

THRIVE

**How to ~~Survive~~
during my
Residency in Peds!**

What R1 taught us about fluid order sheets, kangaroo care, Ventolin prn, VSign and Taco Tuesdays...

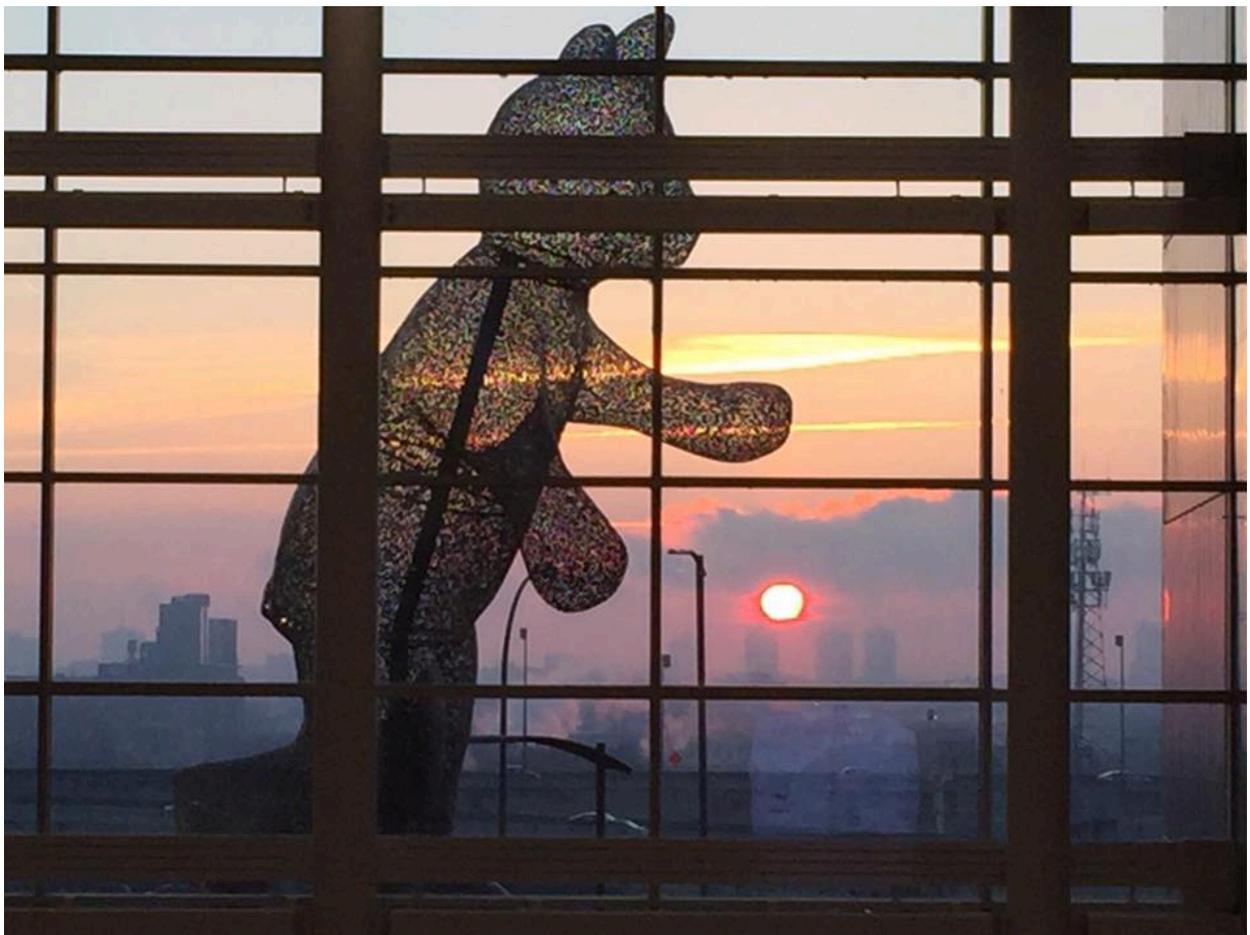
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Wards



Wards: where you go from knowing nothing to doing everything!

