:** *These are generalized guidelines, and your ability to attend Afternoon Case Conference may vary widely with attendings and your elective schedule.* 
  + **Administration:** As scheduled
  + **Adolescent:** Mondays and Thursdays
  + **Allergy/Immunology**: Thursdays
  + **Cardio**: Tuesdays
  + **Child Psych**: Daily
  + **Community/Advocacy**: When schedule allows
  + **Dermatology:** Thursday and Friday
  + **Development**: Friday
  + **Endo**: Thursdays
  + **Genetics**: Daily
  + **GI**: Daily
  + **GP:** Never
  + **ID**: Daily
  + **Nephrology**: Thursdays
  + **Neuro**: Daily
  + **Ophthalmology:** Daily
  + **PSG:** Tuesdays and Fridays
  + **Pulmonology:**Tuesdays and Fridays
  + **Radiology**: Daily
  + **Rheumatology**: Tuesdays and Fridays
  + **Research:** Daily
  + **Sports Meds:** Tuesday
  + **All other:** daily (Unless you have received prior approval to miss)

**Case Selection/Preparation:**

* Once you have an interesting patient, send the MRN to the chiefs so that they may reserve that patient for you
  + Note: The chiefs may notify you with an email if there is a case they would like you to present.
* Special Afternoon Case Conferences:
  + NICU Afternoon Case Conference once a month led by current NICU residents
  + PICU Afternoon Case Conference once a month led by current PICU residents
  + Cardiology Afternoon Case Conference when residents are rotating through cardiology

**General Structure of a Afternoon Case Conference:**

* Cases should be well-structured and succinct with clear discussion points incorporated throughout the presentation. Focus the discussion on either building a differential diagnosis or management of your case.
* Format: we encourage you to follow the format below, but of course depending on the case you may have to stray from this.
  + Initial “one-liner:” Age, Sex, and Race/Ethnicity, chief complaint
  + Histories: The residents are expected to know the patient very well. The history should be presented freely without directly reading word for word from their paper.
    - Residents should be able to answer all *pertinent* questions regarding the HPI and PMH.
    - The entire HEADSS exam should be stated for adolescent patients.
  + Review of Systems: pertinent positives and negatives
  + Physical Exam:Initial vital signs, growth percentiles (weight, height/length and head circumference)
  + Images: Residents should know the images well and be able to explain them. Images should be reviewed with the radiologist and/or neuroradiologist prior to the presentation.
  + Discussion: All relevant differential diagnoses should be included. Zebras are welcome, but only if they are truly a possible diagnosis.
    - The discussion should be led primarily by the resident.
    - The discussion should be interactive and should include the appropriate faculty members. Residents should engage the faculty for discussion points.
    - There should NOT be a formal lecture discussion at the end of the presentation. Any teaching points should be given throughout the presentation during the differential and/or management section.
  + Hospital Course/Follow Up: The end of the case should include the relevant hospital course, follow-up including social issues, outpatient appointments with subspecialties or PMDs. This is a great time to incorporate faculty to teach management/prognosis of your case.

**Things to arrange in advance:**

* Know your patient and their case well! Comb through the EMR and read the H&P, progress notes, pertinent physical exam findings, lab trends, radiology, consults, follow up, etc.
* Review useful resources such as Uptodate, PubMed, Peds in Review, etc. to help you understand the case and lead the discussion.
* Find photos of physical findings and pertinent radiology- if you can get the patient’s own images, even better!
* Reach out to any faculty members that were involved in the case so that they can add their own thoughts/pearls of expertise or help you out if there is a difficult/specific question that someone in the audience has
* Try to meet with a chief resident and/or with a faculty member a couple of days before you present to review your presentation.

**Faculty/Teaching at Afternoon Case Conference:**

* Faculty are encouraged to contribute to the discussion at the appropriate times but are asked to refrain from interrupting the presentation or from redirecting the discussion away from the main area of focus.
  + The chiefs can invite pertinent Afternoon Case Conference attendings and will let you know who they are expecting.
  + Try to communicate with attendings that will be present at your Afternoon Case Conference ahead of time. Let them know if there is a specific part of the history, diagnosis, management, or follow up that you want them to try to answer more in-depth, and then give them an opportunity at that point in your presentation to address those areas.
  + They are wonderful resources and may often help your presentation along.
* **TIP**: Presentations should be concise but complete and include the chief complaint, HPI, ROS, full past histories and physical exam. Ask your Chiefs or a senior resident for a sample outline of Afternoon Case Conference, or how to structure your case. This is a learning process we all go through!
* Major teaching points should be included in the discussion of differential diagnoses and management. Here are some ways to incorporate teaching points into the discussion:
  + Ask the group for differentials, give ten seconds before asking again (gives them a chance to think and respond). I.e. “What might be causing this abdominal pain and what goes for and against this?”
  + For each differential diagnosis, ask the group how they would rule in/out that particular diagnosis (which lab, imaging, test, etc.) and/or how they would manage it i.e. “What testing might support a diagnosis of appendicitis?” or “What might you do next if this diagnosis were confirmed?”
  + Offer a teaching point relevant to the case about that testing or management. Try to be interactive! For example, “In this case, the abdominal CT failed to visualize the appendix and the white count was high, but the physical exam was not a classic presentation. Because the patient was a toddler another consideration might be Meckel’s diverticulum. Does anyone remember the Rule of 2’s?”
  + Save the true diagnosis until last, even if someone guesses it first, to allow creation of a broader differential.
  + Try to come up with about 4-6 teaching points to review at the end. Don’t forget to include the medical students!

**The Aftermath:**

* Ask for feedback from the chiefs or other senior residents and attendings following your presentation.

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## **Newborn Nursery**

**Introduction:**

* Mother-baby unit in the hospital - Steer right at Starbucks and take the elevator/stairs to the 6th floor.
* Wear scrubs and you ID is a **MUST** at all times
* We encourage non-separation, so infants will be found in mom’s room if medically stable
* Most babies are on 6th floor with overflow on the 5th floor. High risk moms (ex. Preeclampsia) will be on “Antepartum” on 5
* To locate baby, look for the room the mom is in. Open moms chart (click “related records” in toolbar room # is in the upper left corner)
  + If there is an “F” next to your patient’s name, they are on the 6th floor.
  + If there is an “E”, they are on the 5th floor.
* The NB resident covers weekdays 6am - 5pm, 1 weekend day for three weekends and 1 golden weekend during your block.
* There are Nursery call shifts on a weekend day for people on electives, so you may work in the nursery before your actual rotation.
* **PRIOR to your first day** of Newborn Nursery, contact the Nursery resident and visit/orient yourself to the day to day flow. Put together your rounds list
  + The census can get very high and you can easily feel time constrained.
  + You are the only resident there during the week, IT IS VERY IMPORTANT to be oriented prior to starting to ensure success
* Success here requires high efficiency and organizational skills
  + You will see a lot of “normal” well babies so it is important to be able to detect and note any abnormalities.
* There is a list that states when an attending **MUST** be called. [NICU Nighttime Resident Coverage.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EZHOmCcY3LVFi1PGim4v1kgB4AXgzFcyC-M1NPv3zKc-uQ?e=zVYWFN)

**Where Things Are:**

* Workstation is behind the partition of the 6th floor nursing station – behind the unit clerk
  + There are enough computers for the med students to use in the morning.
  + In the afternoon you may use the work station in the nursery core by circ room
  + **Make sure three computers are always charged through the night to “survive” rounds.**
* Break room is to left when you exit the 6th floor elevators
  + There is a fridge to store food if you bring lunch.
    - There is a water cooler in the break room – Stay hydrated
  + In the breakroom there is a locker room and a restroom. The code is **1031**
    - In the back there are lockers for residents & medical students. Your belongings MUST go there or in the drawers at the workstation
  + Rest room can be found in hallway behind the work station and there is one in the locker room

**Algorithms / Stony Brook Nursery Resources**

* **Hypoglycemia**
  + [hypoglycemia birth to 4 hours.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EdyIfEOXqKVIqk2koh65ynUB_FlksKcJknf6Bt9M-2E0cA?e=w9Q7EB)
  + [hypoglycemia 4-24 hours of life.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/ERpTiC4U2gRKgdjI0MFtpwgBWAEnY6J2TUwQda9TAkEtWA?e=7Mxh4a)
* **Hypothermia** 
  + [hypothermia algo.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EZd97QaQunRBkrl7oiaArTUBpl2zkY3mp8G_v8S70OXQOQ?e=TNv1kz)
* **hydronephrosis**
  + [Hydronephrosis Guidelines - Copy.pptx](https://stonybrookmedicine.sharepoint.com/:p:/s/PediatricHospitalists/EROUNsKNM_RAny0545UDiU4BZ0H27fcbUbIj_zFVgc-Bvg?e=XVNzpt&nav=eyJzSWQiOjI1NywiY0lkIjo0MDQ3Mzg2NDUyfQ)
* **Hyperbilirubinemia** 
  + Screening algorithm - [Hyperbilirubinemia Screening 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/Ea5z8DoRdMhPinJcfAopDZQBc9Ixt45hNK0sr8W23Pc7Rg?e=cYifU9)
  + Phototherapy treatment algorithm [Phototherapy Treatment 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EVgLy0unHfVNuOSKq-aIgQ8B19Wz8hi0ph7a_u5lpd7WpA?e=bBYh3u)
* **Kaiser Sepsis Score and Usage -** [GBS Guidelines.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/ERtPZbjJ8dNPvVd7yJzuwkgBj_95FF9KB_ZneXbsNB0BYA?e=LhCeow)

<https://neonatalsepsiscalculator.kaiserpermanente.org/>

* **Infants with Exposure to Significant Infectious Pathogens (HIV, HBV, HCV, etc)**
  + [NBN ID review 2024.docx](https://stonybrookmedicine-my.sharepoint.com/:w:/g/personal/lisa_clark_stonybrookmedicine_edu/ETJDCg5R_j1PlR5hHOshgu8BaK2J9K3sZwChz-rX5Okjzw?e=x5xn8v)
* **How to make a Rounds List**
  + [Rounds List for NBN.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/Ed-GNTy_0OJMkAdPmRqpg0cBy7RbgHE1pwyf0eAytTu4XQ?e=XbrS5c)

**Newborn Nursery’s Top Things You MUST KNOW Before Your First Day**

1. Early Onset Sepsis score (aka Kaiser Sepsis Score **(KSS)** within the first 4 hours of life, Notify Attending if YYR, YRR, or RRR.
   * GBS positive or unknown mothers
   * Prolonged rupture of membranes (>18 hours)
   * Maternal temp >=38.0 C
   * Gestational age <37 weeks
2. Visible jaundice in infants UNDER 24 hours of life is pathologic -- likely phototherapy
   * Send a stat bilirubin, hemoglobin/hematocrit, reticulocyte count, and Cord blood for typing
   * Call attending with result as soon as available
3. If OB documents concerns of mom with a Intraamniotic Infection (IAI), chroioamniotis, endometritis – calculate a KSS and contact attending (Maternal fever, foul smelling amniotic fluid, pus in fluid)
4. When a baby is born, the most urgent information to obtain are the prenatal infectious labs & any specific medical problems specific to the mother
   * If any prenatal infectious lab is positive, it is emergent to proceed with the applicable protocol (ID Guide for the nursery).
5. There is a hypoglycemia protocol with an algorithm that they follow. (STAY TUNED)
6. When in doubt, have the nurse save/collect the first urine & meconium for possible toxicology
   * See below for specifics but here are some common reasons for testing - current Substance Use Disorder (SUD) /misuse, known history of SUD in past 3 yrs, poor prenatal care, physician/midwife clinical judgement
7. Respiratory Distress - Tachypnea (RR>60). DDx includes normal transitioning, TTN, RDS, Mec Aspiration, hypoglycemia, temp instability, etc.
   * Do full exam, check oxygen sats and DS -> Monitored until improved
   * If in doubt, call the attending.
8. Signs requiring immediate concern for cardiorespiratory failure include (but are not limited to):
   * Cyanosis, apnea, saturations below 88%, unresponsiveness, retractions, and/or grunting
     1. Call Newborn Rapid Response, Stabilize patient, and Prepare for transfer to NICU.
   * **Resident, NP, or Attending should always be present with an unstable infant, or infant requiring NICU transfer**
9. The Pediatric Hospitalist listed in the computer as the Newborn Nursery Attending is the attending of record at any point in time and should be notified of babies with acute medical concerns
   * If a baby decompensates NICU transfer or RRT should never be delayed.
   * Notify also for reasons listed in “NICU Nighttime Resident Coverage in Newborn” document
10. Never write/sign a note on an infant you have not yet examined

**Newborn Nursery Expectations**

1. You learn how to appropriately care for the newborn and manage the floor, as outlined below.
2. You do NOT need to go to Afternoon Case Conference
3. You DO attend Grand Rounds and Wednesday lectures
4. Read the articles in the **Newborn Curriculum** over the course of the rotation.
   1. See specifics below
5. Be prepared discuss the following topics during your rotation

* Care of the Well Newborn
* Early Onset Sepsis
* Jaundice & Hyperbilirubinemia
* Hypoglycemia
* Infant Feeding
* Newborn Physical Examination
* Neonatal Abstinence Syndrome
* Newborn Respiratory Disorders
* Newborn Screening
* Circumcision
* Congenital Heart Disease
* Newborn Infectious Diseases

1. Attend education on breastfeeding one afternoon with Sara Glynn (Lactation Consultant)
   1. Review the breastfeeding/chest feeding videos (see below)
2. Read the power point on **Circumcision**, (in curricular materials section).
3. Have a **physical exam observed** by your attending, Susan Katz, NP or Lisa Clark, NP.

**Timing/Workflow/Rounds:**

1. **6AM-9:30 – Preround** 
   1. Arrive: Call NICU resident for overnight events (# 4-2000)
   2. Print a census of all patients note which babies are private patients.
      1. DO NOT SEE private patients or make cards for privates, but they need admission orders with correct attending listed

Branch Pediatrics (Ancona, Stern, Flynn-Gameng)

Kids Care Pediatrics (Anna Schwarz & Amy Leonard)

Ask Charge RN (ideally night shift, between 6a and 7a) for a list of patients to be discharged. This can be done verbaly, or they can copy their “typed census” for you. If they are not there, the census is on the main desk in the nursery, and you can write down the discharges or photocopy it

Complete all cards (see below for how to complete)

New admits

Updates on all

* 1. Divide the service in into Team A and Team B ---- Until directed otherwise

**When there are 2 residents on, you will switch between Teams A & B every other week**

* + 1. Team A is 2/3 of the list (Complicated babies, NICU transfers, consults, late preterm NAS etc)
       1. you are responsible for the notes for these babies
    2. Team B babies 1/3 census, activated once census ≥ 12 babies (NON-complicated, mostly male infants)
       1. Yes complete team B card
       2. When only 1 resident, No notes for Team B babies, and complete departs for as able
       3. When 2 residents, 2nd resident must do Team B notes and departs
  1. Print A census for the Team A attending and B census for and Team B attending
  2. **Problems**
     1. **Page attending of clinical changes per the NICU Overnight resident nursery coverage document** 
        1. **including need for phototherapy or clinical illness that you are concerned about**
  3. **Place “Newborn Admission Power Plan” orders for ALL new babies, INCLUDING private babies.**
     1. Do **admission med rec** and **med history** when entering admission orders
     2. For private infants put appropriate attending in admission orders, if infant already admitted to ‘staff’ ask clerk to change to private attending name

Check for glucose gel orders, if not in use the power plan to place them. The correct weight based dose will default

* 1. Review potential discharges – Charge RN will have list of discharges, compare this to your anticipated discharges
     1. Remember, NAS babies will stay 5-7 days, NSVD babies 1-2 days, and C/S babies 2-3 days
  2. **Examine babies, and write notes** (work up to a goal of 10 notes per day by the end of your rotation)
     1. Priorities: Babies with overnight events -> Pending discharged (identify barriers) -> New admissions -> NAS -> Interims
        1. **TIP**: Wear gloves (new babies are not washed for the first 24 hours of life)
        2. **TIP**: Use an alcohol swab to clean your stethoscope before placing on the baby.
        3. **TIP**: Bring ophthalmoscope, red reflex to be done day of admission and discharge

Ask mother about health of her other children if applicable, specific concerns are newborn jaundice, poor weight gain, congenital diseases, sepsis or NICU admissions

* + 1. Interview mother while examining baby. Pertinent discussion includes confirming her medical information, asking about health of other children (issues with jaundice, troublesome weight loss, congenital disease, NICU histories)
    2. **Write your note AFTER seeing each baby.**
    3. Complete the departs for pending discharges – last minute updates can be done on rounds
  1. **This rotation can be overwhelming.** Talk to your attending and NPs for help with work flow
     1. **Always do the cards first**, even if you do not see the babies / finish the notes so you can present on rounds

1. **9:30am – noon - Rounds**
   1. **Talk with your attending about problem babies when they first arrive**
      1. **High weight loss (>8%), poor feeding, resp issues, elevated bilis, etc.**
   2. Organize the cards for rounds as follows
      1. Discharges New Admissions NAS Interims (as this is the order that most attendings like to round).
2. **After rounds-5pm**
   1. Follow up on anything from the AM
   2. Prep departs/discharges for the following day, Give anticipatory guidance.
   3. Start cards when baby is born, and see all the new admits that arrive to the floor before 3pm
   4. Run the list with the attending in the afternoon to go over updates
3. **5pm – You’re done!**
   1. Sign-out to the NICU resident

