Pediatric patient records and case meetings: Practical information and advice

Ellisiv Nerdrum Aagaard

The basics – 4 patient records in total



Three admission records («innkomstjournaler») at either the Ahus or Ullevål Emergency Room



One record with one other student in your group (at one of the wards at Ullevål, Rikshospitalet or Ahus) to present at a **case meeting**



When you have 3 approved records + 1 case meeting, you have what is required to take your exam

Our template and standard

TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2024

Remove sensitive information

In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination. Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in your record. The **record is a legal document** that must describe your thinking and action with the precision and completeness necessary in a courtroom, including negative results – what is not there has not been asked about or examined. Be as precise as possible: In the history: Use dates or "x many days ago", not weekdays. In the status praesens: *Describe what you **observe**, **not** your interpretation of it!* Avoid spelling mistakes if possible.

History:

First, note how you got the information. Who's present? Direct interview? Telephone? Interpreter?

Reason for admission: Why is the patient admitted this time? (important in patients with several problems)

Social History: Patient's age and sex. Ethnic background, birthplace, language-understanding level of parent(s). Siblings and home environment (smoking, pets, carpeting). The child's level of care is important to note, including the number of caretakers, the work situation including occupation (important to give information at the right level) of the parents, childcare while parent(s) are at work (child day-care centre, school, after-school program – friends/hobbies?).

Family History: Diseases and hereditary disorders in the family, or other close relatives. Consanguinity. Deaths in the family if unknown cause.

Pregnancy and birth: Pregnancy, birth, reason for delivery if other than spontaneous contractions in mum at term. Neonatal period, including gestation, birthweight/- length and head circumference Neonatal period, as well as percentiles for all measurements. Nutritional state (length of breastfeeding). Health centre check-ups.

Immunization status (reasons if not vaccinated).

Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual status if patient has psychomotor developmental disorder.

Medical history and hospital admissions: Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies, and non-tolerable foods.

The purpose of the records and the template/standard is:





How to…



1. Organize a calender and book yourself a time slot - maximum 2 students at one time.
2. Go to the ER at the booked time – cancel early if you cannot come
3. Make contact with the doctor on call
4. Ask whether there is a suitable patient for you
5. Take a full history and perform an examination
6. Present the history and examination results to the doctor on call and discuss findings, diagnosis and treatment

** The doctor on call will always examine the patient themselves, and probably take a supplemental history*

The admission record:

1. Norwegian students:

- Create «Innkomstjournal SO» in DIPS. This will be the principal admission record for the patient.
- Send it to the doctor on call for formal approval.

2. Exchange students:

- Write the admission record in a Word document or similar.

TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2024

Remove sensitive information

In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination. Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in your record. The **record is a legal document** that must describe your thinking and action with the precision and completeness necessary in a courtroom, including negative results – what is not there has not been asked about or examined. Be as precise as possible: In the history: Use dates or "x many days ago", not weekdays. In the status praesens: *Describe what you **observe**, **not** your interpretation of it!* Avoid spelling mistakes if possible.

History:

First, note how you got the information. Who's present? Direct interview? Telephone? Interpreter?

Reason for admission: Why is the patient admitted this time? (important in patients with several problems)

Social History: Patient's age and sex. Ethnic background, birthplace, language-understanding level of parent(s). Siblings and home environment (smoking, pets, carpeting). The child's level of care is important to note, including the number of caretakers, the work situation including occupation (important to give information at the right level) of the parents, childcare while parent(s) are at work (child day-care centre, school, after-school program – friends/hobbies?).

Family History: Diseases and hereditary disorders in the family, or other close relatives. Consanguinity. Deaths in the family if unknown cause.

Pregnancy and birth: Pregnancy, birth, reason for delivery if other than spontaneous contractions in mum at term. Neonatal period, including gestation, birthweight/- length and head circumference Neonatal period, as well as percentiles for all measurements. Nutritional state (length of breastfeeding). Health centre check-ups.