Welcome to your new home! You will spend 3 months in your first year on wards and 1 month on nightfloat.

As an R1 on the wards, you will gradually gain more responsibility as you transition from being a junior to senior resident. The wards are more than just managing patients and their diagnoses; it's a place where you get to learn how to present cases, how to supervise medical students, review admissions and eventually manage a whole ward team. There is a lot of learning opportunities and awesome times on the wards, but it can at times be very daunting.

This section is designed to help you remember what's important and how to not wind up in a bed like your patients...

For your first block, remember that your job as a junior resident is not to take care of the whole team and list. This is where you learn how to manage your patient's individual problems. Keep track of their comorbidities, their medications, and their day to day wellbeing. Use this ward block to orient yourself: learn where to find forms, how to call different consultants, how to schedule tests and how to manage discharge planning. Get used to the flow and learn from your senior about how to prioritize the daily tasks and how best to manage your team and all you need to get done. It will be a busy rotation but try your best to read around your cases.

For the second block, take on less patients. The patients you will take on will be more complex and that will give you the ability to handle patients with multiple medical issues involving more than one organ system. However, take on more responsibility in the managerial role as well, by helping medical students, talking to consultants about patients that are not necessarily yours, and helping to manage acute situations and participating in the discharge or management meetings of the patients on your team. This is an exciting time of added responsibility!

For the third block, you'll find that you may not have any patients, or only 1-2 complex ones. Your role is to be the senior's right hand. Talk to your senior about defining your role, but try to take the team phone and deal with issues and admissions that come. This can be a gradual process over the 4 weeks so don't

worry if on week 1 you are not too sure how to get started; your seniors will help guide you through this. Your role will also include reviewing admissions with the medical students, taking the lead in morning rounds, and overall managing the flow of your floor. Make sure you still review everything with your senior and that you recognize your limitations. You are still learning...it's all a work in progress so be kind to yourself!

Sometimes at the Glen, it may happen that there will be two teams instead of three. If this is the case, expect that you might be two juniors on the same team. If this happens during your third block, try to work it out with the other junior and take turns being senior.

For nightfloat, you will be doing two 2-week rotations for a total of 1 month of nightfloat in R1. For this block you will be buddied up with another R1 (typically family medicine) and a senior R2 peds resident. You and the other junior resident will alternate doing admissions overnight. Aside from this however, take initiative and leave your phone number or pager at the nursing station of one of the wards and ask to be called if anything comes up. You'll learn to deal with overnight issues this way. If you feel comfortable, ask your senior if you can be the manager of one of the teams. Keep your senior up to date with what is going on, but try and manage these patients on your own and give report for that list in morning signout.

For your second nightfloat, you can transition to taking calls from the ER about admissions, reviewing admissions with medical students, and addressing any problems that are on the wards. It's a good time to practice because you have a senior resident in house to guide your clinical decision making and who can help you practice a more senior role for when you're in charge the following year.

Tricks of the trade:

1. Expect the unexpected! A day on the wards can go from calm to chaos quickly. As much as possible, try to plan your day and prioritize tasks (eg. call consultants as early as you can, arrange an MRI the day before if possible).
2. Leave at a reasonable time when you can. The wards can be a very heavy rotation and you may not feel tired at first but by the third week you will be exhausted.

3. Try to keep rounds efficient by driving your team forward. A day on the wards with endless rounds will make it very difficult to get work done in a reasonable amount of time.
4. Group calls to similar consultants for your team to limit your time chasing after them... it will make things easier for your team, and the consultants will appreciate not getting paged countless times.
5. Take advantage of consultants when they are around- they can teach you so many interesting things.
6. Arrange imaging and call other services (eg. GI, ID, Respiriology) before working on progress notes. Notes can wait until after; what's more important is to get the job done. Work on prioritizing - this is a valuable skill to have!
7. Try to get discharges out in the morning before noon to help get work done on the wards.
8. Prepare your discharge material in advance- it will save you time at the end of the day.
9. Remember that if you want something to get done, you can do it yourself but remember that the ward is a team and some people can get things done much faster than any of us can (ie. the ward clerks are dynamite)!
10. It's OK to step away from rounds - if you need to call a consultant, put in bloodwork or imaging requisitions, or address an issue on the wards, go do it.
11. Learn to delegate.
12. Get as much experience dealing with acute issues as you can.
13. Eat during the day, drink fluids and take time to go to the bathroom. It's very easy to forget these simple things but it will make you much more efficient and productive.
14. Take the time to get to know the nurses. We have an amazing team of nurses on the ward, and the sooner you get to know them, the easier and more fun your shifts will be!
15. Be open with your senior resident. Try and meet with them early in the rotation and go over both expectations and goals for each ward block. If you feel like you can take on more responsibility, don't be afraid to let them know. On the other hand, if you're feeling overwhelmed or that you can't manage something on your own, be open and tell them. There's no shame in asking for help. Always remember that at the end of the day you both are a team.