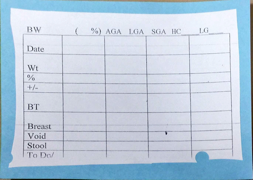
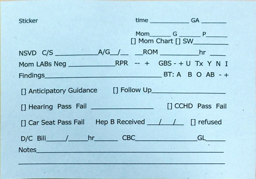
* NICU x4-2000
* Sign-out babies that have active issues, NAS, potential night discharges, pending or abnormal labs (T/D bili, etc), any baby you predict may have issues overnight (hypoglycemia), concerning KSS
* Discuss cut off to call attendings on labs and discharges, most attendings want to be notified for weight loss > 6.5% and bili > 6.5, but discuss cut offs with attending before sign out

**Computer Tips:**

* Become familiar with the Resident View -> Neonate Workflow, much of the information you need is on this page
* Set up your “Rounds List.” This will help you navigate the lab results/information of all babies at once. See below for link on how to set it up
  + [Rounds List for NBN.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/Ed-GNTy_0OJMkAdPmRqpg0cBy7RbgHE1pwyf0eAytTu4XQ?e=XbrS5c)

**The Cards:**

1. Every staff baby gets a card filled out. --- THEY ARE YOUR LIFELINE and will help you keep track as you care for the baby & prepare for discharge (See image of card below)
   1. In mom’s EMR use the “OBGYN H&P” in documents tab, “Results Flowsheets” -> “Delivery Records” tab, and Lab results tab to fill in cards. If SBU affiliated, ultrasounds can be found in clinical notes under “OBGYN ultrasound” or in the radiology tab, otherwise in mom’s paper chart
      1. Maternal labs HIV, HCV, HBV, and RPR are done prenatally **AND** on admission
         1. **Admission labs MUST** be documented in newborns admission note as per DOH - these results are CAPITALIZED when pulled in to your note ----- If all 4 labs are not back when you write your note, **check back later!! You or the attending can addend the note with the updated labs.**
      2. Jot down any maternal history that is pertinent to the infant
      3. Note if a SW cs is needed (see below for indications)
   2. In baby’s EMR use “Resident View” -> “Neonate Workflow”
      1. If the data has not populated to infant chart, you may find it in moms chart, under “Results Flowsheets” & delivery record”.
      2. You can pull the info in yourself by going to Mom’s chart -> Result copy -> click on infant and “ok”.
         1. All things in mint green have not yet been pulled over
2. Document [] Vit K and [] Ery if given or refused. Refusal is becoming more common, and getting missed!
3. Document GBS status, treatment, and KSS if it is required to be done (see below for add’l info)
4. Document maternal blood type.
   1. Order “Cord Blood Typing” for ALL Rh Negative mothers, ALL mothers who are Antibody POSITIVE, and for O+, ab neg mothers who meet following criteria: Anticipate discharge of newborn prior to 36 HOL (most NSVD babies), sibling with history of ABO incompatibility/jaundice requiring PTX, infants < 38 weeks GA
5. Car seat test – check if required (infant < 37 weeks, or < 2,500 g)
6. Back of Card
   1. Weights – use Fenton growth chart. SGA < 10th percentile. LGA > 90th percentile.
      1. The “%” refers to % weight lost from BIRTH WEIGHT
         1. Neonate Workflow -> Measurements will calculate the % weight loss for you
      2. The “+/-“ refers to the amount (in grams) lost or gained from THE DAY PRIOR



* **Hard/Paper Charts:**
  + Baby charts are Blue Moms are Maroon/Red
    - These charts/binders contain patient stickers and prenatal records
      * + If maternal information is not available in the EMR, Check the hard/paper chart
        + If paper chart empty ask the Unit Clerk to call the mom’s OB office.

**Admission Management & Note:**

**1. Assessing Infant Risk for Early Onset Sepsis (EOS) -- Kaiser Sepsis Score KSS**

Calculated for ALL infants at risk of early onset sepsis (EOS), WITHIN 4 hours of birth, OR if infants develop signs or symptoms of sepsis

Risk factors as follows:

1. Gestational age less than 37 weeks (and ≥ 34 weeks)
2. GBS positive or Unknown (regardless of treatment). If planned c-section with NO labor, cervical changes, or ROM, then no GBS abx required.
3. Maternal fever ≥ 38 ⁰C during labor or 1 hour after delivery or concern for Intraamniotic infection (IAI, endometritis, chorioamnitis, foul smelling newborn/amniotic fluid, concern for infected placenta)
4. Prolong rupture of membranes (ROM) over 18 hours.
5. Need for resuscitation/ signs of clinical illness at birth
6. Symptomatic infants, or infants with vital sign instability or clinical exam abnormalities within the first 24 hours of life

Calculating the KSS – <https://neonatalsepsiscalculator.kaiserpermanente.org/>

* Incidence of Early Onset Sepsis - Stony Brook Incidence (0.6/1000)
* Know maternal antibiotics administered PRIOR TO delivery, stratified as below:

GBS specific antibiotics = Penicillin G, Ampicillin, and Cefazolin

No Antibiotics = Clindamycin, Vancomycin, as they do not target GBS well enough

Broad Spectrum = Amp/Gent, other cephalosporins, fluoquniolones, piperacillin/tazobactam, carbapenems or any combination of antibiotics that includes an aminoglycoside or metronidazole

* Management – Interpretation of EOS Risk Score & Management
  + The result in white is the risk of EOS in the infant per 1000 births at birth.
    - Risk is then further stratified by the physical exam and vital signs of infant into green, yellow, and red categories.
  + Physical exam findings:
    - Well Appearing – No persistent physiologic abnormalities
    - Equivocal (trickiest group) – ONE persistent vital signs/PE abnormality lasting ≥ 4 hours or TWO persistent vital sign/PE abnormalities lasting ≥ 2 hours. Categories include HR, RR, Temp instability, and respiratory distress.
    - Clinical Illness – Infant needed oxygen, ventilation, vasopressors, or concern for neonatal encephalopathy/perinatal depression (seizures, Apgar score < 5 at 5 min of life)

Physical exam + Risk Assessment = Plan of care (see example below)

Green – continue routine care

Yellow 1 – “observation only,” Observe in nursery with q3-4 hour vital signs. Urgent MD evaluation and possible NICU transfer if further progression of illness develops

Yellow 2 – “Blood culture,” transfer to NICU for Blood Culture and IV Antibiotics required

Red – transfer to NICU for Blood Culture and IV Antibiotics required

* **Document your findings! You must write a separate note documenting the KSS**

Go to “Documents”  Encounter Pathway  search “Newborn Nursery Event”  open

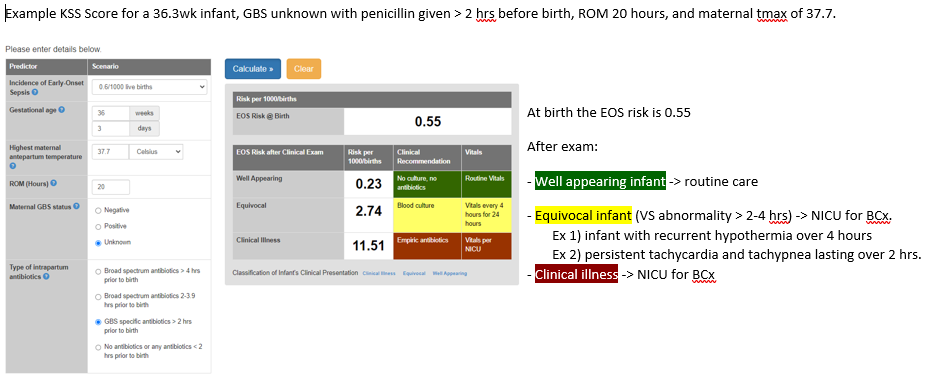
Screenshot the KSS & paste in an event note

Write your assessment and plan based on your exam and vital signs. Is infant well appearing, equivocal, or clinically ill?

**Notify attending if equivocal or clinically ill.**

Include the entire chart, as shown below, so your work can be checked

Further details on documents on curriculum website.



**2. Urine Toxicology Orders**

* Indications to ordering urine and meconium toxicology on infants:
* Current Substance Use Disorder or misuse
* Known history of Substance Use Disorder in the last 3 years
* Late to care prenatal care
  + first visit beyond 20 weeks
  + sporadic prenatal care defined as less than 8 visits (suggesting the patient was seen less than once monthly)
    - This does NOT include mothers who TRANSFERRED their care late – and had sufficient care at the prior location.
* No prenatal care
* Physician/midwife clinical judgement
* Orders: “Maternal Newborn Urine Toxicology Careset” and check off all 4 tests.

**3. Refusal of Vitamin K**

* If Vitamin K refused, form provided by RNs and education should be done within 6 hours. NICU resident to do if infant born overnight.
* In depart attach “Vitamin K Deficiency Bleeding in the Newborn”

**4. Social work Consults - order as Social work Inpatient**

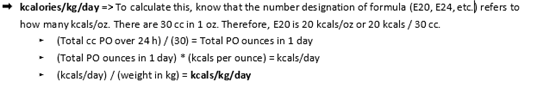
1. Any mother with history of mental health issues – it allows SW to review signs/sx of postpartum depression and provide resource
2. Domestic violence in past 5 years
3. History of intrauterine fetal demise AND concern for difficulty coping/anxiety
4. Concern for or known substance use/misuse. Documented Substance use disorder (current or in the last 3 years). Prescribed pain medications for a medical diagnosis can be referred based on clinical judgement.
   1. If toxicology is positive for illicit medication that was not prescribed, CPS report/referral will be made by Social Worker
5. Insufficient prenatal care (as defined above)
6. Insurance issues
7. Housing needs (ex. Family is homeless, lives in shelter and requires arrangements, etc.)
8. Adoption planning
9. Infant with significant medical issue (Ex. Trisomy, cleft palate, intrauterine exposure to HIV

**5. Neonatal Abstinance Syndrome Babies**

* Infants who had intrauterine exposure to opiates, benzodiazepines, amphetamines, cocaine, or other psychotropic medications. Can be due to appropriately taken prescriptions OR misuse. Most of our mothers are in recovery on prescribed maintenance medication.
* Infants usually monitored 5-7 days to ensure appropriate weight gain, stable vital signs, and controllable symptoms. Once mother is discharged infant will be transferred into the nursery for care. A parent may stay with infant as much as they want, other visiting as per nursing
* Breastfeeding – Allowable as long as no use of non-prescribed illicit medications, and the medications and doses are safe ([LactMed](https://www.ncbi.nlm.nih.gov/books/NBK501922/)). Most infants will need additional supplementation due to withdrawal process
* Admission orders: Admitted to “Special Care Nursery” and initiate Neonatal Abstinence Powerplan
  + Urine toxicology and mec toxicology should be collected. Notify attending/NP if parental refusal to discuss plan
  + Check off infant for 24kcal formula –
    - **If infant is having diarrhea/significant weight loss, we will transition them to 24 kcal similac sensitive formula. This will need you need to put in communication order for 24 cal sensitive formula so it is ordered**
  + Check off speech pathology consult. PT and social work consults also always needed
* Modified Finnegan NAS Scorning by the nurses to monitor infants treatment. Found in EMR under Results FlowsheetsAssessments
  + - Medication typically indicated if 3 scores persistently > 8-10
* In your note:
  + Cures act info to consider:
    - Is significant other aware of all information? If not should confidentially document

Record the range of NAS Modified Finnegan scores for the past 24 hours

* + Note infant’s weight loss/gain, # and consistency of stools
  + Calculate the number of kcals/kg/day they eat. Most of these patients are on 24 kcal/oz formula.



**Opiate Orders:**

* If baby is on morphine and it is time for a dose change, ENTER ORDER CHANGE EARLY in the day -- pharmacy not so fast
  + Check with RN on when to change the dose so RN has current dose and we can get next dose with no gap/delay .
* **Always check with the nurse practitioner Lisa Clark and the attending’s note to determine plans for opiate weaning. The protocol is printed on the bulletin board in the nursery core AND on the SB curriculum website.**
* This is complicated and it’s best to make sure everyone is on the same page. Lisa is our expert on this topic.

**\*\*\* NEVER start a baby on morphine OR wean a baby on morphine WITHOUT discussing with the attending and NP!**

**Admission Note**

1. “Newborn H&P”
   1. Put in your favorites: “Documents”  “Pre-completed”  search “Newborn H&P”  Save
2. When the note first opens you will get a pop up. UNCHECK “measurements from flowsheet” and click OK
3. HPI section, include maternal or prenatal complications
   1. You DO NOT need to write a full HPI. Note significant maternal history, abnormal ultrasound/prenatal labs
      1. Example, uncomplicated infant: “Newborn male w/o any significant maternal or prenatal complications.”
      2. Example, complicated infant: “Ex 36wk infant, born via stat C/S for NRFHT, maternal hx of GDM on insulin”
4. HISTORY section of your template note, **YOU MUST pull in the “Maternal Delivery Information”.**
   1. Pull in “transcribed” prenatal labs, maternal admission labs (RPR, HCV, HBV, HIV – CAPITALIZED), GBS status, mode of delivery (NSVD or C/S), APGARS, ROM time, blood type, etc.
      1. DOH mandate: Must have all 4 admission labs documented in Newborn H&P. If not back when you sign your note, present on rounds so attending can add to note

If information is missing, but is available in mom’s chart you can use copy results to bring it into baby’s chart (as noted above)

Assessment and Plan

Note any plan for significant maternal history or infant findings.

Ex – on Glucose protocol if mom had GDM, or infant SGA/LGA

Note KSS if it needed to be calculated (see below), and if infant is in Green, Yellow, or Red zone, and your plan (ex. Continue monitoring vs needs NICU transfer)

Note if SW consult ordered, don’t need to specify why as child may eventually read notes when older

Indicate if urine tox and mec tox ordered

**\*\*\* You should NEVER sign a note for an infant you have not examined.**

**Interim Management & Notes**

1. On back of card note weight change, # feeds, voids, stools, bili level (if note)
   1. Think of your plan for infants with poor feeding, high weight loos, high bili levels, low outputs
2. Indicate if any important medical changes (Ex. Consults, NICU evaluations)
3. Give anticipatory guidance
4. Ensure PMD in baby’s banner bar, tell family when to make follow up apt
5. Progress note
   1. There are pre-completed newborn nursery progress notes
   2. “Documents”  “Pre-completed”  search “Newborn Progress Notes”  save to favorites & open.

**Discharge Management & Notes**

**Discharges are the number one priority in the morning after you have addressed sick infants.**

**\*\* If you’re concerned infant not meeting criteria for discharge based on the below, discuss with attending at the start of rounds!**

**Departs:**

**Must have correct PMD/Practice, F/u typicall 1-2 days, call to confirm/schedule apt**

**Physician note: Blurb saying infant is doing well, and highlight of concerns (ex. Hydronephrosis, needs f/u US and urology)**

**Education: 1- Laying your baby down to sleep (eng/sp), 2- When you feed me formula (eng/sp),**

**3- NBN Discharge Instructions (eng), or NICU Discharge Instructions Spanish**

Order: “Newborn Nursery Discharge Power Plan”

For provider responsible for dictation, write your own name. Only NAS babies will need a discharge summary.

Indicate if Breast fed (includes if getting supplment), or exclusive formula feeding

1. **To be discharged, infant must meet the following criteria:**
   1. Bilirubin within appropriate range
      1. Use bilitool.org, Inpatient viewpoint -> neonate overview will provide hours of life (IT working on implementing updates)
         1. If mom is O+, ab neg, and infant’s bilirubin is within 3 of the phototherapy threshold, order “Cord Blood Typing” and let the nurse know to send down the requisition. (enter communication order)
            1. Other reasons to obtain cord blood typing:

All moms Rh negative

All moms Antibody (Ab) positive

Any moms O+, ab negative, but: Infant is < 38 wks GA, Sibling history of jaundice, discharge at < 36 HOL, infant bilirubin levels with rate of rise > 0.2

Follow the hyperbilirubinemia screening algorithm,& advance to phototherapy algorithm as needed.

