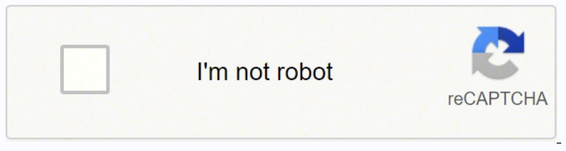

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13 Dictation Instructions ..... • Do NOT black-out or white-out words or areas. Maintenance Fluid and electrolyte requirements are directly related to metabolic rate Holliday-Segar Rule - calculation of maintenance fluid requirements using body weight for resting hospitalized patients (based on 100 cc for each 100 kcal expended): Body Weight Volume in 24 hours Up to 10 kg 100 cc/kg/d (1,000 cc for 10kg child/day) 11- 20 kg 1,000 + 50 cc/kg above 10 kg Above 20 kg 1,500 + 20 cc/kg above 20 kg Weight (kg) Hourly Fluid Requirements (Calculated by "4-2-1 rule") 0-10 kg 4 mL/kg/h 11-20 kg 40 mL/h + (2 mL/kg/h for each kg over 10 kg) >20 kg 60 mL/h + (1 mL/kg/h for each kg over 20 kg) Insensible water losses = cutaneous + pulmonary water losses which are calculated as ~ 300 – 500 cc/m2 During fluid management, we should assess factors affecting insensible and/or urinary fluid losses Normal Na+ and K+ requirements 2 – 4 mEq/kg/day During fluid management, we should assess factors that affect Na and K balance Adding 5% dextrose to maintenance solution prevents protein catabolism Most commonly used solution in children: D5 ½ NS + 20 mEq/L KCl or D5W/NS + 20 mEq/L KCl D5 ½ NS + 20 mEq/L KCl = 4 mEq/100cc/d Na+ and 2 mEq/100cc/d K+ D10W: use in Neonates and Hypoglycemia MacPEDS MBL 2011 51 52. - Only if no admission dictation completed, indicate full history of presenting illness (HPI), Past medical history, and initial physical examination prior to 'Course in Hospital' COURSE IN HOSPITAL: - Describe briefly the events and progression of illness while in hospital including status upon discharge - If the child has multiple medical issues, this section can be done by system (cardiovascular, respiratory, fluids and nutrition, ID, hematological, CNS, etc) - List complex investigations (with results) under a separate heading. • Do you feel you have enough friends? How is the patient coping with the active symtpoms, progression, better/worse. 2L?) Focused P/E of system involved plus CVS, RESP, ABDO, EXT/MSK common for hospitalized patients to develop problems in these systems Investigations (Ix): New lab results, imaging or diagnostic tests/interventions MEDS: reviewed daily for changes regarding those that are new/hold/discontinued/restarted Assessment & PlanImpression (A/P or Imp): Summarize what the new findings mean, what progress is being made Improved? UTI Day 2 of Empiric Abx, likely 14 day course required. - Cranial nerves: by observation in infants, formal testing in older children - Motor: strength, tone, deep tendon reflexes, coordination - Sensory: touch, temperature, position/vibration sense MacPEDS MBL 2011 38 39. What does your child do for fun? Hold 2. Clinic Note Enter Chart Number (#) – the ID # after the 'M' Enter Patient Type (#) 1. Deficit Replacement – Assessment Includes: Severity: Represents the percentage of body weight loss, acute weight loss reflects losses of fluid and electrolytes rather than lean body mass Most commonly estimated based on history and physical exam See table on next page To calculate fluid deficit: % x 10 x body weight (pre-illness) Type: A reflection of relative net losses of water and electrolytes based on serum Na+ or osmolality Important for pathophysiology, therapy and prognosis Affects water transport between ICC and ECC 70 – 80% pediatric dehydration is isotonic Type of Electrolyte Status Clinical Features Dehydration Hypotonic or Serum Na+ < 130 mEq/L, Exacerbated signs of Hyponatremic Serum Osm < 270 dehydration Risk of seizure Isotonic or Serum Na+=130-150 mEq/L, Isonatremic Serum Osm 270 – 300 Hypertonic or Serum Na+ > 150 mEq/L, Decreased signs of Hypernatremic Serum Osm >300 dehydration Irritable, increased tone and reflexes MacPEDS MBL 2011 52 53. • Surgical history Medications – including dose changes, compliance Allergies – list specific reaction ∗ Immunizations – ask specifically about Prevnar, Menjugate, Varivax PEDIATRIC HISTORY AND PHYSICAL EXAMINATION (Continued) Feeding History (if relevant): • Breast feeding: exclusively?, duration, frequency • Formula: brand, how is it prepared/diluted, # of feedings/day, quantity • Solids: when started, tolerated, any reactions • Vitamins (especially iron and Vit D): which ones, how often, dose • Present diet: cereals, fruit, vegs, eggs, meat, amt of cow's milk • Any difficulties with feeding? Prioritize 7. 