NICU



NICU can be one of the most overwhelming (AND REWARDING) rotations. We don't mean to scare you with this, rather to provide you with tips that hopefully can make your first NICU rotation smooth 😊

1. First and foremost: YOU ARE NOT ALONE!

Easily said, but is even more easily forgotten. Remember, there is always someone there ready to help you out or answer your questions. Residents, NNPs (who are amazing and know TONS), staff, nurses, RTs... Do not hesitate to look out for help or call!

2. Ask questions and get exposed!

Don't worry if you feel lost or do not understand. It is TOTALLY OK NOT to know things... There are, however, many opportunities to learn. NNPs, staff, senior residents, RTs, nurses are all great teachers. During orientation on your first day, you will have many lectures on basics in the NICU, ask your questions! Run to deliveries, volunteer to assist with the insertion of umbilical lines, and ask many questions! Please don't be shy!

- Pharmacists: great resource in regards to fluid sheets and drips
- RT's: great resource on ventilation and how to approach management
- Nutritionists: great resource on basic fluid and nutrition needs of newborns at different gestational ages, breastfeeding resource and also the milk sheet
- NNP's: surgical procedures and case management
- Senior residents and Staff: ANYTHING (or perhaps tailored...)

3. Know your schedule and try to organize your day accordingly.

You will see, not only is NICU busy but our own schedules are too! Protected teaching time, RCC, mock codes, lectures... you will feel like there's always something interrupting your day. It is fine! Just keep it in mind and prioritize your tasks, in order to avoid wasting your valuable time. Your day typically starts at 7:30 in the conference room for handover. You pre-round from 8-9:00 and at around 9:00 you start rounding with the rest of the team. You will learn how to present your patients after hearing the nurse's handover and make a plan for the day. Rounds usually end around 11-12:00. The rest of the day is for seeing your patients and writing notes. There are three separate teams that alternate every day: transport, resuscitation and consult team during the day and you may be part of one of them.

4. Try to do as much as possible during rounds.

NICU is not only a service where you will learn about Neonatology... but where you will learn about time management and organization!

Babies are born and being transferred AT ANY TIME! So you never know when you will be interrupted, called or have to run to the birthing center. So try to optimize your time as much as you can: Fluid sheets, milk sheets, orders, notes, can often be either started, updated or even done during rounds (and you will have nurses, pharmacists and nutritionist there with you in case you need their help).

However, do not get obsessed: Sometimes it is not possible. But as much as you can, try to get paperwork done while rounding so you can forget about it afterwards!

5. Useful resources & where to get your information from.

- The NRP course and textbook are very useful tools in preparing for your NICU rotation; they are a great place to start as you start to build knowledge in not only neonatal resuscitation, but also in the management of acute clinical situations amongst your patients.
- You will also be provided with the NICU USB key with many interesting protocols and guidelines! You don't need to learn them by heart, but carry it with you so you have easy access to useful information.
- Nurses in the NICU are great resources and they really know their patients well. At the beginning of a night on nightfloat it's a great idea to do quick rounds on all your patients and introduce yourself to all the nurses. Check in to see if they have any pressing concerns, to review the plan for the night, review the planned blood work for the morning etc.
- Get familiar with flowsheets and charts so you won't waste time looking for the information you need during your pre-rounds!
- Ventilation can be a challenging topic to grasp as an R1. Respiratory therapists are a wonderful resource, on rounds, during the day, and during nightfloat. They have a lot of expertise on the matter and it can be a wonderful learning experience to ask them their opinion on everything from respiratory settings, blood gases, and respiratory status assessment of your patients.