* + - * 1. Screening algorithm - [Hyperbilirubinemia Screening 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/Ea5z8DoRdMhPinJcfAopDZQBc9Ixt45hNK0sr8W23Pc7Rg?e=cYifU9)
        2. Phototherapy treatment algorithm [Phototherapy Treatment 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EVgLy0unHfVNuOSKq-aIgQ8B19Wz8hi0ph7a_u5lpd7WpA?e=bBYh3u)
      1. If infant has high bilirubin: Review infants I/Os and weight loss.
         1. Is this breastfeeding jaundice?
         2. Does infant need a feeding plan?
         3. Speak to the attending or NP (non-urgently) if you’re concerned about feeding to get a plan in action
  1. Weight loss less normal for age, and adequate number of voids/stools for age
     1. Weight <10% below birth weight or high for age. Neonate work flow -> neonate measurements
     2. High weight loss is a problem (8-10% should be always addressed, & weight loss > 90th percentile on NEWT should be discussed).
        1. Use this link to help determine age / mode of delivery appropriate weight loss norms for age.
           1. Newborn Weight Loss Tool (NEWT) - <https://newbornweight.org/>
        2. Bring up when attending first comes in for rounds--- GET UP STREAM!
     3. Based on Newborn Weight Loss Tool, Weight loss < 6.5-7% at 25 HOL is above 90th percentile for loss.
  2. Feeding Voiding Stooling appropriately
  3. PMD appointment within 1-3 days pending age and status of newborn
     1. Check correct PMD name listed in banner bar of baby
        1. If not correct, correct it or the actual PMD will NOT get the depart faxed to them
           1. A PMD can be added or changed by clicking “PM Conversation” at top toolbar, then clicking “Provider Update” and choose “provider update” from drop down. You can then type the PMD’s last name under where it says “Primary Care Physician”
        2. Instruct families to follow up as below:
  + Infants younger than 24 hours, follow up within 24 hours of discharge
  + Infants 24 to 48 hours of age, follow up within 48 hours of discharge
  + Infants older than 48 hours, follow up within 72-96 hours of age
  1. Anticipatory guidance given ( see below)
  2. Depart process complete include Dx, med rec, patient education (NBN\_Discharge\_Instructions\_SBUH(Custom)), follow up date
  3. Hearing screen completed --- Can be found in resident view or depart – Check depart if a follow up required
     1. If failed, urine CMV must be in process before discharge and audiology follow up appt scheduled
  4. CCHD screen passed also can be found in depart or resident view
     1. Pulse ox check of right arm compared to right leg. One sat has to be above 95% and there can not be more then 3% difference between the two readings.
     2. If baby failed once - repeat If fails twice -- notify attending TRANSFER TO NICU
  5. G6PD in process
  6. All premature babies <37 weeks, or infants with birth weight <2500g, or infants with congenital airway anomalies (ex. trisomy 21) will need a car seat test prior to discharge
  7. Hepatitis B vaccine given OR provided education & documented reason deferred – (MAR or neonate workflow immunization)
  8. Metabolic screen (PKU) obtained and in process (RNs usually check on this before sending home)
  9. Discharge Note

1. **Early Discharge Considerations: (Age 25-36 Hours of Life)**
   1. If mom O+, anitbody neg cord blood type result to be included in depart with maternal blood type
   2. PMD follow up NEXT DAY is ideal, but can do within 24-48 hours in some cases – check with attending
   3. Adequate feeding
      1. Good bottle intake or at least 2 successful breastfeeds with good latch scores, with normal output
   4. Weight loss should be less than 6.5%, or with clear feeding plan established
   5. Observation At LEAST 36 hrs in hospital if at high risk for sepsis based on KSS (GYR, GRR)
2. This rotation
   1. You do NOT go to Afternoon Case Conference
   2. You do attend Grand Rounds and Wednesday lectures.
      1. **Depending on the census, try to come in earlier on Wed-- you need to be done with cards by the start of Grand Rounds at 8am.**
      2. **You will then go to Wednesday lectures, so prep your discharges, finish the cards and then as many notes as you can and check in with your attending with any concerns/questions prior to going to Grand Rounds.**
      3. **You can write on the printed attending census any small problems that need adjusting (ex. High bilis, high weight loss).**
      4. **Notify the attending of any big issues (ex. Respiratory issues, phototherapy) prior to leaving the unit.**

**Anticipatory Guidance:**

Everything is important. HOWEVER, new families are tired, it is important to try to get a few KEY things across about infant care.

The best way people learn anything is to actively engage in it – so making it conversational will be most effective.

Additionally - Each attending may also have a different style, so observe them doing this at the beginning and see what works best for you.

***You can introduce the topic “So now I’d like to give you some tips and reminders about care of the newborn”***

Based on the needs of the patient, you can tailor the following information:

**Normal newborn care**

* Feed every 2-3 hours. Wake the infant up on schedule until birth weight has been regained
* Write down babys output – goals are noted in the booklet. Notify your pediatrician if output is below normal.
* **Umbilical cord** falls off around 7-10 days. Until then keep it dry and above the diaper. No alcohol application needed. Sponge bathe infant only - do not submerge area until after the cord has fallen off and healed.
* **Skin care**: Avoid lotions, creams or oils unless directed by a doctor. Avoid direct sunlight during summer, especially between 10a-4p
* **For baby girls,** there may be some thick white discharge or even bloody discharge the first few days. This is a mini-period as the baby is clearing maternal hormones from the delivery. It is normal to have, and to not have.

**Illness in the Newborn:**

* **If baby appears sick, lethargic, feeding poorly, or is off, take a rectal temperature. Must got to ED for temperature below 97⁰ or greater than or equal to 100.4⁰**
* Increasing jaundice or yellowing of the skin can be normal (especially of the face, and chest), but too much can be problematic. Notify your doctor if you notice the baby’s arms/hands/lower legs are beginning to turn yellow, feeding poorly, or lethargic.
* The best way to prevent illness is by encouraging good hand washing (soap/water or hand sanitizer) prior to handling the baby. Advise not to let others touch/kiss the baby’s hands/lips, since they can get their hands to their mouths and ingest germs.
* Vaccines also prevent illness. Encourage TDAP booster for all family members/caregivers. Flu vaccine for all >6 months old in the home during October-March, and COVID 19 vaccines.
* **If family ‘refused HBV**’ **you can use these prompts to help encourage vaccination**:
* ***“I see the hepatitis B vaccine has not yet been given to the baby, would you like it now or before you are discharged?”*** If not, ask why not, and if they have questions about the vaccine. Can assure them it is since use vial without preservatives. Document conversation in your note. If they consent, you will need to reorder vaccine.
* Other talking points:
  + “Hepatitis B is very transmissible, lives on surfaces up to 7 days, and many people do not realize they have it. It is associated with liver failure and liver cancer. To protect your baby, I’d like to offer it again.”
  + “Most of the pediatricians in the area agree with the American Academy of Pediatrics recommendations to give it within the first 12-24 hours of life/prior to leaving the hospital to best protect the baby

**Safety:**

* **Back to Sleep (SIDS prevention) & the ABCs**.  Baby sleeps **alone** in the **crib** or bassinet on his/her **back**, no pillows or stuffed animals on a FIRM mattress. Never in bed with a sleeping adult.
  + Support person can help keep nursing moms awake, or remove baby from mom if she falls asleep
* **Car seats:** Parents must have one before leaving the hospital. **Should be a 5 point harness, that is rear facing until at least the age of 2,** but ideally to continue until the infant outgrows rear facing car seat based on manufacturers recommendations.
* **Smoke Exposure**: Second hand smoke increases the risk of SIDS and Asthma.
  + Opt to Quit referral in Ad Hoc section of Power chart – if interested, family member can sign up for this NYS Quitline ‘

**Transfers to NICU:**

* Anytime a baby is ill If possible, discuss with attending or the private attending BEFORE consulting NICU or transferring.
* If the baby looks critically ill or concerning, CALL A RAPID RESPONSE FIRST. No one will ever fault you for this.
* If your attending agrees that the infant needs NICU evaluation, call over to the NICU to discuss with a NICU resident or fellow, who will come to evaluate the infant.
* If the NICU accepts the transfer:
  + Always go with the baby to NICU.
  + When you get there, sign out to the resident (and fellow, if necessary).
  + As with any transfer, write a thorough transfer note including the reason for the transfer.

**Transfers from NICU:**

Ask the overnight NICU resident & check the census every morning to make sure there were no new transfers overnight. No one likes surprises!

* NICU transfers are first accepted by the **attending**
  + Babies who are 35-36 weeks may be transferred to NBN after 24 hours of monitoring and determined to be stable.
  + Babies must weigh > 2100g at the time of transfer.
  + Term newborns with any physiologic instability/delayed transition may be transferred to NB after consult with the accepting physician
* Then you will receive sign out from NICU
  + Ask who infant’s PMD is, if it is a private pt the private MD must be called to accept
  + Be sure to put or check for the Newborn Nursery Admission Power Plan (or Late Preterm Power Plan) if needed.or NICU to NB transfer Powerplan
  + You do not need to write a NICU to NB acceptance note; however, if the infant arrived overnight, you NEED to write progress note.
  + Every transfer baby will need a card filled out
* Notify the charge nurse so they can prepare
* If mother is being discharged that day, typically infant should be discharged from NICU instead of coming over.
* You do not need to write a NICU to newborn acceptance note; however, if the infant arrived overnight, you will need to write a progress note.
* Every transfer baby will need a card filled out, just like all other babies in the Newborn Nursery.

**Nurse Practitioners**

* **Lisa Clark** and **Susan Katz (Use Teams Ap to contact them)**: Newborn Nurse Practitioners

The NPs help “run” the nursery by assisting the team with any number of tasks. They spend a considerable amount of time with the many psychosocial issues as well as with any NAS babies.

It should not be assumed that they will be available to assist with morning rounds or pre-rounding work, but they are a great resource for questions if available. They can also help with babies you are worried about.

One of the **NPs should observe one physical exam of the newborn**, and document progress in new innovations

**Breastfeeding/Chestfeeding Education**

* **Sara Hickert:** lactation consultant
  + Sara will schedule a time to meet with you, review breastfeeding, and see a consult
  + Prior to meeting with her make sure to complete the breastfeeding modules on the curriculum website
    - Helpful increase your comfort in providing better patient care for giving anticipatory guidance and addressing concerns.

**Additional resources for review (HIGHLY RECOMMENED)**

Supporting and Promoting Breastfeeding, Chestfeeding, and Lactation in Health Care Settings

* + [Supporting and Promoting Breastfeeding | University at Albany](https://www.albany.edu/cphce/supporting-and-promoting-breastfeeding-chestfeeding-and-lactation-health-care-settings)

Webinars -> Complete Hospital/Birthing Settings Part 1 and Part 2

CHAMPS

* + - [Breastfeeding | Human Medicine Universal on Vimeo](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fvimeo.com%2F460534113%2Fa4f6186fa6&data=05%7C02%7CCandice.Foy%40stonybrookmedicine.edu%7C5060042a0b5d4a89729208dc6b70d91a%7Ceafa1b31b194425db36656c215b7760c%7C0%7C0%7C638503379647961000%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=kmKoRvdZikOktpkhIJDtlWPlb7jMdi7ThebhrhtpyzI%3D&reserved=0)

**Medical Students:**

* There will be 3-4 new third year medical students each week
* They are there only for 1 week of their pediatrics rotation
* Mondays, teach them to help fill out the I&Os and weights on the cards.(you are responsible for accurate info on those cards – thier work)
* Starting Tuesday they should examine as many babies as they can and present 2-3 patients on rounds
* They should write their own notes, but this does not count as an official note for the baby
  + When the census is reasonable, medical student babies should be examined by the resident as well
  + and resident should write their own note.
* HOWEVER: **your primary job is ALWAYS to get the cards done**, regardless of the presence of medical students.
* **Prioritize patient care and your work** before teaching medical students.
* Goal for the medical students is to learn what a normal newborn exam is
  + Teach as much as you can, even if it’s only pearls of wisdom here & there. They’ll appreciate it & they will love you. We all need some love!

**Weekend Call:**

* Weekends are structured exactly like weekdays
  + ONLY Difference is there will be a senior resident there for short-call
  + They do discharges first, and if there is time they can help see additional babies until 11AM.
* You should arrive by 6AM
  + Most attendings like to arrive early
  + They will round with the senior first which gives you some more time to finish up your work
* If another resident is covering a weekend day, sign out any pending issues to NICU on-call Friday evening.
* In the beginning of the year, it is nice to orient the weekend person & give them a heads up of potentially complicated patients or discharges

**“NICU Nighttime Resident Coverage in Newborn” Document**

**Expectations**

* Prior to calling the Newborn attending, **evaluate the infant you are calling about and present a suggested plan**
* Any time a newborn is evaluated, the resident must document the evaluation in the EMR.
* The parents of the newborn should be updated on the assessment and plan
* **Algorithms located on Newborn Nursery Curriculum website, and in Cerner power plans, as well as below**

**Situations Requiring Discussion with the Newborn Attending**

* Infant requires transfer to the NICU
* Mother of infant positive for HepBsAg, HIV or RPR. Guidelines [NBN ID review 2024.docx](https://stonybrookmedicine-my.sharepoint.com/:w:/g/personal/lisa_clark_stonybrookmedicine_edu/ETJDCg5R_j1PlR5hHOshgu8BaK2J9K3sZwChz-rX5Okjzw?e=x5xn8v)
* Any time an infant is started on phototherapy
* Yellow or Red Kaiser Sepsis Score – based on infant’s physical exam findings (see below)
* Infant with a critical lab value (examples given below, but are not limited to these examples)
  + Hyperbilirubinemia for age
    - Call attending if needs phototherapy or infant is DAT positive
    - Release infant blood type if within 3 of initiation of phototherapy
      * Screening algorithm - [Hyperbilirubinemia Screening 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/Ea5z8DoRdMhPinJcfAopDZQBc9Ixt45hNK0sr8W23Pc7Rg?e=cYifU9)
      * Phototherapy treatment algorithm [Phototherapy Treatment 2024.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EVgLy0unHfVNuOSKq-aIgQ8B19Wz8hi0ph7a_u5lpd7WpA?e=bBYh3u)
  + Hypoglycemia – follow algorithm – NICU transfer typically indicated for baby with 3rd glucose <45 after 4 HOL despite frequent feeding/supplementation, Post feed glucose <35 requires immediate transfer to nursery if infant >4HOL, infant is both hypoglycemia and hypothermic. Consider hypothermia and obtaining rectal temp for recurrent hypoglycemia
    - [hypoglycemia birth to 4 hours.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EdyIfEOXqKVIqk2koh65ynUB_FlksKcJknf6Bt9M-2E0cA?e=w9Q7EB)
    - [hypoglycemia 4-24 hours of life.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/ERpTiC4U2gRKgdjI0MFtpwgBWAEnY6J2TUwQda9TAkEtWA?e=7Mxh4a)
  + CBC with **WBC >35** **or I:T ratio >= 0.20** (other WBC counts may be flagged as critical, but do not require a call if <35**)**
* Concerning Physical Findings or Symptoms **(examples below, NOT limited to these examples) – remember to adjust the KSS based on exam findings**
  + Bilious emesis
  + Hypothermia (rectal temp <36C) – Remember to check dstick.
  + Babies with hypothermia <36C should not be fed. Infant should go to NICU if hypoglycemic and hypothermic.
    - [hypothermia algo.docx](https://stonybrookmedicine.sharepoint.com/:w:/s/PediatricHospitalists/EZd97QaQunRBkrl7oiaArTUBpl2zkY3mp8G_v8S70OXQOQ?e=TNv1kz)
  + Tachypnea lasting beyond 6 hours of life **OR** associated with retractions/resp distress/hypoxia at any age.
  + New tachypnea in a baby >6 HOL.
    - Infants with RR >60 or other signs of respiratory distress should not be fed
    - Make sure to monitor for hypoglycemia.
  + Abnormal or unstable vital signs (i.e. hypoxia, bradycardia, tachycardia, etc)
  + Jaundice before 24 hours of life
  + Concern for testicular torsion (hard, swollen testicle, scrotal bruising or erythema)
  + Possible seizure-like activity
  + Anal atresia
  + NAS scores: 3 or more scores >8, or 2 consecutive scores >12
  + Failed CCHD *(see Protocol for CCHD Screening)*
  + Lack of urine output since birth at age >24 HOL
  + >8% weight loss with <2 stools or wet diapers in the past 24 hours and exclusively breastfeeding or other feeding difficulty
    - Unless a plan regarding supplementation was signed out, please discuss recommendations for supplementation with the attending prior to discussing with the family.

**Suggested Learning Schedule and Recommended Readings:**

Just like the Wards, there are weekly reading topics that you should read and be ready to discuss with the attending, as well as a breastfeeding course, all available on the curriculum website

* Week 1:
* Care of the Well Newborn
* Early Onset Sepsis Screening
* Jaundice and Hyperbilirubinemia
* Week 2:
  + Hypoglycemia
  + Infant Feeding, including Breastfeeding
  + Newborn Physical Exam
* Week 3:
  + Neonatal Abstinence Syndrome
  + Newborn Respiratory Disorders
  + Newborn Screening
* Week 4:
  + Circumcision
  + Congenital Heart Disease
  + Newborn Infectious Diseases

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## **NICU**

**So, You’re Starting Neonatal icu…**

* The resident call room is across from the locker rooms. The code to the hallway door is 2011. The code to the actual call room door is 6765.
* You wear scrubs every day. You must wear the light blue, “NICU scrubs” ONLY. These are provided in the scrub machine via ID swipe outside the NICU. You can also get a scrub jacket from the machines. Your ID cards will be loaded with the correct scrub size default during orientation.
  + These scrubs should be returned to the return machine at the end of the day. You grab new each ones in the morning. DO NOT take them home and wash them yourselves.
* No eating or drinking at all on the unit. There’s a break room, a mini-fridge in the call room, and cubbies near the NNP’s office used for beverages. There is also a water dispenser rig the NPs office

**Preparation:**

You must try to get oriented before your first day as there is a steep learning curve no matter when in the year you do NICU. Please schedule doing so by communicating with the intern on NICU before you. If they are really nice, they will show you around and teach you how to do numbers. Also, you must get sign-out from the departing intern the night before your first shift.