46 Discharge Summary Template – Pediatrics ..... 49 Fluids & Electrolytes ..... 6 McMaster Pediatrics Daily Schedule ..... 7 Resources: Handbooks, PDA, Websites ..... MORE WEBSITES ... Dr. Ross Pennie's homepage - Peds Infectious Disease Home of the Antibiotic Safety Zone and a new Immunization schedule. 1800 Kcal, 2200 Kcal), Cardiac Diet, TPN etc. Monthly publication by AAP. Again write no comments as to what others did, will do, or said, etc. Inpatient 2. Deficit Replacement – Oral Rehydration Therapy (ORT): First-line treatment for Mild to Moderate dehydration Requires close monitoring and compliance of patient and parents Contains balanced amounts of sodium and glucose Basic treatment is replacing the deficit over 4 – 6 hours and replacing ongoing losses (eg. Multi-Disciplinary Rounds: Team 3 will occur on Thursdays. The L2N patients will be discussed from 1300-1400 in the Communication Room in NICU. Team 1 and 2 MDR will occur on Tuesdays. Team 1 will be from 1300-1330; Team 2 will be from 1330-1400. Updated November 2010 MacPEDS MBL 2011 12 13. Stable? State your name, designation; Attending MD name Press 8 to end dictation, and write down job # on face-sheet of chart MacPEDS MBL 2011 49 50. Orovec, 645-8573 664-9992 Natalie O'Toole, 524-7609 575-0611 Frank Roy, Madan 2023 x75639 Seigel, Sandi 3008 628-0054 Wahi, Gita 905-540-2662 523-7920 Wahi, Shobha 572-1464 523-7920 Sub- Pager Office Specialty Specialist Number NICU Dutta, S 2116 X 73689 Neonatology El Helou, S 2560 x73903 or Neonatology 73490-Menika Fusch, C 2045 x76763 or Neonatology 75721- Marrin, M 2705 x76648 or Neonatology 73490-Menika Murthy, P 2140 x76486 or Neonatology 73490-Menika Shah, 1502 x73490 Neonatology J Shivananda, 2403 x73489/73490 Neonatology S Thomas, S 2747 x76487 or Neonatology MacPEDS MBL 2011 19 20. Solution Glucose Na K Base Osmolality (mEq/L) (mEq/L) (mEq/L) (mEq/L) WHO 111 90 20 30 310 Rehydrate 140 75 20 30 310 Pedialyte 140 45 20 30 250 Pediatric 140 45 20 30 250 Electrolyte Infantlyte 70 50 25 30 200 Naturlyte 140 45 21 48 265 MacPEDS MBL 2011 55 56. MacPEDS MBL 2011 42 43. For session dates and times contact: Diane Larwood 34077 MacPEDS MBL 2011 27 28. • How does child compare with siblings? UTI with 2° dehydration) Diet: DAT (diet as tolerated) NPO (nothing per os/by mouth; if going for surgery or procedures) Sips Only, CF (Clear Fluids), FF (Full Fluids), Thickened Fluids (dysphagia), Advancing Diet (NPO to sips to clear fluids to full fluids to DAT), Diabetic Diet (indicate Calories eg. • Stability of support network: relationship stability, frequent moves, major events (death in family etc), financial problems, substance abuse in the home • School adjustment, behaviour problems, habits (nail-biting, thumbsucking etc), sleep changes MacPEDS MBL 2011 32 33. Enter Physician Author Dictation ID Number (0995) 4. • What does your family do for fun? How many other children? In a home vs. Why do you use X ? Note: no K+ in bolus! (ii) Subsequent Therapy o Goal: continue replacement of existing deficit, provide maintenance and electrolytes, replace ongoing losses o Solution: D5 ½ NS + 20 mEq/L KCL or D5NS + 20 mEq/L KCL in isotonic dehydration o Deficit Replacement Time: usually over 24 hours ½ deficit in first 8 hours, second ½ deficit over next 16 hours o Subtract boluses from deficit calculation o Source of Electrolyte Losses: 60% ECF and 40% ICF For every 100 cc water lost, electrolyte losses: o Na+: 8.4 mEq/L / 100cc o K+: 6.0 mEq/L / 100cc o Cl-: 6.0 mEq/L / 100cc (iii) Final Therapy o Return patient to normal status and to normal feeding MacPEDS MBL 2011 56 57. 