6. Centricity is a software used to document our assessments when we attend a birth at the birthing unit. A centricity summary should be done on each birth that you get called to, regardless of whether the baby is admitted or not. This summary should be a quick timeline of the steps taken in the initial steps or resuscitation of the baby. Details that are important to include are:
- Reason you were called to the birth
 - Pertinent details concerning the baby and mother (term baby, SVD vs. C-section, GBS positive but antibiotics covered etc.)
 - Whether the baby was vigorous or not
 - Crying or not at birth
 - Respiratory effort at birth
 - Coloring of the baby
 - Heart rate - did it always remain above 100?
 - Oxygen saturation - did it follow the trend expected for minutes of life?
 - Any interventions - which ones and for how long (CPAP, PPV, oxygen)
 - State of baby when admitted/returned to mom
 - Follow-up plan, if any (ex. CBC on a baby whose mother had a fever during birth)

Example:

NICU called to term SVD with meconium, mother GBS negative. Baby was born vigorous and crying. Pink color. Baby was dried, stimulated and suctioned. Baby's heart rate stayed above 100 and saturation >95%. Baby was moving all 4 limbs equally and had good suck. Normal female genitalia. Exam otherwise unremarkable. Baby was then bundled and returned to mother for skin to skin. No need for further follow up.

7. Make sure when it's the best time to examine your patients with their nurses
Babies and nurses will appreciate that you respect their own schedules!
8. Despite your busy schedule, spend some time with babies and their families.
This is probably the most rewarding time of the day ☺ And promote Kangaroo care!

9. And once again, remember: You are not alone.

Feeling overwhelmed and lost at the NICU is something we have all went through. Talking about it and sharing your feelings does not make you any less or any weaker. On the contrary, it will help you out releasing any anxiety you might be experiencing, seeing things differently, finding answers and getting some perspective!

Things get better with time and you will realize how much you learn with experience.

PICU



Quick reminders at a glance:

- Recognize your own limits, don't hesitate to ask for help
 - PICU fellow - 25652
 - Respiratory therapist
 - Nurse in charge
- Daily progress notes are written on VSign
- Start transfer notes early and keep them updated (your nightfloats will be forever grateful and this will make things much easier & safer for patients when urgent transfers need to be arranged)
- Review your PALS algorithms & carry your PALS card
- Familiarize yourself with the basics of mechanical ventilation:
 - Mechanical Ventilation Module - <http://openpediatrics.org/>
- Familiarize yourself with the conditions commonly encountered in the PICU (list below)
- Take a look at our inotropic & sedative agents quick guide below

The Unit

Welcome to the Montreal Children's Hospital Pediatric Intensive Care Unit (PICU). It is an 18 bed unit (12 PICU beds & 6 ACU beds (step-down unit)). You will be providing care to acutely-ill children with a variety of medical and surgical issues. McGill pediatrics residents are among the rare pediatrics residents in Canada who will have exposure to the PICU in the first year. It is one of the most enriching learning experiences for residents and you should definitely take this opportunity to ask as many questions as possible and learn as much as possible with a special emphasis on the pathophysiological aspect of pediatric pathologies and their treatments. You will learn to become more comfortable dealing with sick patients, anticipating problems and recognizing and dealing with a deteriorating patient early. These skills will be of primordial importance for many of the other rotations you will be going through during your 3 to 4 years of pediatric residency.

The PICU can seem like an overwhelming environment at first. Don't worry, everyone feels this way. We will try in this short document to share with you some of the knowledge we acquired while rotating through the PICU as R1s as well as tips/advice we have collected from our fellow R1s as to how you can make this rotation more pleasurable and manageable.

Residents are primarily responsible for caring for the children that they are assigned to (anywhere between 3 to 8 patients, occasionally more when it comes to weekend & night coverage). You are integral members of the team, and are first in line in diagnosis and implementation of care for your patients, with the obvious ongoing support, guidance and assistance of PICU fellows (in-house coverage at all times) and PICU attendings.