**Division of Labor:**

NICU patients are divided into two teams:

* The Red team is the resident team and the Green team is the NICU Nurse Practitioner team (the NNPs)
  + The NNPs are amazing and are very helpful teachers so be really nice to them! They will be a huge help overnight and when you go to deliveries.
  + Be sure to vocalize when you want to do procedures and to utilize your fellow as well.

**Where Things Are:**

* “Red” patient charts sit behind the clerk in the cubbies under the counter and contain patient stickers, consent forms, etc.
* “Blue” patient charts are located in each baby’s room (sometimes nurses have them at their computers) and contain daily rounding forms that the attendings use on rounds

**Consents:**

* *Mom is the consenting parental unit always unless there is a CPS issue!*
* *Dad can give consent ONLY if he and mom are legally married!*
* When a baby is first admitted, the consents you have to get are:
* NICU – give permission to be in the NICU
* Privacy Statement – acknowledges we gave her info on privacy/HIPAA
* Hep B Vaccine – only if baby is >2kg at birth
  + Otherwise until weight > 2kg or at 60 days of life, whichever comes first
* Circumcision – Offer for all males if mom is interested
* Consent forms will either be clipped in the blue chart or in the “consent” section of the red chart. You can also ask the clerk to print them for you. It’s under DAS Forms in PowerChart if you want to print it yourself.
* Moms can visit shortly after birth, when they are “recovered”, and after baby has had ~1 hour for admission settling in. If mom is not in room, grab the forms and head over to L&D – *your goal should be to get consents signed within 4 hours of admission!*
* Make every effort to complete them on your shift. If you have admitted a new admission, and for any reason cannot complete the consenting process on your shift, make sure to sign out to the next shift that they still need to be done.

**Weekly Tasks/Reminders:**

* Weekly labs: H&H, retic, etc.
  + Checked on Tuesday – order on Monday during rounds
* Weekly measurements: length, head circumference
  + Checked on Wednesday (depending on baby, can be more frequently). Order Tuesday during rounds as needed.
* Ophtho exams – every Wednesday, performed weekly (monitoring for ROP). You will be given a list of babies who need ophtho exams on Tuesday afternoon – make sure to place the orders for them and hold onto the list. Orders can be found in the NICU Ophthalmology power plan (includes medication for eye dilation, etc.). Put the date for Wednesday in the Special Comments section of the order.
* TPN renewal: every day
  + This is taken care of by the fellows. Any associated labs for TPN will be discussed/ordered during rounds. Maintain awareness of the changes they make.
* Weight adjusted medications: Thursdays
  + Since these babies are (hopefully) always growing, medication dosing and fluids need to be changed accordingly

**A Day In The Life:**

*Day Schedule:*

* 7:00-7:20am - NICU Morning Brief:
  + Pre and Post-call Residents join NICU staff around the charge nurses’ desk in the NICU for announcements, as well as a short “radiology rounds” where we review XRs that happened overnight with the attendings, fellows, and NNPs.
* 7:20-8:00am - Resident Sign-Out (in NICU call room)
* 8:00-9:15am - Pre-rounds
  + Examine all “watcher” babies/babies with acutely changing clinical status (note: often times, you will not be able to examine all the patients, so prioritize as above)
  + Review all overnight labs, meds, and events.
    - Another note is to make sure you look at what is actually hanging next to their bed; as fluid orders can change and rates babies are receiving are sometimes not reflected by what is ordered. You will need to know all fluid and TPN components and the rates they are running at (should all be in the red book)
* 9:15am -12:00pm (ish) - Rounds:
  + Round with red team attending and fellow.
  + All deliveries during this time are usually covered by green team.
* 12:00-7:00pm:
  + Complete any discharges that are leaving today.
  + Work on tasks for the day, orders, orders, and more orders.
  + In spare time, work on discharges on the shared drive.
  + Work on new admissions and volunteer for procedures.
  + Also go to deliveries!
  + Work on sign-out throughout the day (via Medicine Physician Worklist) so you are not overwhelmed at 6:30 PM and can’t remember everything that happened all day.
  + *Goal of 4 notes per day. Admission notes count!*
* Miscellaneous:
  + Mini teaching sessions by attendings/fellows, mini-presentations by residents (sometimes asked to present a topic to the team), monthly MFM presentations.

*Night Schedule:*

* 7:00-7:10pm - NICU Evening Brief, then resident sign-out in NICU call room
* 7:10-8:00pm - Resident Sign-Out (in NICU call room)
* 8:00-9:00pm - Run the list: close communication loops/tasks/orders as per signout
* 9pm - “Lightning Rounds:” Round with the fellow/NNP/attending/nurses on all patients (red and green)
  + You do not have to prepare for these rounds as you just need a general idea of the plan for the night. Each baby’s presentation is driven mainly by the nurses
  + Feel free to add to the discussion as the group goes over plans for the night with nurses. Very stress free!

**Crunching Numbers:**

As the night resident, we calculate “numbers” on all of the red team patients. The numbers must all be written in the red binder to help with morning rounds. Numbers refers to calorie intake, TPN amounts, daily weights, labs etc. Have a senior resident go over this with you before you start nights. Some general tips below:

* For around the first week of life (days 1 through 7), all numbers are based on birth weight.
  + Starting day 8, you begin using daily weights.
* It’s important to keep meds and lab levels updated in the binder. Even if a baby has been off caffeine for a week, a covering attending will want to know the last caffeine level. You don’t have to list ALL of the result as you make sheets, just the most recent/pertinent.
* Little kids need fluids. Their total fluids will vary with their gestational age and issues. Most kids will either start with 100cc/kg/day (little kids) or 80cc/kg/day (bigger), and we’ll work up from there.
* You care about two things:
  + How many cc/kg/day the baby is getting
  + How many kcal/kg/day the baby is getting
  + Remember, have a senior go over these calculations with you before you try them yourself! They can be very confusing. Below are examples of how to do them, but there are other short cuts you can take as well.
  + There are 2 calculators in the shared drive to help you but do not use them until you understand the calculations by hand first!
* Kids get fluids in 2 ways: parenteral and enteral. Enteral is easy so we’ll do that first:

*Calculating PO Fluids:*

* **cc/kg/day** = (Total cc PO over 24h) / (Weight in kg)
* **kcalories/kg/day =>** To calculate this, know that the number designation of formula (E20, E24, etc) refers to how many kcals/oz. There are 30 cc in 1 oz. Therefore, E20 is 20 kcals/oz or 20 kcals / 30 cc.
  + (Total cc PO over 24 h) / (30) = Total PO ounces in 1 day
  + (Total PO ounces in 1 day) \* (kcals per ounce) = kcals/day
  + (kcals/day) / (weight in kg) = **kcals/kg/day**

*Calculating TPN: DEXTROSE:*

*Total fluid volume Total calories*

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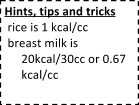
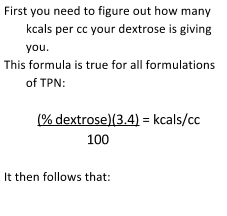


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*Calculating TPN: Protein:***image32.png**

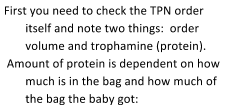
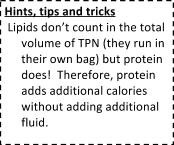
 

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*Calculating TPN: Lipids:***image36.png**

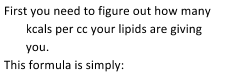
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*Crunching Numbers: Other Fluids:*

* Anything dripping in (morphine, sodium acetate, etc.) Counts for cc/kg/day but provides no calories.
* Anything being put out (i.e. OG, Replogle) must be subtracted from cc/kg/day

**Orders:**

* During rounds, while you’re presenting, another resident (or fellow) will usually put in orders for you depending on what is being discussed. **Make sure the nurse is aware, especially ALL STAT orders** (this goes for all rotations, not just here).
* We are not responsible for TPN orders as residents, the fellows do this. We are however, responsible for ordering regular fluids (D5, D10, etc.) as well as medications.

**The Delivery and Operating Rooms: Baby Baby**

* **Go to lots of deliveries!** You need to go to 3 with the fellow/NP in order to become certified to go by yourself with a DR nurse for uncomplicated deliveries (repeat C/S or uncomplicated NSVD). If you’re uncomfortable attending a delivery by yourself, someone will always be there to go with you. You’re never truly alone. Our staff is very eager to teach.
* On the weekdays, there is a fellow and an attending assigned to deliveries while you are rounding, they are usually on the green team (not red, which is the resident team).
* You’ll never go to complicated deliveries on your own. These include meconium aspiration, twins/multiple gestations, premature babies, etc.,
* If you’re the one catching the baby in the OR, you’ll have to surgically scrub. Don’t forget your hat and mask.
* The attendings, NPs, and fellows will go over DR/OR proceedings in more depth. However, be aware that your primary role is airway – which puts you at the head of the radiant warmer. **Review your neonatal resuscitation handbook! We cannot stress this enough!**
* You also will need to assign the APGAR score and resuscitation measures in the EMR.

**NICU Admission Criteria:** *(From NICU Manual, Kathy Gilsbach, RN, MS)*

* The following babies must be admitted to NICU:
  + Babies less than 351/7 weeks as documented on the yellow “Birth Record” and less than 2000 grams. These babies must come to the NICU for a period of observation to ensure normal transition.
  + Infants >35 weeks have no specific length of time they must stay in the NICU. In general, the transition period should be no less than 4 hours.
  + Infants <35 weeks must stay for a minimum of 24 hours of cardiopulmonary monitoring.
  + Any baby who shows signs of delayed transition/physiologic instability, including tachypnea, grunting, flaring, etc., should come to NICU for observation and monitoring, but as above, do not have to stay once normal transition is ensured. Keep in mind that normal newborn nursery has limited ability to monitor babies, both in terms of equipment and staff.
  + 5-minute APGAR total of 6 or less
  + Persistent Hypoglycemia
  + Maternal temp >100.4 and/or any documented diagnosis of chorioamnionitis prompts NICU admission for rule out sepsis in the newborn
  + Infants who receive naloxone (Narcan) at delivery (for 24 hours of monitoring)

**NICU Admission Orders:**

* When a baby is admitted to the NICU, after he or she is stabilized, the most important thing to do is write the admission orders. **Use the NICU admission power plan**.
* One of the fellows or respiratory therapists will be around to show you how they like to do respiratory orders. Every change in vent settings or mode of support, requires a new order.
* Ask the attending that is on if they would like you to write an admission note.
* Obtain consents from the mother (or father if married). Remember, these should be done within 3-4 hours!

**Discharge Checklist:**

*Discharge Summary:*

* There is a template in the shared resident drive that will highlight the baby’s major NICU events and hospital course by systems. This template (once completed) can be copy and pasted into your discharge summary note (which is labeled as “discharge summary (standard)” in the EMR
* Fill in ALL follow-up appointments with the name of the physician, phone number and time-frame.
* All NICU discharges require a discharge summary unless they are transferred to the Nursery.
* Prior to changing teams at the end of the month, divide up all of the babies that have been in the NICU for a long time and update the discharge summary template on the shared drive for the next team.

*Discharge Orders:*

* If the baby is going home, discharge the baby to home as you would in Newborn Nursery via the “Discharge Orders home” order.
* If the baby is going to Newborn Nursery, you need “Transfer Orders” to Newborn Nursery. Call the Nursery resident to give signout on the transfer. Initiate the Newborn Nursery or Late Preterm admission Powerplan so the baby has what he or she needs when they get to the nursery.
* An attending or fellow must oversee ALL discharge med recs prior to discharge.

**Signing Out:**

* Make sure to sign out anything pending overnight and for the AM.
* Focus mostly on the sick infants when signing out. It is ok to spend a bit less time on “feeder-grower” baby signouts if they are stable.

**Overnight:**

* You’re in charge of all the red team babies and concerning nursery babies (NICU resident covers newborn nursery overnight)
  + The newborn resident will call at 5pm and signout concerning babies, all NAS babies, and any babies with pending labs (CBC, T/D bili, etc.)
  + It is your job to follow up these labs just as if they are your NICU babies!
  + Anytime during the night, you may get called to the nursery about any acute nursery events.
  + Examine the baby then call either the service or PVT attending on call. Remember to write an event note and sign out the event to the Nursery resident when they call at 6am. There will be a document about when to call the overnight attending for newborn nursery issues; this will be hung in the NICU as well as newborn nursery room. It is pasted below for your knowledge here!
* Keep in mind, you are the sole person in charge of the newborn nursery babies at night. If you’re ever unsure about something, you may ask the NP or fellow to come take a look at an infant, however you are ultimately the physician that makes the call regarding management and possible transfer to NICU for these babies.
* There will be an attending, an NNP, and a fellow on call with you at night. However, you’re first in line if there’s an issue with a resident baby – the call will come to you.
* You should wake up early enough in the morning for enough time to follow up all pending labs, update the list, and crunch all of your numbers before 7am.
* Don’t forget to follow up anything signed out to you from Newborn Nursery and to give an update on these items when the nursery resident calls you in the morning.

**GBS Guidelines:**

1. Requirements for GBS prophylaxis of Mother (1 dose of PENG, Amp, or Cefazolin at least 4 hours prior to delivery)
   1. Any mother laboring and delivering at <37 weeks gestation
   2. Active labor with vaginal or c/s delivery with a GBS + culture, or h/o GBS bacteriuria during pregnancy
   3. Mother with history of a prior infant with invasive GBS disease/sepsis
   4. Mother’s GBS status unknown and mother with either prolonged ROM >18 hrs., or intrapartum temp >100.3
2. Inadequate treatment = PCN < 4hours prior to delivery, treatment of mother with Vanc or Clinda (even if sensitivities available)
3. Mothers having a planned c/s, do not require ppx for GBS positive status as long as not active labor, cervical changes, or ROM
4. GBS positive with inadequate treatment
   1. Assess for risk factors: ROM >18 hours, GA <37 weeks, maternal fever, maternal/fetal tachycardia
   2. Calculate Kaiser Sepsis Score using online tool
   3. Well appearing with no risk factors: **routine care as per Kaiser Sepsis Score guidelines, discharge after 48HOL (consider CBC w/diff)**
   4. Well appearing with 1 or more risk factor: **observation for min 48 hours as per Kaiser Sepsis Score guidelines. Consider CBC w/ diff at 6-12 HOL.**
   5. Ill appearing +/- risk factors: **Transfer to NICU, as per Kaiser Sepsis Score guidelines**
5. GBS unknown
   1. Calculate Kaiser Sepsis Score
   2. Assess for risk factors: ROM >18 hours, GA <37 weeks, maternal fever, maternal/fetal tachycardia
   3. Well appearing with no risk factors: **routine care, as per Kaiser Sepsis Score Guidelines**
   4. Well appearing with 1 or more risk factors: Follow Kaiser Sepsis Score guidelines, and consider **CBC w/ diff at 6-12 HOL**
   5. Ill appearing +/- risk factors: **Transfer to NICU, as per Kaiser Sepsis Score Guidelines**
6. Prolonged ROM, GBS negative (not covered by GBS guidelines), calculate KSS. Follow corresponding guidelines.
7. Consider CBC if ROM >24 hours

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## **Night Intern**

**So, You’re Starting Nights…**

1. The night intern rotation consists of two 2-week blocks of nights from Tuesday to Tuesday, with both Saturday nights off.
2. Weekdays: your night starts with 6PM sign out. The floor team and Heme/Onc residents will sign out all their patients to you and the senior. Listen carefully for any pending orders/labs as well as which sicker/watcher patients you may have to keep a closer eye on. Always ask for clarification if something is unclear and ask for contingency plans. The more contingency plans you have (“if blank happens, do blank…” etc.), the smoother your night will go and the less stressful your night will be.
   1. Weekday AM: signout is at 6:30am for interns (supervised by night senior) and 7am for seniors.
   2. Saturday and Sunday AM: signout is at 7am
   3. Saturday and Sunday PM: signout is at 7pm
   4. Pediatric board review starts in the Fall for the graduating 3rd year seniors. These are scheduled once a week from 5pm to 7pm. If the night senior is a 3rd year, signout in the evening will begin at 7pm. If BOTH floor seniors are 3rd years, signout will also begin at 7pm. If the night senior is a second year and there is one second year floor senior signout begins at the normal time (6:00pm).
   5. **TIP:** When sign out is done, run the list with your senior to go through list of tasks and know what to prioritize

**Overnight Duties:**

1. Admit patients from ED or transports from outside hospitals.
2. If patients are coming from the ED, the ED resident should be calling the overnight attending and obtaining the plan BEFORE they admit the patient– they should then tell you what the attending wants when they call you for sign out. You are not required to call the overnight attending unless there are any questions.
3. If a patient is a transport from an outside hospital, the ICU attending that is in house will get the sign out and then decide whether the patient goes to the PICU or the floor. If the patient comes to the floor, the overnight hospitalist attending needs to be called because they were never notified of this patient. Your senior will be making the calls to the attending HOWEVER, TRY TO BE THERE WHENEVER YOUR SENIOR IS GETTING SIGN OUT/ TALKING TO AN ATTENDING!
4. Tend to overnight problems/events.
5. Check vitals and labs frequently. If something looks suspicious or impossible (respiratory rate of 0, for example), get clarification! Make sure to have the nurses or CNA repeat any abnormal looking vital signs.
6. If you are called to the bedside for whatever reason, write a 2-3 line event note in the chart stating why you were called, what you did, and what the resolution of the event was.
7. Eat, sleep (seriously), and go to the bathroom when you can!
8. Make sure list is updated in time for sign-out
   1. **TIP:** Update the list throughout the night and as admissions occur to avoid missing any important info/events. If you do not have time to do this, make sure you write down anything that happened overnight on your sign out sheet this way you can reference it when you update the list.
   2. See **Signout Section** for further night intern signing out details
9. Remember, you are never alone on nights! Your senior’s job is to be there to help you! If you ever feel overwhelmed, ask for help with admission notes or any other activities.