51 Developmental Milestones ..... PEDIATRIC HISTORY AND PHYSICAL EXAMINATION (Continued) Hydration Status - Comment on mucous membranes, tears, skin turgor, sunken eyes, in addition to appropriateness of vital signs, etc - For classification of mild, moderate, severe dehydration – see "Fluids & Electrolytes" HEENT: - Head: dysmorphic features, shape of skull, head circumference, fontanels in infants - Eyes: strabismus, pupillary response, fundoscopy, red reflex in infants, conjunctivitis - Ears & pharynx exam in any child with a fever! - Nose: turbinates, deviation of septum, presence of polyps? PROGRESS NOTE: PEDIATRICS General Pediatrics Ward (3B/3C) – Clinical Clerk Progress Note Date ∗ Always note the Date, Time, Your Name and Pager Number ∗ Time ID: age, sex with a history of (non-active/chronic issues/previously well) admitted with (list active/acute issues for why patient is admitted) eg. RESOURCES Handbooks/Pocketbooks: • Hospital for Sick Children Handbook (11th ed, 2010). 142 Diabetic Ketoacidosis Guidelines ..... Up-to-date An evidence-based summary of common topics in adult medicine and pediatrics. Motherisk Program A comprehensive program for evidence-based online information about the safety or risk of drugs, chemicals and disease during pregnancy and lactation based at Hospital for Sick Children. What has changed since the previous note. - Chest wall deformities: kyphosis, scoliosis, pectus excavatum/carinatum - Finger clubbing MacPEDS MBL 2011 37 38. PRESS 1. • Any change in sleep pattern? Division of General Pediatrics CTU 1, CTU 2, CTU 3 Weekly Schedule Handover: Handover is to take place from 0715-0745 hrs. It is therefore important to complete a succinct handover within the allotted 30 minutes. The senior residents should touch base with the charge nurses from 3B/3C/L2N to review potential discharges. CTU Huddle/Discharge Rounds: CTU Huddle will take place each morning from 09:15 – 09:30 am Monday to Friday in the 3C conference Room. The two ward Attendings, the Senior Residents and Nurse Managers will attend and discuss potential discharges and bed management. Patients that can go home will be identified at this time and discharges for these patients should occur promptly. Discharge planning should always be occurring and patients that could potentially go home should be discussed by the team the night before. This would then be the time to ensure that if those patients are ready that the patients are discharged. The Team 3 Attending will huddle with the NICU at 9:50 to discuss potential discharges and transfers in the Communication Room in NICU. See Patients: During this time the team will see their assigned patients. The chart and nursing notes should be reviewed to identify any issues that have arisen over night. The patient should be seen and examined. All lab work and radiological procedures that are pending should be reviewed. The house staff should then come up with a plan for the day and be ready to present that patient during ward rounds. It is not necessary that full notes be written at this time, as there will be time allotted for that later in the day. Ward Rounds: During ward rounds the attending paediatrician, with/without Senior Resident, and house staff will round on patients for their team. These are work rounds. All efforts should be made to go bedside to bedside to ensure that all patients are rounded on. Some spontaneous teaching during rounds MacPEDS MBL 2011 8 9. 11-20 40 + (2/kg/hr) Consider ISOTONIC IVF for the following patients: >20 60 + (1/kg/hr) • CNS disorder, Diabetic ketoacidosis IV solution Na (mEq/L) K (mEq/L) Cl (mEq/L) % Electrolyte • Patients at risk of hyponatremia: acute infection, post-operative patients Free Water and burns, Plasma Na < 138 (EFW)* Add K+ to provide 1-2 mEq/kg/day, if patient has urine output H 0.2% NaCl in 34 0 34 78 Add Dextrose to prevent hypoglycemia/ketosis (exceptions: hyperglycemia,brain injury) y D5W p o 0.45% NaCl 77 0 77 50 t in D5W Consider HYPOTONIC IVF for the following patients: o n Lactated 130 4 109 16 • Patients with an EFW deficit - e.g. hypernatremia, ongoing EFW losses i Ringers (renal, GI, skin) c • Patients with established 3rd space overload - e.g CHF, nephrotic 0.9% NaCl in 154 0 154 0 syndrome, oliguric renal failure, liver failure D5W (ISOTONIC) • Limited renal solute handling indicated - e.g. neonatal population, *Based on a sodium plus potassium concentration in the aqueous phase of plasma of 154mEq/L, assuming that hypertension plasma is 93% water with a plasma sodium of 140 mEq/L and a potassium concentration of 4 mEq/L Step 3: MONITORING while on IV fluid Measure and record as accurately as possible Clinical status: hydration status,urine Fluid balance: must be assessed at least every Labs: output, ongoing losses, pain, vomiting, 12 hours Serum Electrolytes - at least daily if primary source peripheral edema, and general well-being. Waiting investigations/consult? 