There will be two fellows during the day (medical fellow and cardiac fellow) and a single fellow overnight. Staff physicians are on call for 24hrs but will not usually be in-house overnight. In addition, a nurse practitioner will usually actively participate in the care of patients (they are extremely knowledgeable and experienced, don't hesitate to ask for their help when you need). A charge nurse is assigned to coordinate the daily function of the unit and the Nurse Manager oversees the unit (bed management). The PICU also has a designated social worker, pharmacist, dietician, physiotherapist, and occupational therapist. Finally, in doubt, ask and trust your nurses! They know their patients, are extremely knowledgeable and have excellent clinical judgement.

Typical Day

The typical day in the PICU starts with sign out. Morning sign out is at 8:00 on week-days and 8:30 on week-ends.

It's a good idea to have a look at your patient's most recent lab work in order to be more efficient during rounds. X-rays will be reviewed during sign out with the respiratory therapist (RT).

Then, bedside rounds take place with the entire team including residents, fellows, staff, RTs, nurses, nurse in charge, and pharmacist. You'll be expected to give a one liner about your patient to the team. Then, the nurse goes through a system-based review of the patient's status/problems. You should then try to come up with a plan for your patient and suggest it to the team. It forces you to think through things and commit yourself to decision-making and is the best way to learn. Nobody will fault you for coming up with a plan they don't agree with. See it as an opportunity to develop your autonomy and to have an educational exchange/conversation with colleagues.

Consultants should be called early (don't be afraid to get the ball rolling by calling specialists even during rounds on the spectralink). Do a full exam on all your

patients. You will want to have a baseline exam to be able to better recognize any change in your patient's status should you be called to the bedside by a nurse to reassess a patient. Daily progress notes are done on V-sign, you can either type-in your exam & impression/plan or fill them in by hand at the bedside. Writing a problem based impression and plan by hand is often a good idea because it is much faster and will allow specialists consulting the chart to more easily appreciate the team's thought process and plan then trying to decipher the whole VSign summary.

If you are not late, you should sign out your patients to the late resident around 5 PM. If you are the late resident, you will stay until 8 PM and sign out to the night resident.

The weekend days are a little different only because the team is smaller and you have a larger patient load. Try to get your notes done early, as you will likely also have to do consults/admissions during the day.

Typical Night

The typical night in the PICU varies a little bit according to the fellow you are on call with. You arrive at 8 pm and get a sign out from the late resident and/or the fellow.

After dealing with any acute issues (admissions, acutely ill patients & post op cardiac patients), a good way to start the night is to round on all the patients and introduce yourself to the nurses, ask for a baseline status and get a baseline exam of the patient to recognize any active issues. This can be done with or without the fellow depending on their style. Follow-up with any pending things that were signed out to you by the late resident and then find your fellow and discuss your impressions & plans for active patients. It is the night resident's responsibility to put in X-ray requisitions in Oacis before midnight for the following morning and to work on transfer summaries/orders for possible next day discharges. You will round more formally with the fellow and nurse in charge around midnight to make sure the plan is clear for the night and the fellow will then often head to bed if things are quiet and controlled. They remain in-house and on the unit and will be happy for you to call if you have any concerns or questions.

Tips and Tricks:

- Never hesitate to ask for help from the fellow overnight. They want to know everything relevant! Always better to err on the safe side and ask.
- Don't take it personally if nurses call the fellow directly if they are worried, their main concern is the patient's safety and if they are acutely concerned they will bypass the middleman to get the quickest response possible.
- Do introduce yourself to nurses though so they know who you are and feel that you are more actively involved. They will then feel more comfortable coming to you for help.
- Do try to make a plan with the fellow before they go rest on how they want you to follow up on active issues or with specific lab tests (i.e. when do they want to be called).
- Make sure you have snacks and water to keep yourself going! It will often be difficult for you to leave the unit to get food or drinks.
- Make sure you sleep during the day. Some nights get busy! However, if things are quiet and you are done with your whatever you had to do, don't be afraid to catch a few hours of sleep.
- When doing the discharge/transfer notes, try to see it as a learning opportunity and read around the cases. For example, what was the working diagnosis, why did they do certain investigations or start/stop antibiotics or other therapies, etc. It will also make for a better transfer note and your ward buddies will be grateful!
- Make sure to ask for a good sign out. Fellows know all the patients on the back of their hand but the PICU daily notes are not always detailed. Don't waste too much trying to read through all those VSign notes...
- It may be OCD, but if you can combine the PICU/ACU lists on Oaxis and try to keep up with new results (labs & imaging) by removing all bolded/red items. Makes it easier to see new results (especially abnormal results) when they come out.