**Notes:**

1. On Friday and Saturday nights, the night intern is responsible for writing the daily Saturday and Sunday progress notes, respectively for all the service/subservice patients for the day team.
2. **TIP**: Round on the patients early and ask questions and do your physical exams. Prep your notes early (you never know when the night might get busy), but the **notes must be signed and timed for after midnight.**
3. If there is an admission before midnight, there must be an admission note and then a progress note timed for after midnight.
4. Admission notes and orders function the same as when you are Ward Intern (See **Ward Section)**

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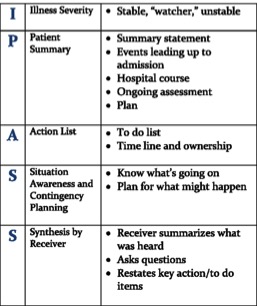
## **Signing Out**

Hand-offs, or “signing out” are a critical part of health care and requires, above all, excellent communication. You will get better at it as the year progresses but here are some general tips and sign-out structures that incorporate the key information for each type of sign-out:

* **As a general rule, ward interns are not permitted to accept sign-out on a patient being admitted from the ED or transferred from PICU. The senior resident needs to do that. It is ideal for the intern to be present while the senior is getting sign-outs to avoid multiple sign-outs on the same patient.**
* Interns may not sign out a patient to one another in the morning or evening without a senior resident for that patient present.

**General structure of a sign-out = IPASS**

* Staying organized when giving sign-out is critical to good and safe patient care. **IPASS** is a structured form of communication that reduces errors and improves patient safety during transitions of care. The following includes the elements of the IPASS pneumonic which you are expected to practice and refine during your verbal patient handoffs:



* + The **summary statement** is your one-liner which includes, age, sex, relevant past medical history, reason for admission, and active problems. The rest of the patient summary is hospital course briefly summarized, and an assessment of how the patient is doing now (i.e. patient has been clinically improving on IV antibiotics and has been afebrile for the past 36 hours”).
  + Your to-do list includes not only discrete action items, but also a relevant contingency plan (e.g. “Please continue the IV antibiotics overnight, but if the patient loses his IV again, you can change the antibiotic to oral for the time being.”)
  + As the resident giving sign-out, it is your responsibility as the messenger to make sure that your message is understood by the oncoming resident, the receiver. This is where the “synthesis by receiver” comes in when the resident receiving the verbal handoff summarizes the sign-out, asks clarifying questions, and reiterates the to-do.
  + Night intern: same IPASS structure, focus on overnight events

**Things to avoid in a sign-out:**

* *Rambling/commentary* – Try to stay focused on getting key points across
* *Disorganization* – Try to use a problem or systems-based approach for more complex patients, do not jump around
* *Oversimplification* – Do not omit critical information the next person will need to continue managing the patient
* *Assuming things have remained the same* – Always provide the basic one liner and current status on every patient, and always provide an update on changes
* If you find that sign out is taking too long or you are constantly getting out late, try to review your strategy with your senior beforehand. They can help you fine tune the pertinent information that needs to be relayed. Efficiency is key!

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## **USMLE Step 3/COMLEX Level 3 Process**

**Scheduling:**

* Start planning early in the year once you have your Block schedule. You might not have a specific date in mind, but you may be able to determine a good block in which to schedule your test.
* Let the chiefs know as soon as you have a block in mind. They can arrange your schedule to accommodate your exam dates.
* Not recommended taking Step 3 on: Ward Intern, Night Intern, Heme/Onc, NICU, Nursery (unless 2-person month), ER
  + Vacation is meant to be a time to rest and relax so try to avoid taking your exam then unless you are finding it difficult otherwise. This leaves electives, which are the preferred time.
* Don’t forget, you can use your educational money to pay for books and Q banks, but not the test itself
  + Keep all receipts and submit to Certify/Adis Misciagna ([adis.misciagna@stonybrookmedicine.edu](mailto:adis.misciagna@stonybrookmedicine.edu)).
* Taking and passing USMLE Step 3 or COMLEX Level 3 is an expectation for all interns by the end of intern year!
  + DOs: You do not need to take both exams (taking just COMLEX Level 3 is fine)

### **COMLEX:**

* https://www.nbome.org/assessments/comlex-usa/comlex-usa-level-3/ : Here you can learn more about the exam.
  + On the left-hand side are a bunch of links that provide information about eligibility, examination format, registration and scheduling, testing accommodations, practicing, and scoring.
* It is recommended that you use a Level III question bank (ComQuest, Combank, UWorld, etc).
  + Differing opinions exist on which question bank is better, but the bottom line depends on which one you are comfortable with and how many questions you will be able to finish.
* Do not forget to review OMT!
  + The same material you used for Level II should suffice, along with a Level III question bank.
  + The most high-yield information remains innervations, Chapman points, and muscle energy techniques.
  + The green OMT Review by Severese is very good!

### **USMLE:**

* <https://www.usmle.org/step-3/> : Here you can learn more about the exam.
  + Structure of USMLE Step 3:
    - Day 1: 8 hours, multiple choice questions
    - Day 2: 8 hours, part multiple choice questions and part CCS (clinical cases in “real time” where you order things and address outcomes as you are notified a computer-based software)
    - The two days can be in either order – questions first or questions/cases first.
      * If you call Prometric to schedule, they can often tell you which one is being given on the first day.
* Use Step 3 UWorld question bank

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## **Wards**

**So, you’re starting the pediatric floor…**

* The pediatric ward is located on 6W, in between PONC and the PICU.
* The resident call room is in the corridor with the Ronald McDonald room and the Break Room. The code to almost all the locks on the floor is 2019.
* The dress code is typically business casual but has been scrubs due to COVID19 pandemic.
  + We do not wear white coats on pediatrics.
* Infection control:
  + Handwashing is our best defense against the spread of any infection. We are also constantly being watched by hospital staff regarding this. Sanitize before entering a patient’s room and immediately after exiting the room.
  + Especially in the current COVID19 pandemic, please make sure to follow all required precautions for isolation rooms. Please wear a surgical mask at all other times.
* There are two floor teams. Each team will have 1 senior, 2 interns and 2-4 medical students.
* Patients will be split as evenly as possible but expect to carry at least 3-5 per day on average. During the busier months, this number can easily increase to 7-9 per intern. There is no cap on the number of patients each person carries.
* Tip: Time management will likely be the most important thing you learn your intern year.
* Remember – you play an active role in your education, of which the inpatient rotation is an important piece. Since time will be limited, try to learn/read as much as you can while you have the patient as you will be very exhausted in the evenings to catch up.
* Please feel free to ask ANY AND ALL questions you may have.

**Scheduling:**

* During each month of floor rotation, your work hours are officially 6:30am (intern signout) – 6pm (signout). Your schedule will be found in New Innovations.
* **All notes have to be completed before rounds** (which start at 9:30am) so plan ahead and come in earlier if you know you need extra time pre-rounding or if there is a high census.
* For every four weeks that you’re on the floor, you’ll work a Saturday daytime shift, a Saturday overnight shift, and a Sunday daytime shift. Weekend daytime shifts start at 7am, and signout on Saturdays and Sundays is at 7pm. The remaining weekend is a “golden” weekend (both Saturday and Sunday off).
* Weekends are a skeleton crew with 1 intern and 1 senior so be prepared to cover all the patients for both floor teams. Since you can access Cerner from home, it is helpful to skim over patients the evening before your shift so you are familiar with the patients.
* If you’re the Saturday night intern, it is your job to write the daily notes for the day team.
* Be prepared to push the 80-hour work week limits. Sleep when you can, eat when you can, and **don’t forget to keep yourself hydrated**!

**Preparation:**

* Before you start the floor, familiarize yourself with where everything is.
* Many people find multi-colored pens or clipboards to be helpful, but you will figure out what works best for you!
* The day before you start, you will get a senior supervised sign-out on your patients from the previous intern. Take notes during the verbal sign-out, comb the chart for pertinent information (H&P and off-service notes are key, if the latter is applicable), and go through the computer for current orders, latest labs and previous discharge summaries.

**Physician Handoff:**

* On Powerchart, there is a ‘Physician Handoff Worklist’ that can be accessed through Cerner and is used as our sign-out/daily list. It is updated by all residents, you should be updating your patients throughout the day. Updates include a one liner, pertinent daily events and actions for overnight residents as well as situational awareness and planning. This must be completed, printed by team, and brought to the sign-out room by sign-out.

**Charts:**

*Cerner Powerchart:* our EMR

* Orders
* Meds/MAR Summary
* All vitals (including height, weight and HC) and I/Os.
* Lab results and radiology (PACS) and old records (Eclipsys)
* Power Notes (admission, progress, and event notes are written electronically for all service, Pediatric subspecialty, Orthopedic Surgery, Neurosurgery, and Colorectal Surgery patients)
* Discharge Summary

*Red Charts/Paper Charts:* usually found next to the clerk in the chart shelf.

* Patient stickers
* ED and outside records
* EKGs, consents, pathology/special IR handwritten reports

*Forms/Consents/Paperwork:*

* Ask a clerk or your senior. The clerk will print consents or special forms, but you can also print them yourself from Cerner.

*Other Items:*

* Crash cart - *usually* located in the core on 6W
* Oto/ophthalmoscope cart and tongue depressors, however they may be stored in the Med room
* A quick reference of Frequently called phone numbers (also see Appendix section of this document) can be found near the work area
* Printer (PAV\_0601\_0607). There is a fax machine next to this printer.

**A Typical Day:**

* 6:30 - 7am: Intern signout in MAART Conference Room
* 7 - 8:30am: Pre-rounding, finish notes, touch base with senior
* 9 – 9:30am: Finalize before rounds- ie. sign unfinished notes, follow up labs, call consults, finish seeing patients, prep discharges, etc
* 9:30am - 12pm (ish): Attending Rounds
* 12 – 6pm: Work - this includes tasks for the day, discharges, lecturing medical students, new admissions, wellness walks to Starbucks (☺), etc.!
  + *ACC – Tuesdays & Fridays from 1-1:30pm*
  + *Hospitalist ward teaching – Mondays & Thursdays at 2pm*
  + *Throughout the day: Update your senior! Bring your medical students around with you to teach/show them!*
* 6pm: PM signout in MART Conference Room

**AM Ward Signout:**

* See Signout section!
* Intern signout begins at 6:30am in the MAART conference room. It’s extremely important to be on time.
* This is when overnight events are communicated from the night to day team. New overnight admissions are also signed out during this time. Interns may leave the room quietly and begin their prerounding/notes once they have received signout on all their patients.
* Senior signout begins at 7AM after intern signout. Touch base with your senior resident after their signout with updates, to clarify the day’s plan for each of your patients or ask any questions/help.

**Pre-rounding:**

* After sign out, begin seeing all of your patients. See patients with acute issues/concerns first. If the patient is sleeping and there are no acute issues, you can finish prepping your notes and see the patient a little later on – just don’t sign the note until you’ve done the physical exam!
* Review vitals (which are on your sign out), ins and outs (cc/kg/hr, make sure to look at net balance also), asthma scores, new labs, etc. Look at radiology studies done overnight (tip: don’t just read the report).
* You should be able to see all of your patients prior to Afternoon Case Conference. Again, patients with acute issues take priority.
  + Tip: Organize yourself while pre-rounding in order to prepare for attending rounds. Write down labs, radiology, etc on your daily worklist and begin a checklist of what you foresee to be the day’s plans.
  + Tip: Senior signout and Nurse signouts both occur from 7-7:30am. Try to see as many of your patients during this window as you can and unless truly necessary, do not interrupt others’ signouts.
  + Tip: Prepare your families and **ask for their permission to involve them in family centered rounds while pre-rounding.**

**Attending Rounds:**

* Attending rounds begin around 9:30am in front of the classroom on 6W. Rounds are family-centered at the bed-side.
* Do your best to alert the nurses when you are rounding on their patients so they can be present.
* If the patient is established (i.e. Not a new admission from overnight), your presentation will be brief and follow the SOAP format. Try to present your plan in either a problem-based or systems-based format to demonstrate your organized thinking to the attending.
* If the patient is a new admission, you will have to present the entire H&P.
* Medical Students will present patients on rounds. Depending on the census and how many medical students you have, you might not have any patients to present. Most attendings will like to observe you presenting a patient in the beginning of your ward blocks, so try to at least present one patient when you have a new attending.

**Private PMDs:**

* Some community pediatricians have admitting privileges. If a patient is admitted under a private PMD, he or she is the attending in charge of that patient.
* Most private attendings come in to round between 7am and 8am, but some come during Afternoon Case Conference. Be sure to catch them while you can to discuss the daily plan on your patient otherwise you will have to call them later and discuss it over the phone while they are in their clinics.
  + Tip: Check for an EMR note from the PMD after Afternoon Case Conference in case you missed them. Follow up their plan.
* Because there are no formal attending rounds, you should have a low threshold for calling them during the day for any situation.
* For a list of PMDs and their contact information, see the Appendix section.
  + Tip: Call to Update the PMD at least once daily before evening signout
  + Tip: If the PMD has multiple patients on the floor, try to batch phone calls.

**Orders:**

* All order writing is done electronically through Powerchart. **You should notify the patient’s nurse of ANY new or discontinued orders, especially if the order is written as STAT, otherwise it may be missed/drawn late**.
* Lexi-Comp online (http://online.lexi.com/crlonline) is our hospital-approved reference for medication dosages. There is a direct link to Lexi-Comp from Powerchart and also from the main hospital intranet page. We cannot stress the importance of Lexi-Comp enough! This is what we use for all medications.
* Make sure you are checking every day that no medications have fallen off of the MAR.
  + Tip: IV Tylenol/Ofirmev, 1:1 safety watches, restraint orders only last 24hours unless renewed
* Compare active orders to what the patient should be getting to exactly what the patient is getting (MAR) every day. This is called “med rec’ing.” Some attendings like to do this on rounds, however you should be doing it yourself each day.
* Orders for phlebotomy/Lab collect need to be put in for the exact times of 6:00am and 11:00am Routine (no STAT orders). If you want the phlebotomy team to draw the labs, make sure you select “Nurse collect” -> “No” when placing the order in Powerchart.
* If you are too late for phlebotomy or would rather have the nurses collect blood for you, put in the order as a “Nurse collect” **and tell that patient’s nurse.**
* If the patient has a central line or is an especially “hard stick,” labs will always be drawn as “Nurse collect”.

**Radiology:**

* After putting in orders, call the appropriate department to make them aware. Get an estimated time that the study will be done, especially if they need to be NPO.
* In general: Patients who need studies under anesthesia or CTs with contrast will need to be NPO for a certain amount of time before the study.
* MRIs without sedation usually do not require a patient to be NPO.
* If a patient requires MRI with sedation, this can become a complicated process. Below is a document sent out by Dr. Foy that outlines the procedure for scheduling this. Don’t be afraid to ask your senior or attending for help should you have issues!

**MRI Scheduling**

This is the current protocol. It is subject to change, so the most important thing about scheduling an MRI is to be flexible and patient.

**\* Reminders \***

* Standing pediatric MRI time slot Mon/Thurs at 7:00 am
* To use the 7am time slot, MRI must be a short case (< 45 min long). Examples of short cases below ◊. Double check with the MRI tech at 6-2047 if you are unsure.
* Patients with 7am cases should begin being transported down at 6:30am
* Rads to Peds Attending discussion maybe needed for Emergent/Same day sedated MRIs
* Your patient maybe added on for a same-day case if you are calling on Mon/Wed/Thurs, so keep patient on NPO or clears until scheduled
* Attending to Attending discussion will need to happen for urgent same day cases to ensure the MRI ordered is appropriate
* MRI w/ sedations + LPs are usually too long for the 7am time slot
* You MUST call radiologist to ensure normal MRI prior to preforming LP

**A) Urgent Sedated MRIs (needed < 24 hrs from scheduling)**

* Order MRI and in comments note “to be done under anesthesia,” and if additional procedures will be done. Confirm with MRI tech at 6-2047 order was received. MRI tech can also confirm if case is “short” if you need it to qualify for the 7am Mon/Thurs time slot.
* Call OR Scheduling at 4-2444 and say “I would like to book a case for a sedated MRI for “\_\_date/time, with or without additional procedures (ex. LP) \_”. The case will likely be an “Add On” (see section C for special considerations for LP).
* If MRI is wanted on Mon/Thur, ask for the 7am slot if the MRI is a short case◊
* During the week, Eleanor / Jerry at Elective Procedures (4-2924) may be helpful in arranging the procedure / looking at the schedule for the next day to estimate times.
* If you are confirmed for the 7am Mon/Thur morning slot email the details (date/time/MRN) of the case to SOM\_Anesthesiology\_Faculty\_Pediatric\_Division@stonybrookmedicine.edu AND Stephanie.Moses@stonybrookmedicine.edu
* Communicate with nursing the time of the MRI. If scheduled for a 7am slot, the patient needs to start being transported to the MRI suite at 6:30am. Please note, there will be no “call for the patient;” the 7am patient is the first case and just needs to go down. Call the MRI tech to confirm if there are any questions about time.
* The morning of the scheduled MRI:
* Around 6am call the MRI Tech at 6-2047 to verify the order and confirm timing. Can call Donna / Lucy at 4-2424 if there are scheduling/coordinating issues
* Call MRI Anesthesiologist at 4-7481 to confirm. Notify them if any procedures are to be done. Please give them 10-15min to answer you back before calling again.
* If patient is an “Add On,” keep them NPO from midnight until as long as possible. CAN give clears up to 2 hrs before procedure but should confirm w/ MRI Anesthesiologist and MRI Tech prior to giving clears that you will have >2 hrs before next available slot.