17 Pediatrics Staff Dictation Codes and Pagers ..... Accommodation Services On-Call Rooms: • Key: sign out from Front Desk/ Switchboard, must be returned by 11:00 AM the next day • Location: 2nd floor, Resident call room # 213 follow Gold Signs to Father O'Sullivan Research Centre • Additional Key: unlock Washrooms + Showers or Code 2 4 3 • Residents' Lounge (Microwave & TV): Code 2 4 3 across from vending machines on 2nd floor before call rooms • Problems: communicate to Switchboard or Mike Heenan x2218 Cafeteria Hours: Charlton Cafeteria MON – FRI: 7:30 AM – 6:30 PM 2nd Floor, Mary Grace Wing SAT – SUN: Closed Garden Café @ CMHS MON – FRI: 9:30 AM – 10:30 PM & 11:30 AM – 1:30 PM Charlton Second Cup Daily: 7:00 AM – 10:00 PM Information Services Clinical Brower Passwords & Training: • Passwords obtained from: Computer Room 5th Floor of Mary Grace Wing G507 x32218 for Passwords • Must accept password and confidentiality agreements by signature • For additional information on Clinical Browser or training call: Shauna Stricker x35286 PACS Passwords & Training: • PACS passwords same as Clinical Browser, except all UPPERCASE • You may change your password once you have logged on • PACS training is only offered at the Monthly Medical Learner Orientation Sessions. • Relevant family history (3 generations) – autoimmune hx in Type I DM, atopic hx in asthma etc • Draw pedigree if possible for genetic assessment Review of Systems: General: feeding, sleeping, growing, energy level Signs of illness in kids: activity, appetite, attitude (3 A's) HEENT: infections (how often, fever, duration): otitis, nasal discharge, colds, sore throats, coughs, nosebleeds, swollen glands, coughing or choking with feeding Cardio: Infants: fatigue/sweating during feedings, cyanosis, apneas/bradycardic episodes Older kids: syncope, murmurs, palpitations, exercise intolerance Resp: cough, wheezing, croup, snoring, respiratory infections GI: appetite, weight gain (growth chart), nausea/vomiting, bowel habits, abdominal pains MacPEDS MBL 2011 33 34. For this section just remember all the things you can culture: CSF, Sputum, Urine, Feces, Pus from wounds, Blood Imaging: CXR, CT, MRI, EKG, PFT, Spirometry Consults: Social Work, Neurology, Infectious Diseases Drugs All medications patient is already on (Past), medications the patient needs right now (Present), anticipate what the patient might need: prophylaxis, sleep, nausea and pain (Future) 10 Patient P's: Problems (specific medical issues), Pain (analgesia), Pus (antimicrobials), Puke (anti-emetics, prokinetics, antacids), Pee (IV fluids, diuretics, electrolytes), Poop (bowel routine), Pillow (sedation), PE (anticoagulation), Psych (DTs), Previous Meds Ensure you date and time your orders, put the child's weight and list any allergies on the order sheet. Found in Check-In # field (usually beside Patient's Name) on any PACS Workstation • If you are unable to find Check-In # field on the Workstation, then call Diagnostic Imaging staff for assistance: x33606 or x36009 Instructions 1. Outpatient 3. 28 PEDIATRIC INFORMATION History & Physical Examination Outline ..... 2. You cannot testify to the truth of the event if no personal knowledge. Disconnect 6. • What do you like/dislike about X? 72 Neonatal Nutrition Guidelines Enteral .....73 TPN ..... It may also be helpful for clinical clerks during their time on the pediatric wards, as well as for pediatric residents and elective students. - Developmental status ("pulling up to stand in crib", "running around room") - Dysmorphic features – look specifically at face, ears, hands, feet, genetalia Vital Signs: - Include Temperature, Heart Rate, Respiratory Rate, Blood Pressure and O2 saturation NORMAL PEDIATRIC VITAL SIGNS Age HR SBP RR Newborn (

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