PICU Admissions

PICU admissions can come from the ER or from the wards. All PICU admissions/consults should go through the fellow. If you get called directly by mistake, make sure you let the fellow know what was signed out to you and what they want you to do about it (often you'll end up seeing the consult/admission first

without the fellow, unless acutely ill or new ER patient). The admissions notes are typed on a new system template (shortcut found on the desktop) and are always system based. You only get the relevant past medical & family history but don't need to dive into it as extensively as for admissions to the wards. PICU admissions are better when more targeted and concise, you want to focus on the acute issues. Of note, nurses & RTs often like to know the patient's weight early on to prepare the admission and crash sheet, certain medications, and start setting up the ventilator! Often, if a patient is sick enough to warrant a PICU admission, you should stay by their side until they make their way to the unit.

Common PICU Pathologies you should familiarize yourself with:

- Coagulopathy (DIC)
- Diabetic Ketoacidosis
- Electrolyte disturbances
- Intoxications
- Meningitis/Encephalitis
- Respiratory failure
 - Acute Respiratory Distress Syndrome
 - Bronchiolitis
 - Status Asthmaticus
 - Pneumonia
- Shock
 - Cardiogenic Shock (Arrhythmias, Myocarditis, CHD, Cardiomyopathy)
 - Distributive Shock (Sepsis, Anaphylaxis, Neurogenic)
 - Hypovolemic Shock (Hemorrhage/Trauma, Fluid loss/Dehydration)
 - Obstructive Shock (Pneumothorax, Tamponade, PE, LVOT obstructive lesions)
- Pneumothorax
- Pericardial tamponade
- Status Epilepticus
- Traumatic Brain Injury/Increased Intracranial Pressure

Quick Guide to Inotropes

Agent	Dosage	Mechanism of Action	Effect (s)
Dobutamine	2-20 μg/kg/min	β1-agonist (predominantly) β2-agonist α-antagonist	↑cardiac contractility & ↑HR ↑HR & ↓SVR ↓SVR
Dopamine	2-20 μg/kg/min	β1-agonist (5- 15μg/kg/min) β2-agonist (5- 15μg/kg/min) α-agonist (>15μg/kg/min)	↑cardiac contractility & ↑HR ↑HR & ↓SVR ↑SVR
Epinephrine	0.1-1 μg/kg/min	Dose-dependent α- agonist β1-agonist β2-agonist (low dose)	↑Heart Rate ↑cardiac contractility & ↑HR ↑HR & ↓SVR
Norepinephrine	0.1-2 μg/kg/min	α-agonist β1-agonist	↑SVR ↑cardiac contractility (↑HR blunted by ↑SVR)
Milrinone	0.25-0.75 μg/kg/min	PDE3 inhibitor	↑cardiac contractility, ↓SVR, improved diastolic function, little effect on HR

Quick Guide to Sedatives

Agent	Dosage (Bolus)	Dosage (Infusion)	Comments
Opioids			Analgesia, sedation, amnesia Respiratory depression Histamine release (pruritus, vasodilation) N/V, constipation, urinary retention
Morphine	PO: 0.15- 0.30mg/kg IV: 0.05- 0.1mg/kg	IV: 10- 50μg/kg/min	
Fentanyl	IV: 1-2μg/kg	IV: 1- 5μg/kg/hour	100x more potent than morphine More rapid onset & shorter duration. Rapid infusion → chest wall rigidity.