**B) Patients who need a semi-elective sedated MRI (ex. A patient who can wait > 24 hrs for MRI) – Usually done Mon/Wed/Thur**

* Order MRI and in comments note “to be done under anesthesia,” and if additional procedures will be done. Confirm with MRI tech at 6-2047 order was received. MRI tech can also confirm if case is “short” if you need it to qualify for the 7am Mon/Thurs time slot.
* Call Elective Procedures at 4-2924 (Eleanor / Jerry) to schedule MRI at least 24 hours in advance, and you will be placed on the schedule as able. Eleanor will then contact the MRI personnel to schedule. Let them know if additional procedures to be done.
* If MRI is wanted on a Monday or Thursday, ask for the 7am slot if the MRI is a short case◊
* Day before procedure (If sedation is scheduled for Monday, this would be Friday) Contact Eleanor/Jerry at 4-2924 to get an estimated time that your patient will be going down.
* If you are confirmed for the 7am Mon/Thur. morning slot email the details (date/time/MRN) of the case to SOM\_Anesthesiology\_Faculty\_Pediatric\_Division@stonybrookmedicine.edu AND Stephanie.Moses@stonybrookmedicine.edu
* Clarify NPO orders
* Communicate with nursing the time of the MRI. If scheduled for a 7am slot, the patient needs to start being transported to the MRI suite at 6:30am. Please note, there will be no “call for the patient,” the 7am patient is the first case and just needs to go down. Call the MRI tech to confirm if there are any questions about time.
* Morning of MRI call the MRI Anesthesiologist at 4-7481 to confirm. Notify them if any procedures are to be done. Please give them 10-15min to answer you back before calling again.

* **C) Sedated MRI followed by sedated LP:**
* Once the MRI is scheduled call the radiology tech to ask for the name of the covering radiologist. You MUST page the radiologist on call either the morning of the MRI or 2 hours before to explain that an IMMEDIATE read of the MRI is required before you can proceed with the LP (to ensure there are no contraindications to the LP). Note the radiology contact name/number/pager so you can reach them prior to performing the LP.
* Morning of MRI or once MRI time is scheduled call the MRI Anesthesiologist at 4-7481 to inform them procedure is needed. Please give them 10-15min to answer you back before calling again.
* When the patient is being escorted down for MRI call the radiologist to inform them the patient with the required immediate read is on their way down for the MRI.
* As soon as the MRI is finished contact the radiologist for a read of the MRI.
* Perform the LP when radiology reads the MRI as long as there is no contraindications to the LP.
* Record the name of the radiologist you spoke with in the procedure note for the LP.

**◊ Examples of Short MRIs (< 45 minutes) that will qualify for the standing 7am time slot:**

* MRI Brain without contrast
* MRI Brain without and with contrast
* MRI Orbits without
* MRI Orbits without and with contrast
* MRI IAC without
* MRI IAC without and with contrast
* MRI Brain and Orbits without
* MRI Brain and Orbits without and with contrast
* MRI Brain and IAC without
* MRI Brain and IAC without and with contrast
* MRI Cervical Spine without contrast
* MRI Cervical Spine without and with contrast
* MRI Thoracic Spine without contrast
* MRI Lumbar Spine without contrast
* MRI Lumbar Spine without and with contrast
* if you are unsure if your image qualifies, please check with the MRI techs at 6-2047

**Electronic Prescriptions:**

Powerchart allows electronically transmitted prescriptions directly to pharmacies via “E-scripts.” To write your patient’s E-scripts at the time of discharge, follow these steps.

* Confirm your patient is going home and which medications they will need a script for once at home. This includes any new medications prescribed while admitted, continuation of chronic meds that they may need a refill on, etc.
* Ask the parent for the name of the patient’s preferred pharmacy – most local pharmacies, including several “mom and pop” pharmacies in the area are included in our electronic pharmacy list.
* Go to Power Orders and click on Med “Reconciliation” → drop down “Discharge”
* For the inpatient medications that the patient should continue at home that they do not need a refill for, select the green arrow icon. To prescribe an inpatient medication prescription, select the middle column. To prescribe a new medication that is not listed, select “+Add”. To discontinue an inpatient order/medication, select the red square icon.
* Double check the appropriate formulation, dose, frequency, duration, number of doses, and number of refills to be ordered.
* It is often helpful to fill out the “special instructions” section with a set of clear instructions for the patient/family to see on their discharge paperwork also so there is no confusion as to what you intended for them to do “Please take 2 tabs with food every 8 hours for the next 7 days.”
* Once you have selected all medications, completed their prescribing information, and assigned the pharmacy, click the bottom right button that says “Reconcile & Sign.”
  + Tip: Do not click “Reconcile & Sign” until you are ready to send the prescriptions to the pharmacy!
* Your prescriptions are sent! Let your patient/family know they are being prepared.
* For Spanish-speaking only patients, you can write “Spanish speaking only” in the pharmacy special comments so the prescription will print in Spanish.

**Controlled Substances:**

Residents have the ability to prescribe controlled substances. When patients need to go home on rectal diastat for seizures or oxycodone for pain management, we need to send these controlled medications to the pharmacy. As with any other medication that will be prescribed, the order is completed through PowerChart. Instructions to follow as below:

* Select the medication you want to order and ensure all the details are correct before you hit sign
* A window will pop up with “WARNING” and will provide a link to the NY State Prescription Monitoring Program (PMP). This link will lead you to the NYS Health Commerce System (HCS). After logging in, you will be able to look into the patient’s history of prescribed controlled substances. Ensure that the last prescription was performed 1 month or more ago before prescribing another course of controlled medication.
* You will prescribe the medication just like you do with any other medication. However, you will get a pop-up on your phone with the Imprivata code to enter that confirms that you are prescribing the medication. Just follow the prompts – it's pretty fool proof 😊

**Consults:**

* Never call a consult without attending approval. Always make sure to have your question ready to present to these attendings/fellows. It is not okay to call a consult and not know why you are calling it!
* Look on the oncall switchboard to see who is on-call and page them via Spok.
* Never initiate a plan proposed by a consultant without attending approval.
* Sometimes residents are on electives and covering inpatient floors, which is great! But just because you told them about the consult doesn’t mean you have officially consulted the service. You MUST page the attending or fellow on call.

**Admissions:**

**General Pediatric Services:**

* Patients who are admitted to a general pediatric service (service, private PMD, non-surgical subspecialties) will require:
* A complete history and physical
* Admission orders via “Pediatric admission Powerplan”
* PMD notification. Also, notify subspecialists if your patient has a chronic illness and follows with one frequently.
  + Unit clerks are now performing PMD notifications
* Don’t forget to complete the Admission Medication Reconciliation to resume your patient’s home meds (this is tracked by the department). We cannot stress the importance of this. **Getting an accurate medication reconciliation at time of discharge, especially for complex patients, will make discharge so much easier!**
* New admissions are split between the two teams. The seniors assign them try to keep the two teams balanced. You are responsible for doing admissions with the senior resident and your medical student.
* Obtain a full H&P, Write a full admission note, and don’t forget to ask for the PMDs and obtain a HEADSS exam (when indicated).

**Surgical Services:** Depending on the surgical service, we have different duties in patient care. Regardless, we always are responsible for notifying the patient’s PMD.

*Orthopedics/ENT:*

* We co-manage these patients which means we write daily notes that are sent to the service attending. We also round on them.
* The primary surgical team will write all of the orders for the patient and ultimately make all decisions regarding their care. They will also do the discharge paperwork, write prescriptions, and be responsible for dictations.
* Patient issues or questions about plan of care should be deferred the primary surgical team.
* We co-manage these patients to ensure things don’t get lost between the cracks while the surgical residents are off the floor. Thus, check orders and if an order needs to be changed, check with your senior and service attending and the primary surgical team.

*Pediatric Surgery, Urology, Plastic Surgery, OMFS, Neurosurgery, Trauma Surgery:*

* We are involved with surgical patients as we are on the floor 24/7 while the surgery residents are often in the OR when situations arise. We do not round on these patients or write notes, but you should know your surgery patients as well as all of your other patients. Our main job is to maintain awareness but knowing the patient is key, especially if they have a rapid response.
* DO NOT write orders or notes on these patients unless it is an emergency!

**Progress (SOAP) Notes:**

* There should be a progress note in the electronic/paper chart for each patient every day.
  + Exception: If the H&P of a new patient admitted overnight after midnight, a progress note is not required for that day.
* Complete daily progress notes prior to attending rounds at 9:30am.

**The SOAP format: a Refresher Course:**

* One liner of your patient to refresh the reader of whom this patient is
* S (subjective): How the patient did overnight, any events, any complaints.
* O (objective): Vitals, weight, Physical exam, I/Os, labs, radiology.
* A (assessment): Summary of status.
* P (plan): either by systems or problem-based
* All notes by medical students should be reviewed, discussed and co-signed. The medical student’s note does not count as an official note and does not take the place of your daily progress note.

**Notes types and Forwarding to the proper attending:**

* Service (SVC), Ortho, ENT= Send to the service attending you are rounding with for the week.
* Peds subspecialists (Neuro, Pulm, GI, Endo, ID, etc). = Send to the subspecialist attending on for the week. To determine the attending, click the “on call” button in the Cerner Powerchart menu. Select the 2nd “on call” tab then scroll until you find the proper service (ie, Peds neuro, Peds Pulm, etc.)
* Again, do not write daily notes/H&Ps on Pediatric Surgery, Urology, Plastic Surgery, OMFS.

**PMD Notifications:**

* To provide complete patient care and maintain proper communication with community Pediatricians, we must notify every child’s PMD when they are admitted to Stony Brook Children’s.
  + The unit clerks are currently performing the PMD notifications, but be aware if this is not done, it needs to be done. If simple admission, just give a brief reason for admission and can leave a message. Call yourself and ask to talk to the physician on call if more complicated admission and need to discuss history/hospital course/recommendations with the pediatrician.
  + Don’t forget to document this either in your H&P or a separate free text note otherwise your effort doesn’t count

**Discharges:**

* In order to discharge a patient, you must complete the discharge process in Powerchart under “Depart”. This is where you e-prescribe necessary prescriptions, include follow up information with PMD and any consulting services (contact consultants prior to discharge and ask if they would like follow up if not addressed in their note) and patient education.
* Begin the Discharge paperwork and process as soon as possible, especially if you anticipate social work involvement to prevent delaying discharge.
* We write the discharges for all service and Pediatric subspecialty patients. Surgical services do their own discharges.
* Make sure there is enough information on each discharge summary so that a resident covering for you could discharge the patient successfully.
* Make sure to write the responsible intern’s name under “responsible discharge resident” on the discharge order or else the dictation will get sent to you. Everyone admitted for 48 hours or longer requires a dictation (discharge summary).
* If the patient has been hospitalized for less than 48 hours, no discharge summary is required
* Let the patient’s nurse know that the patient is going home and you put in the discharge order so they can print/prepare the paperwork!

**Unusual Medications:**

* If a patient is going home on an unusual medication, call the outside pharmacy and make sure they will have it available in a timely manner.
* If the pharmacy is closed or will not have the medicine in an acceptable period of time, it is sometimes necessary to find a 24-hour pharmacy close to the hospital (pro-tip – there is a 24-hour CVS on 4331 Nesconset Hwy, Port Jefferson Station)
* This is particularly important when discharging on holidays when numerous places are closed!

**Discharge Summaries:**

* All patients admitted for more than 48 hours will require a dictation.
* Discharge summaries need to be completed in a timely fashion.
* Under message center on PowerChart, you can look under the Work Items section which contains the “Documents to Dictate” to see if you have any discharge summaries to complete.
* To complete a discharge summary, begin a new note with the note type “Discharge Summary” and under Encounter pathway, search for the note template “Discharge Summary (Standard).”
* Complete all parts highlighted in yellow and send the discharge summary to the **attending responsible at the time of discharge (it doesn’t always autopopulate the correct attending – check the notes from when the patient was admitted to see the attending who was covering).**
* It is vital to include all significant events and changes that took place while the patient was hospitalized as this document is seen by PMDs who need to know what happened with their patient.

**Transfers:**

*Accepting a Transfer:*

* This includes PICU downgrades or direct transfers from an outside hospital
* Read through chart thoroughly. PICU transfer notes are generally very helpful with an overview of the hospital/PICU course and are also found on Powerchart under “Documentation” with the regular admission H&P and progress notes.
* Talk to the patient, get history, do physical.
* You write an “Peds Acute Acceptance Note” for PICU transfers. It is very similar to the PICU transfer note, you can essentially take that note (from PICU resident) and tailor it to your 6W plan. You will write a full H+P for hospital-hospital transfers.
* Don’t forget to do the medication reconciliation→”Transfers”. Discontinue any orders that pertain only to the ICU – i.e. Cardiac monitor, 1hour vitals, etc.

*Transferring to Another Service (PICU):*

* You MUST write a transfer note, which is SOAP note format with more detail and include a brief HPI and hospital course.
* Write transfer orders in Powerchart (“transfer patient to”)
* Reconcile meds using the “transfer” option.
* Sign out to the resident accepting the patient.
* Note: patients go to PICU because they are unstable, which means there is usually some sort of rapid response prior to transfer. Rapid responses need an SBAR event note!

**Running the List:**

* Throughout the day, update your senior and your patients/families frequently.
  + Tip: Parents should not be asking the night team about long-term plans! If they are, that is a clue that you should be more on top of updating your families before signing out to the night team.
* 3pm is when your senior will meet with the charge nurse for Discharge Rounds. You should update your senior on potential discharges BEFORE this time
* At 5pm, you should be updating the Physician Handoff, giving your senior final updates and preparing to signout. You should review the most recent vitals for your patients, complete respiratory checks, etc and have a good idea of what the night team should expect overnight. This is key to leaving the hospital on time.

**Discharge Process:**

* The discharge process begins as soon at the patient is admitted and should be as complete as possible. The goal is to be able to discharge patients during rounds therefore it is important to begin/complete the “Depart” prior to rounds if you are planning on discharging your patient that day. This includes sending prescriptions to the pharmacy, follow up appts with PMD and subspecialists, patient education, reviewing the asthma action plan, etc. It also includes prepping your patient’s summary of their stay.
* The day team should identify areas where the night team can help with discharge and let them know during PM sign-out. For example, sign out to the night team to wean IV fluids or space asthmatics to q4hours overnight if they can. That way, they will be ready for discharge during morning rounds rather than later that day.
* Also, anticipate if your families will need services that required coordination with social work, etc and begin obtaining these services as early as possible.  For example, an ALTE’s family may need CPR training or an asthmatic who needs a nebulizer machine obtained through social work.

**Medical Students & Teaching:**

* There will be 3-4 third yr medical students assigned each team. Typically, they will co-follow 2-4 of your patients. Help them pick good bread and butter cases. They should take ownership of their patients (pre-rounding, seeing their patients, writing notes and following up labs.) They should also be presenting during attending rounds.
* Be sure to take time to teach, even if it’s only pearls here and there, or tips and tricks for internship.
* Constructive criticism is especially important in history taking, physical exam skills and note writing. Before co-signing medical student notes, they should be reviewed and discussed. **Remember, medical students notes do not count as your daily note.**

**PM Signout:**

* See Signout section
* Evening signout begins at 6PM in the MART conference room.
* Presentations to the night team should be brief, but they should also include any and all pertinent information about your patients that would be important to know overnight. Signout follows iPASS format.
  + Start with a one-liner
  + Report pertinent daytime events and pertinent plan/actions for the night team, including your updated vitals
  + Briefly list important medications.
  + Finish with a summary of night issues/things to look out for or accomplish overnight, as well as labwork expected in the AM if there is a value that needs to be watched for and what to do with that lab if abnormal.
* If necessary, also sign out if anyone needs to be called for a specific parameter (i.e., page the Endo fellow with D-sticks at 10PM if >250)

**Completing an Asthma Action Plan:**

Because childhood Asthma/Reactive Airway Disease are such common and often difficult-to-manage diagnoses, it is critical that a strategic “going home” plan be in place for the patient to follow once they have met their goals for discharge from the inpatient ward.