Benzodiazepines			Sedation, anxiolytic, amnesia, anticonvulsant Respiratory depression
Midazolam	IV: 0.05- 0.2mg/kg	IV: 0.5-5 μ g /kg/min	
Diazepam	PO generally 3- 4x IV IV: 0.05- 0.2mg/kg		1mg Midaz IV \rightarrow 2.5mg Diazepam PO
Other			
Ketamine	IV: 0.5-2mg/kg	IV 5-20 μ g /kg/min	PCP derivative (primarily NMDA antagonist) Generally maintains BP Bronchodilation but increases secretions
Dexmedetomidine		IV: 0.2-0.7 μ g /kg/h	Steroid-sparing agent Short acting α 2-agonist Vasodilation (\downarrow BP) & \downarrow HR
Clonidine	PO: 0.5- 4mcg/kg q8h		PO equivalent of Dexmedetomidine Helpful adjunct in Tx withdrawal

The Postop Cardiac Patient

You will not be expected to care for children in the immediate post-operative care following cardiac surgery. However, it is a good idea to be at least somewhat involved in a few of these cases during your rotation. There is a lot to learn about postop cardiac pathophysiology and it is very useful to gain confidence and comfort in dealing with these sick patients. There is a PICU fellow assigned to cardiac patients during the day, ask them how you can help out and pull out as much teaching from them as you can.

Below is a simple, general approach for the assessment of the postop cardiac patient:

1. Things you should know:
 - a. *The heart disease diagnosis* - This is necessary to understand the hemodynamic alterations presented before surgery, whether it is a cyanotic or acyanotic heart disease, if there is pulmonary overflow and if the heart disease is simple or complex

- b. *The procedure performed* - This will help you understand what hemodynamic alterations have occurred and which monitoring parameters are expected postop
- c. *Anesthesia* - Ventilation details (intubation or ventilation difficulties), types of anesthetics used (pharmacology may affect myocardial function postop), vasoactive drugs used, blood products
- d. *Intraoperative events* - Arrhythmias, need for shock/CPR, hypoxemia, surgical complications, injury to myo/pericardium/pleura/peritoneum/thoracic duct
- e. *Associated diagnoses or diseases*

2. Approach to assessment (postop cardiac ABCs)

- A. Airway
- B. Breathing
- C. Circulation
 - A. Arrhythmia
 - a. Familiarized yourself with the different arrhythmias that may be expected postop for different surgeries
 - b. Pacemaker settings (ask fellows & staff for basic tutorial)
 - B. Bleeding (Check drain output)
 - C. Cardiac output
 - a. Perfusion & u/o
 - b. NIRS (Near-infrared spectroscopy): look at trend, not absolute number
 - c. Mixed venous saturation (SvO₂): how much O₂ is extracted from blood by organs (normal 60-80%); if CO is low then more O₂ extracted from RBC and SvO₂ will be lower



The McGill MedWell office:

"Mission: The Faculty of Medicine's MedWell office is dedicated to supporting medical learners throughout their training by creating, promoting and sustaining a culture of wellness and resilience within the learning environment."

<https://www.mcgill.ca/medwell/aboutus>

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Ways to Get Involved!



The MCH Peds Resident Leadership Guide; includes committees from Athletics, to Mentorship, to Social Activities and Wellness. These committees are created for residents, by residents...here for you to participate in, help lead, and enjoy!!



Resident Leadership Guide

McGill University
Pediatrics Program

Annual Retreat

Every year our entire resident group is excused from all clinical duties for two days in order to attend our annual retreat. This past year we headed up north to the beautiful Esterel Resort where we participated in financial and mindfulness sessions, went dragon boat racing, relaxed at the spa and fostered beautiful friendships.





Positivity Board

Check out our positivity board and message board in the resident lounge where we post favorite quotes, encouraging messages to each other, and little reminders to laugh and smile. We hope this little addition to your morning routine and on your way to your locker makes a difference in your spirit.



How we Stay WELL!

- Ordering from Chef on Call and Boustan during nightfloat!
- Taco Tuesdays after teaching!
- Wellness afternoons, with free ice cream, puppy therapy and yoga!
- Team dinners, lunches and breakfasts while on the ward!
- Talking to each other about our challenges, successes, worries...residency is an adventure worth sharing!
- Our WhatsApp Group Chats - where we update each other not only on where to show up on the first day of a new rotation, but also on trips, life milestones, and share a joke or two!

Finally, we're here for you!