* Minimum goals asthmatics must reach for home-going are:
  + Tolerating q4h albuterol (preferably on MDI)
  + Keeping sats >92% on RA both day and night (no supplemental O2)
  + No longer requiring IV access (good po and UOP, no abx)
  + Completed a Pulmonology consult if warranted
  + Plans to follow-up closely with PMD +/- Pulm
  + Family has completed Asthma Education and has a completed and reviewed Asthma Action Plan.
* Every patient with an asthma/RAD diagnosis requiring albuterol **MUST have an Asthma Action Plan (AAP)** filled out in Cerner and reviewed with the family prior to discharge!!
  + - * To create an AAP:
        + Click “Ad hoc” located in the top menu bars in Cerner Power Chart. Check “Asthma Action Plan” then hit “Chart.” Fill out the form using the check boxes or dropdown menu options, particularly any required yellow areas. At the bottom, select “yes” for Follow up with SB Affiliated Physician then search for their PMD’s name in Follow Up with: \_\_. Type in the Provider’s phone number and type “1-2 days” in the Follow Up Appointment. Once you have finalized the AAP and are ready to review the AAP and discharge the patient, click “yes” for AAP reviewed with and copy given to the patient/family. When you are done, click the green check mark in the top left. If you are not ready, do not click yes and instead, click the disk icon to save the AAP.
      * To print the AAP:
    - Click “Task” in the top left in Cerner PowerChart. You will see a popup menu, Select “Reports” then check “Asthma Action Plan.” At the bottom under Printer Destination, scroll to “asthma” then click “Print.” The asthma printer will print the AAP in color and is located by the main 6W Clerk station.
  + Once you’re done and have your AAP in hand, review it with your medical student and your patient/family prior to discharge.

**Child Life Specialists:**

Certified Child Life Specialists are trained in child development and are equipped to deal with the effects of hospitalization on children. They work closely with the healthcare team to assess and address the individual needs of young patients and their families. They are a great resource for our kids and are available on the Wards, ED, Heme/Onc and PICU. Their goals include:

* Minimizing overall stress and anxiety
* Providing normal play opportunities
* Enhancing normal living patterns and experiences within the hospital

environment

* Promoting normal growth and development during hospitalization
* Lessening the emotional impact of illness and hospitalization
* Advocating and supporting the patient’s and family’s roles in the healthcare team

**We are an Ouchless Children’s Hospital:**

* + We have LMX or Sucrose built into our Power Orders to ensure that our patients receive proper measures to decrease the amount of discomfort during procedures such as: phlebotomy and PIVs.
  + We also utilize Child Life Services for diversion during procedures that a child is fearful of such as PIVs, MRI/CT scans, etc.

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## **Ways to Shine on Your Rotations**

There are some things on each rotation beyond the general requirements that will help you stand out, improve workflow, and improve patient care. Some are mentioned throughout this guide, but here are some specific tips for doing well on your rotations.

**Presenting in the ED:**

Aside from medical/surgical/social considerations, start thinking about the **disposition** of the patient **with your initial assessment**. Will this patient need to be admitted (Private vs Service)? Are you going to observe after treatment? How long? Consults? Social work? CPS? Will a CT read influence your decision? Will these labs change your management? Will the patient need sedation for a procedure? NPO?

* While not part of the textbook/board management, this is real life. Setting these things into motion will not only make your life easier, but it will also help the inpatient team accepting your patient, allow nurses to maximize their patient contacts, and ultimately improve patient care.

**Discharging patients in the ED:**

If a patient will require a course of antibiotics, steroids, or some other medication course, give them their first dose in the ED prior to discharging them. This ensures the patient will get at least one dose that day just in case there is an issue at the pharmacy and demonstrates that the patient can tolerate the medication and likely won’t have an issue taking it at home.

When in a bed crunch, the nurses may be busy taking care of sick kids, so you can help out by discharging your patients yourself.

* After you have filled out the follow-up appts, sent prescriptions, and your attending has signed the discharge form with printed patient education, have the patient’s parent sign and provide a phone number (should they need to be contacted regarding any labs, imaging, etc.)
* Before the patient physically leaves, make sure they have seen registration. Also, make sure to remove their IV!
* Take the rest of the chart and place it in the ‘Discharge’ bin at the clerk’s desk. Inform the clerk and nurse that the patient is gone so that they may remove the patient from the board and turn the bed for the next patient.

**Communication in the ED:**

Often, you and the staff are constantly walking between patients and rooms, so stopping to provide updates may be difficult. Nurses will often ask for Motrin, Tylenol, and Benadryl orders prior to patients being seen, especially if there is a long wait. This is OK to do as long as you have reviewed the patient’s allergies in the chart prior to ordering. Always seek your attending’s attention for any new labs or radiology (especially if disposition dependent).

* You can leave comment in the tracking board for the staff to let everyone know what is pending. (This should never supplant actual communication, just as a reminder!). There is a comment section which is visible on the public tracking board and a ‘Pvt Comment’ section, which only staff can see on their workstations. Choose carefully what to list. (i.e. keep CPS or psych private).
  + Examples for appropriate comments: Ortho consult, PO challenge, Motrin, XR read, recheck vitals

**Teamwork on the Ward:**

This is where teamwork can really play a significant factor. Remember, you are no longer competing for that elusive Honors grade or ranking.

* When you are on a team, remember to be aware of the other interns’ patients as well. You will be responsible for them when your co-intern goes to clinic. Additionally, you should be able to answer questions about the patient and put in orders if asked. This seems like a lot in the beginning but will get easier as the year goes on! NEVER respond to anyone’s questions by saying that is not my patient - it won’t end well, trust us!
* You and your colleagues are evaluated on your own merit and part of your competencies includes interpersonal communication and ability to work as a team.
* Your patient’s team includes not just the physician team but medical students, nurses, and other staff (CAs, social workers, consultants, etc.), so treat everyone as an equal member of the team. Have patience, communicate clearly, and speak with respect.
* Focus this year on improving your management plans, identifying patients who are sicker than others, and learning how to anticipate and prepare for discharging patients in a safe and appropriate manner.

**Heme/Onc Tips:**

This is an emotionally draining rotation – much more than others intern year – so make sure to get your rest and have fun when you do have time off. Also, unless you request heme/onc as an elective 2nd year, you don’t go back until 3rd year so use this opportunity to learn everything that you can. You’ll be taking care of these patients at night and on the weekends while on the wards.

* Many of these patients and their families will be admitted for weeks at a time and are scared/confused about their diagnosis. We know it’s a hard rotation and your tired but don’t forget to be a friendly face for them each day.
* Know the possible side effects of the chemotherapeutic medications or other medications you are using when you present for rounds.
* Try and think one step ahead (i.e. Plan for what to do if your patient has a fever, know which antibiotics they are on and which ones you would add to broaden coverage, know if the attending wants to be notified, know which labs needs to be sent with the fever spike, etc.)
* Be nice to the nurses and keep them updated about changes in the plan or new labs that you ordered, don’t just expect them to find the orders on their own. Many have a wealth of experience and can help teach you about the complex care involved with heme/Onc and how to approach speaking with families in different situations.
* There are heme/onc NPs that are often working in an office on the unit, utilize their kindness and expertise if you’re ever questioning a patient’s clinical status, labs, or treatment.
* There is a heme/onc ward officer handbook available. Ask your seniors/chiefs for this document.

**Leaving The Ward smoothly on Clinic days:**

When you are leaving the wards in the afternoon for clinic, try your best to have as many things prepared for your covering intern. This includes any discharge preparation that you can anticipate (depart write-up, medications, follow-ups, home care), any consults to call, etc.

* Give your co-intern a detailed sign-out and update on the plan from rounds, what you have done, what is left to follow-up and any pertinent information for the rest of the evening.
* Don’t be late to clinic even if there is a lot going on. If you’re on wards, let the attending and senior know before rounds that it is your clinic day so that they are aware you need to leave by noon. Budget time for your commute and a quick bite to eat. Everyone has clinic days, and it is expected you fulfill your requirements for clinic as well as the services you rotate on.

**Wednesday morning Crunch:**

All interns attend Grand Rounds (Wednesdays at 8am) and conference/lectures on Wednesday mornings (9a-1p) while seniors and medical students round and manage the ward until the interns return.

* *Due to COVID and social distancing guidelines, Grand Rounds have been virtual. You are expected to log on and log your attendance via the QR code provided prior to the start of the lecture.*
* You can arrive earlier than usual for sign-out and pre-rounding on Wednesdays if you feel crunched for time. Manage your time appropriately, especially since all of your notes should be done by about 7:50am before you head to Grand Rounds.
* DO NOT be late to Grand Rounds! If needed let your senior know what is keeping you.
* Update your medical student on the plan for the patient’s they are following so they can be prepared for rounds without you. They should act as an extension of your coaching/teaching and plan which will also help your senior manage rounds while you are gone.
* If there is lunch, remember to bring back an extra plate of lunch for your senior covering for you!

**Social Work/Care Management:**

You may not realize until this year how invaluable this team is on any service you rotate on.

* They can help you with things like calling CPS to address concerns for abuse/neglect, obtaining prior authorizations for medications, arranging for placement at a separate facility (physical rehab, substance use rehab, skilled nursing, etc), and arranging home health care services and equipment for your patients.
* Because most of the social workers are in high demand and work weekdays 9-5, it is imperative that any concerns that need to be addressed by social work be communicated to them as soon as reasonably possible, especially if it is a Friday. Anticipate needs and notify social work in the morning, otherwise you risk not being able to have those concerns addressed on a Friday afternoon and through the weekend.
* There are weekend social workers on call to help with pending discharge concerns, but they are usually not able to take time to address routine matters.
* Find their notes in the “Clinical Notes” or “Allied Services” tab in Powerchart.
* Follow up the social work/care management notes daily if you have consulted them to see what the situation is. Always check if there is a CPS hold on a patient before discharging them home.
* Don’t be afraid to pop in and out of the office during the day to check on the progress of the task at hand. Leave your number with the social workers and case managers in case they need to reach you for a quick question.
  + Where you can find them: 6th floor by the 300’s side of patient rooms on the way to the PICU
* *Bottom line: Consult social work early and keep tabs on the progress of your patient’s needs, otherwise SW issues may hold up discharge!*

**Electives:**

While elective time usually means more free time, don’t miss out on opportunities to learn from experts in their fields!

* No matter which elective you’re on, even if it wasn’t your top choice, there is always something to learn so show up on time and prepared to learn.
* Try to find ways to relate the subspecialty to your interests and let the attendings know. They know not everyone wants to be an endocrinologist or cardiologist, but they’re willing to gear your 2 weeks of teaching towards your chosen field.
* These subspecialists will be consultants you have to call while on the wards, heme/onc, PICU, ED, etc., so create relationships with them while you’re on their elective block, that way when you have to call them at 2am, the conversation may go a bit smoother (probably).
* Ask lots of questions!

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## **What to See and Do in Long Island**

**Dining:**

* Long Island is rapidly becoming well-known all around the country both for the cuisine it is presenting as well as producing (hey, Food Network’s Ina Garten, aka the Barefoot Contessa, makes her home in East Hampton)! The North Fork is well-known and well-renowned for its wineries and has too many to count (there are a few wineries on the South Fork but go figure, the climate and soil is just different enough that it makes growing almost all varieties of grapes impossible). In addition, the forks and even parts of central Long Island are dotted with amazing farm stands that produce and sell many fresh fruits and vegetables, as well as great flowers. You will become well-acquainted with Briermere farms during your tour around Long Island.
* Long Island restaurants are some of the finest around and some rival many experiences you will have in New York City. Many restaurants now are starting to offer some sort of prix fixe menus either all the time or on certain days of the week and are usually a great way to experience fantastic dining on the cheap or at least at a bargain. In addition, twice a year Long Island has its own “Restaurant Week” where numerous spots on the Island have set per-person menus and a great opportunity to experience local flare. Last year as a bonus the Smithtown Chamber of Commerce did their own restaurant week as well in addition to the 2 previous ones. Get a Zagat; you’ll be surprised at how many amazing restaurants are in Suffolk County alone.
* Don’t be afraid to wander into the Hamptons, especially in the summertime! Cowfish is one of the best restaurants out there and you can take a boat to their sister restaurant Rumba!

**Entertainment:**

* Long Island has plenty to offer in the way of entertainment be it from movies, concerts, plays, etc. It isn’t hard to find the local movie theatres, so we’ll skip those. (If interested, the nearest is on 347 & Hallock Rd.)
* The Long Island Philharmonic Orchestra is an excellent group that performs many times a year and often gives at least one free concert a year outdoors. Theater Three in Port Jefferson is a quaint, local playhouse that puts on 5 or 6 productions a year, in addition to small local productions that run in and out of the playhouse all the time. There is an outdoor amphitheater in Oakdale that presents numerous concerts all throughout the summer. However, by far the biggest concert day on Long Island is the day that the Jones Beach summer schedule is announced.
* The theatre at Jones Beach has roughly 25 different acts every summer and is an outdoor amphitheater right on the Atlantic Ocean. You should avoid seats in the very top section but otherwise there generally is not a bad seat in the house. It is usually a popular stopping spot for any big groups touring during the summer. If you search for the theatre online it is located in Wantagh, NY and is about 45minutes from Stony Brook.

**Exploration:**

* Do not forget to take time to EXPLORE! Every week toward the end of the week Newsday (LI’s newspaper) publishes things to do over the weekend on Long Island and usually comes out with weekly top-ten lists or best of lists to help navigate you throughout LI life. Look them up at [www.newsday.com](http://www.newsday.com) .
* Don’t forget that we have great downtown areas on Long Island too. The top three downtowns in Long Island are: Huntington (about 30 minutes from Stony Brook), Port Jefferson (about 10 minutes from Stony Brook) and Northport (about 45 minutes from Stony Brook). Patchogue also has a rapidly developing downtown with lots of great bars and restaurants. And within an hour’s drive are Bridgehampton, Southampton, and Easthampton (i.e. The Hamptons), a great area to shop, eat, and go searching for local celebrities!
* And remember, Stony Brook is about 1.5 hours by train from New York City! The closest Long Island Railroad (LIRR) station is Stony Brook or Port Jefferson (train runs ~every 1.5-2hours), Ronkonkoma (hourly trains), or Hicksville which is about a 40-minute drive from SB (q15minute trains). Parking is free at these stations and the LIRR will take you directly to Penn Station in Manhattan. Depending on the station, the fare ranges $10-18 one way. Be sure to buy your ticket at the machine or on the MTA app before you board the train otherwise it’ll cost a few dollars more once boarded. From Penn station, you can then connect to any NYC MTA subway via a Metrocard to go anywhere in the city.
* If you would like to get away for a weekend and head to the Northeast, there are two ferries to Connecticut that leave multiple times each day year-round. The first ferry is from Port Jefferson (5-10 min from SB) and ends in Bridgeport, CT. The other leaves from Orient Point on the very east end of the North Fork (~45min from SB) and connects to New London, CT. You can check out the website for ferry times and prices: <https://www.88844ferry.com/>

**Holidays Around Long Island:**

* The winter on Long Island has much to offer in the way of both traditional as well as modern celebrations. In Port Jefferson, one particular event for people regardless of religion/denomination/faith is the Dickens Festival in December. Main Street in PJ is transformed into a Dickensian village complete with horse rides and chimney sweeps roaming the street greeting people as they go into shops or sit down for meals at the restaurants. It is a lot of fun and always is hallmarked by Theatre Three’s production of A Christmas Carol. There are multiple tree lightings around the local towns as well as festivals and celebrations for all faiths and denominations.
* In the summer, Long Island holds its annual Strawberry Festival which is pretty much exactly how it sounds.
* The Long Island Balloon Festival is an annual show in August that spans 3 days of a weekend and has a carnival, shopping, lots and lots of food-cart eating, and of course, many, many hot air balloons that take off into the sky for dazzling displays. Do not miss the nighttime balloon glow where the balloons go up and all glow under their fiery canopies.
* Check out Sagamore Hill, the home of 26th US President Theodore “Teddy” Roosevelt. TR was the only President to make his permanent home on Long Island.
* Of course, not to be left out, are Long Island’s amusement park and waterpark. Splish Splash is located about 30 minutes from Stony Brook (exit 72, LIE) and is annually rated one of the ten best water parks in the US. Travel Channel recently named it #5 on its list. Go toward the end of summer and the lines are much shorter. Labor Day weekend is actually the last weekend the park is open and, weather permitting, is the ideal time to go. But it’s enjoyable any time of the year.
* Adventureland is in Farmingdale (about 30 minutes from Stony Brook). It is not exactly Six Flags but is a very fun place to go (and admission is free) to spend a cool evening. They have their own log flume, roller coaster, [lame] haunted house, bumper cars, etc. It is also the inspiration for the recent movie of the same name, since the writer of the movie worked at the amusement park when he was a teenager. If you go expecting a quaint, campy, fun amusement park you will not be disappointed.
* During the summer, almost every town has a fair, like Northport’s Cow Harbor Day, or Freeport’s Nautical Mile which has multiple events throughout the summer. Basically, search any town name and “festival 2023” and you’re bound to get something fun.

**Seasonal:**

* Memorial Day Weekend there is a great Air Show at Jones Beach that is free admission (you only have to pay to park). Each year the show is traditionally ended by the US Air Force Thunderbirds and they should not be missed if you feel the Need for Speed.
* Every Autumn the farms around the area get ready for the season with Pumpkin/Apple picking. Prices are very reasonable and some places only charge by the bag rather than the pound. So, you can stuff 30 apples in a bag and make apple pie for all your friends and third year residents who are on call.

**Shopping:**

* Everyone has their favorite places to shop, and of course Long Islanders are no exception. The two big players are the Smithaven Mall and Roosevelt Field. Smithaven is 10 minutes from the hospital and has a fair amount of clothing and electronics stores. Right next to the Smithaven Mall is a Barnes & Noble that welcomes many authors for frequent talks and signing, and a Dick’s Sporting Goods where you can by the Frisbee that you are going to take to the many State parks.
* Roosevelt Field is a huge mall about 45 minutes from Stony Brook. It has all the stores you would expect in a mall and then some including Armani-Exchange, Bose, Tourneau, the Franklin Mint, just to name a few.
* The other 2 shopping megaspots not be missed on Long Island are the two huge Tanger Outlets, one in Riverhead and the newer one in Deer Park, the “Arches” (accessible by train on the Ronkonkoma line). Both also have ample parking if you want to drive out there, about 45 minutes to either one from Stony Brook.

**Sports/Recreation:**

* Long Island is home to only one professional sports team and one minor league baseball team. New York City similarly is home to one professional baseball team, the New York Yankees, and one minor league team, the New York Mets 😉. Both ballparks are easily accessible by train, and both are accessible by car if you’re willing to pay a pretty penny for parking. On LI itself there are the Long Island Ducks who play in Central Islip at Citibank Park and are a great value at $8 a game. The New York Islanders are the aforementioned only LI pro team and play hockey at the Nassau Coliseum in Uniondale, about 45 minutes from Stony Brook. There are many local leagues anyone can join as well as intramurals on campus.
* The US Open Tennis Tournament is held every August/September in Flushing Meadows, 45-60 minutes from Stony Brook. For tennis fans, the qualifier matches are free and are typically a few days before the actual tournament.
* The US Open Golf Tournament has been held on Long Island 3 times in the last 10 years, once at Shinnecock Hills and twice at the Bethpage State Park Black Course.
* Don’t forget about Stony Brook Seawolves Athletics. The Men’s Basketball team has made it to the NCAA tournament the past two years and the Baseball team made the NCAA College World Series for the first time in June 2012.

**State Parks/Beaches:**

* Long Island is an absolutely beautiful place to be outdoors any time of year. Long Island is home to one National Seashore (Fire Island), numerous beaches (over 1000 miles all-told), and many, many parks. The State Parks on LI are beautiful and many even have events in the winter. Some are pet friendly and some have exquisite hiking trails and fishing and kayaking among other activities.
* [**Http://nysparks.state.ny.us/regions/long\_island.asp**](http://nysparks.state.ny.us/regions/long_island.asp) has a listing of all the parks in the region.
* Many of the beaches on the South Shore of Long Island are highly acclaimed and are incorporated into the State Park system meaning they generally are well taken care of and looked after. The closest beach to Stony Brook is West Meadow Beach which is 5 miles from the SB hospital and the larger, soft sandy beaches are Robert Moses Beach, Jones Beach, Hamptons, etc. (all are about 45 minutes to1-hour drive from the hospital).

## **Resident Recommendations**

**Restaurants:**

American:

* Tiger Lily Café (Vegetarian/Vegan) - 156 East Main Street, Port Jefferson
* SE-Port Deli- 301 Main St, East Setauket (cash only)
* Bliss

Brunch:

* Toast Coffeehouse – 650 Rte. 112, Port Jefferson Station
* Crazy Beans- 97 A Main St, Stony Brook
* Soul Brew – 566 N Country Rd, St James
* Maureen’s Kitchen- 108 Terry Rd, Smithtown
* Sweet Mama’s - 121 Main St, Stony Brook
* Nantucket’s - 9 Traders Cove, Port Jefferson
* That Meetball Place – 54 W. Main St., Patchogue
* Rhum (Caribbean) 13 E. Main St, Patchogue

Bars/Pubs/Happy Hour:

* Brewology295 – 201 Main St, Port Jefferson
* Barito – 201 Main St, Ste C, Port Jefferson
* Danford’s – 25 E Broadway, Port Jefferson
* The Bench Bar & Grill – 1095 Rt 25A, Stony Brook
* Harmony Vineyards (closest winery nearby)– 169 Harbor Rd, Head of the Harbor
* Fifth Season- 34 E. Broadway, Port Jefferson

Coffee/Tea:

* Robinson’s Tea Room – 97 Main St, Ste E, Stony Brook
* Local’s Café – 106 E Main St, Port Jefferson
* Roast Coffee & Tea Trading Company
* BAMBU (bubble tea!) - 2350 Nesconset Hwy, Stony Brook

Juice Bars & Smoothies/Ice Cream & Frozen Yogurt:

* Bango Bowls – 199 Main St, East Setauket
* SoBol – 412 North Country Rd, St James
* Ralph’s Famous Italian Ices – multiple locations including Port Jeff and Stony Brook
* Mad Over Yogurt – 2184 Nesconset Hwy, Ste A, Stony Brook
* Port Jefferson Ice Cream Café – 109 W Broadway, Port Jefferson

Italian:

* Ruvo Restaurant East - 105 Wynn Ln, Port Jefferson
* Pasta Pasta - 234 E Main St, Port Jefferson
* O Sole Mio- 2194 Nesconset Hwy, Stony Brook
* The Trattoria – 532 N Country Rd, St James

Asian/Sushi:

* Iron Poke- 2350 Nesconset Hwy, Ste 600, Stony Brook
* Slurp Ramen – 109 W Broadway, Port Jefferson
* Ssambap Korean BBQ- 2350 Nesconset Hwy, Stony Brook
* Splendid Noodle- 1320 Stony Brook Rd, Stony Brook
* Kotobuki- 377 Nesconset Hwy, Hauppauge, NY
* Ichi Sushi Ramen

Middle Eastern/ Greek:

* Pita House - 100 S Jersey Ave # 27, East Setauket
* Z Pita- 217 Main St, Port Jeff
* Istanbul Café- 2139 Middle Country Rd, Centereach
* Zorba Greek- Port Jefferson Station

Thai:

* Lemonleaf Grill - 208 Route 112, Port Jefferson Station
* Raan Thai- 203 Terry Rd, Smithtown
* Phayathai- 735 Hawkins Ave, Ronkonkoma

Indian:

* Curry Club - 111 W Broadway, Port Jefferson
* Hicksville, NY (~35min drive) has numerous places!

Mexican:

* Salsa Salsa – 142 Main Street, Port Jefferson
* Cabo Fresh Mexican Grill- 2182 Nesconset Hwy, Stony Brook
* Green Cactus Grill - 1099 Route 25A, Stony Brook
* Del Fuego- located in St. James or Patchogue

**NATURE**

* Avalon Nature and Preserve
* Blydenburgh State Park
* David Weld Sanctuary
* West Meadow Beach
* Sunken Meadow State Park

**SUPERMARKETS**

* Stop & Shop (multiple locations)
* King Kullen (multiple locations)
* Shop Rite (Patchogue & Selden)
* Wild by Nature (E. Setauket)
* Trader Joe’s (Lake Grove)
* Whole Foods (Lake Grove)
* Uncle Giuseppe's (Smithtown & Port Jeff Station)
* Target (S. Setauket, Medford, Central Islip, Commack)
* Walmart
* Costco
* Aldi (Lake Grove)

**BANKS**

* Island Federal Savings Bank (Branch in the HSC)
* Bank of America
* TD Bank
* Chase Bank
* Capital One
* Wells Fargo
* HSBC
* Citibank

**MECHANIC/AUTO**

* Bruno’s Garage, St James
* Penney’s North Country Car Care Center, St. James
* Port Jefferson Car Care (owned by George) - Port Jefferson Station
* Mike’s Mechanics, Port Jeff
* Setauket Auto Body, E. Setauket
* Firestone
* PepBoys

**GYMS**

* LA Fitness
* Planet Fitness
* World Gym
* Stony Brook Campus
* Numerous Crossfit gyms
* Retro Fitness
* Pure Barre
* Orange Theory Fitness
* Crunch Fitness

**MOVIE THEATERS**

* AMC Loews, Stony Brook on 347
* Cinema De Lux Island 16
* Port Jeff Cinemas
* Regal Cinemas Ronkonkoma 9

**PRIMARY CARE**

* SB Med-Peds – Dr. Tique or Dr. Feld\*\*
* SB Family Medicine - Dr. Lovedhi Aggarwal
* SB Internal Medicine- Dr. Susan Lane

**EYE DOCTOR**

* SB Tech Park
* Davis Vision (multiple locations)

**DENTIST**

* Dr. Schwartz, Shirley
* Cool Smiles
* Joseph LaCarribba
* Gentle Dental
* SB Dental
* Port Jefferson Dental Group
* Sweetwater Dental Care (Dental 365)

**OB/GYN**

* Dr. Pilliteri, Deer Park
* Dr. Lochner
* Three Village Women’s Health
* Stony Brook OB/GYN

**CELLPHONE PROVIDERS**

* Verizon
* AT&T
* T-Mobile
* \*Poor Sprint service in the area

**INTERNET/CABLE/PHONE**

* Optimum/Cablevision
* Time Warner
* Verizon

**SELF CARE**

* Symmetry Salon – Stony Brook
* Muses Nails- St James
* Off 7th Salon- Centereach
* LaVida Salon for massages and facials

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## **Important Websites**

* **Stony Brook Pediatric Curriculum Site:**
  + - <http://medicine.stonybrookmedicine.edu/pedrescurriculum>
      * Username: sbp
      * Password: sbpediatrics
    - Has links to the readings for each rotation
* **AAP Pedialink Prep Questions:**
  + - <https://www.pedialink.org/>
      * Required to do 20-30 per month
* **EMR Remote Access from home:**
  + - <https://apps.stonybrookmedicine.edu/logon/LogonPoint/tmindex.html>
* **SOLAR:**
  + - <http://www.sunysb.edu/it/solar.shtml>
* **HSC Library to access databases, journals, etc.:**
  + - <http://www.hsclib.sunysb.edu/>

## **Helpful Apps**

* **UpToDate**
* **Lexicomp**
* **Epocrates**
* **Medscape**
* **MDCalc:** helpful equations
* **CDC Vaccine Schedule**
* **NRP:** reviews neonatal resuscitation program
* **BiliCalc:** calculate phototherapy level
* **Cyracom:** translation
* **Microsoft Teams**

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## **Appendix: Frequently Called Phone Numbers**

**General:**

**Extensions starting with 4 = 631-444-####** **Extensions starting with 6 = 631-216-####**



**Dietary:**

4-8233

**NICU:**

4-2001, 4-2000

**Newborn Nursery:** 4-2110

**Poison Control:** 1-800-222-122

|  |  |
| --- | --- |
| **SB Pediatric Offices** | **Phone Number** |
| Appt Line | 631-444-KIDS (for peds) / 631-444-DOCS (for adults) |
| East Moriches | 631-638-2900 (FAX: 631-878-8084) |
| Islip | 631-581-9330 (FAX: 631-581-9561) |
| Patchogue | 631-444-6319, 631-444-6314 (FAX: 631-444-6327) |
| Smithtown | 631-979-7222 |
| Lake Grove | 631-444-9976 |

**Private PMDs with Admitting Privileges to Peds Acute:**

**Updated 8/2022**

|  |  |
| --- | --- |
| Ancona, Stern, Flynn-Gameng | Branch Pediatrics |
| Leonard, Schwartz | Kids Care Pediatrics |
| Sosulski, Chernobilsky | Smith Haven Pediatrics |
| Sanchez, David | Suffolk Pediatrics |

**Private PMDs with Admitting Privileges to NBN:**

**Updated 8/2022**

|  |  |
| --- | --- |
| Ancona, Stern, Flynn-Gameng | Branch Pediatrics |
| Leonard, Schwartz | Kids Care Pediatrics |
| Sosulski, Chernobilsky | Smith Haven Pediatrics |
| Sanchez, David | Suffolk Pediatrics |

|  |  |  |  |
| --- | --- | --- | --- |
| 0B**Stony Brook Pediatrics Elective Rotations and Contact Information** | | | |
| Contact the rotation director 1-2 weeks prior to the start of your elective unless otherwise specified in their specific instructions. | | | |
|  |  |  |  |
| **Rotation** | **Rotation Director** | **Email** | **Specific Instructions from Rotation Director** |
| Adolescent Medicine | Dr. Zachary Jacobs | zachary.jacobs@stonybrookmedicine.edu |  |
| Administrative Elective | Dr. Robyn Blair | robyn.blair@stonybrookmedicine.edu |  |
| Advocacy | Dr. Gillian Hopgood | gillian.hopgood@stonybrookmedicine.edu |  |
| Allergy/Immunology | Dr. Susan Schuval | susan.schuval@stonybrookmedicine.edu |  |
| Anesthesiology | Dr. Joy Schabel & Sharri Fassberger (coordinator) | sharri.fassberger@stonybrookmedicine.edu ; joy.schabel@stonybrookmedicine.edu |  |
| Backup/Academic Block | Dr. Stuart Holzer | stuart.holzer@stonybrookmedicine.edu | Email when your rotation starts |
| Breastfeeding | Dr. Monica Lee | monica.lee@stonybrookmedicine.edu |  |
| Cardiology | Dr. Kenneth Bayle | ken-michael.bayle@stonybrookmedicine.edu |  |
| Child Psych | Dr. Anjali Narayan | gita.narayan@stonybrookmedicine.edu |  |
| Community | Dr. Gillian Hopgood | gillian.hopgood@stonybrookmedicine.edu |  |
| Dermatology | Blair Bohnhorst (Derm Residency Program Coordinator) | blair.bohnhorst@stonybrookmedicine.edu | Email one month prior to your rotation |
| ED-elective | Dr. Carl Kaplan | carl.kaplan@stonybrookmedicine.edu |  |
| Endocrinology | Dr. Diana Kaplan | Diana.Kaplan@stonybrookmedicine.edu |  |
| Gastroenterology | Third year GI Fellow and Dr. Anupama Chawla | anupama.chawla@stonybrookmedicine.edu |  |
| Genetics | Dr. Patricia Galvin-Parton | patricia.galvin-parton@stonybrookmedicine.edu |  |
| Hematology/Oncology | Dr. Devina Prakash | devina.prakash@stonybrookmedicine.edu |  |
| Hospital Medicine | Dr. Taly Glaubach | taly.glaubach@stonybrookmedicine.edu |  |
| Infectious Diseases | Dr. Andrew Handel | andrew.handel@stonybrookmedicine.edu |  |
| Living with Chronic Diseases | Dr. Katharine Kevill | katharine.kevill@stonybrookmedicine.edu |  |
| Medical Education | Dr. Katherine Biagas | katherine.biagas@stonybrookmedicine.edu |  |
| Nephrology | Dr. Robert Woroniecki | robert.woroniecki@stonybrookmedicine.edu |  |
| Neurology | Dr. Bridget Leone | bridget.leone@stonybrookmedicine.edu | Contact the peds neuro fellow at the start of your rotation |
| NICU-elective | Dr. Shanthy Sridhar and Dr. Jennifer Pynn | shanthy.sridhar@stonybrookmedicine.edu ; jennifer.pynn@stonybrookmedicine.edu |  |
| Palliative Care | Dr. Grace Ker | grace.ker@stonybrookmedicine.edu |  |
| Patient Safety/Quality Improvement | Dr. Candice Foy and Dr. Randi Trope | candice.foy@stonybrookmedicine.edu ; randi.trope@stonybrookmedicine.edu |  |
| PICU-E | Dr. Ryan Hirschfeld | ryan.hirschfeld@stonybrookmedicine.edu |  |
| Point of Care Ultrasound | Dr. Carl Kaplan and Dr. Linda Solomon | carl.kaplan@stonybrookmedicine.edu |  |
| Pulmonology | Dr. Mathew Ednick | mathew.ednick@stonybrookmedicine.edu |  |
| Radiology | Dr. Johanna Monsalve | johanna.monsalvevillamizar@stonybrookmedicine.edu | Email the week prior to your rotation |
| Research | Dr. Rachel Boykan | rachel.boykan@stonybrookmedicine.edu |  |
| Rheumatology | Dr. Julie Cherian | julie.cherian@stonybrookmedicine.edu |  |
| Sports Medicine | Dr. Brian Cruickshank | brian.cruickshank@stonybrookmedicine.edu |  |
| Teaching Resident | Dr. Rachel Boykan | rachel.boykan@stonybrookmedicine.edu |  |
| Telehealth | Dr. Erin Hulfish | erin.hulfish@stonybrookmedicine.edu |  |
| Well-Being | Dr. Susan Walker and Dr. Josette Bianchi-Hayes | susan.walker@stonybrookmedicine.edu ; josette.bianchi-hayes@stonybrookmedicine.edu |  |

**Don’t forget to refer to this guide as you change rotations during the year!**

**questions? Please ask!**

**Congratulations & Best Wishes PGY-1’s!**