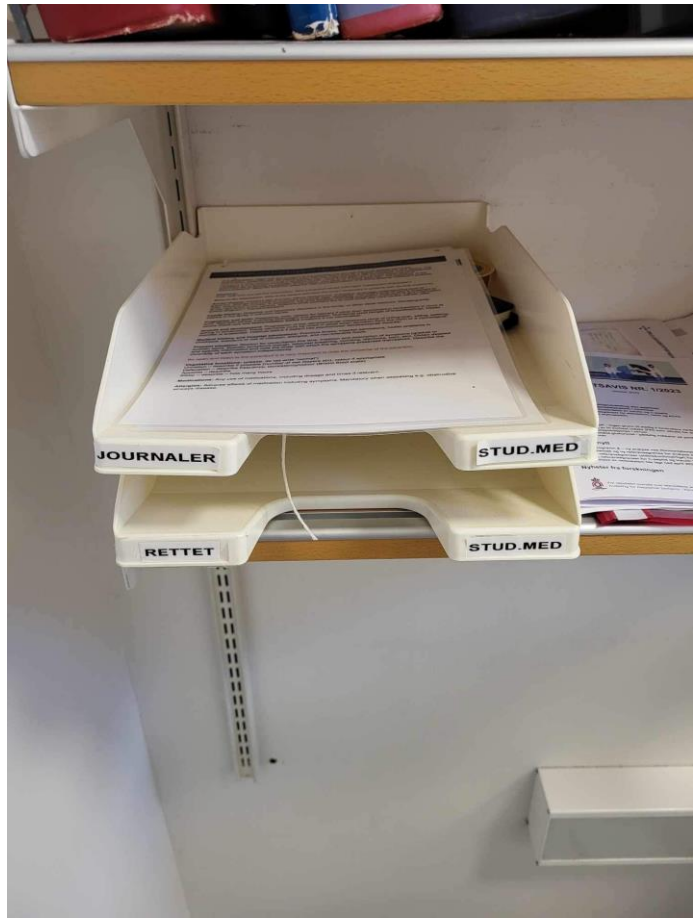
Immunization status (reasons if not vaccinated).

Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual status if patient has psychomotor developmental disorder.

Medical history and hospital admissions: Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies, and non-tolerable foods.

Then…

1. Print the document before you leave.
2. Use the scissors to ***remove the patient's ID from the record!!!***
3. We want the results of **all** lab and radiology ordered on admission, in the patient record.
   - If there are pending test results when you print the record (there usually are), bring the record home, **come back a day or two later, check the lab results, fill in by hand**, and hand it in at our mailbox
4. **Voilá!** Hand in the record in designated box!
5. Allow us 10 days +/- to correct it ☺



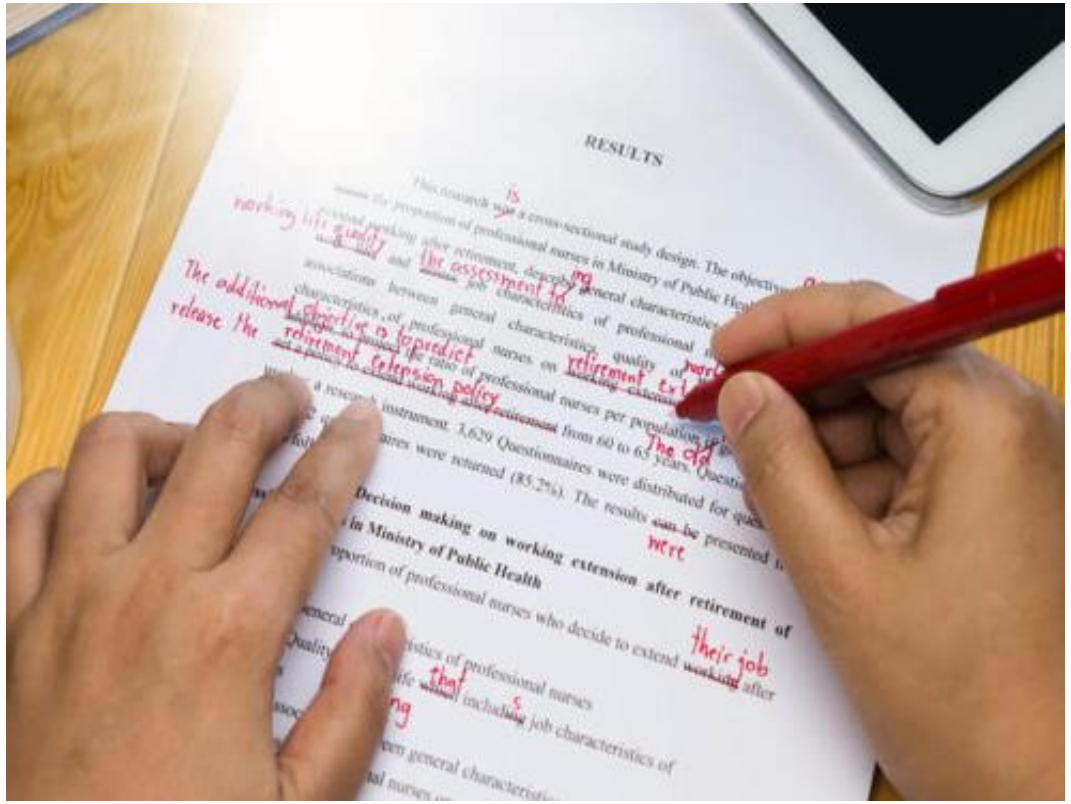
If the patient`s ID is not removed;

- We will not correct your journal!
- You have to make a new journal on another patient!



After correction…
then what..

Pick up your corrected admission record from the message box :





Approved

a) Please take notes of our remarks/suggestions/praise

b) we will look for development in your next record.



Corrections

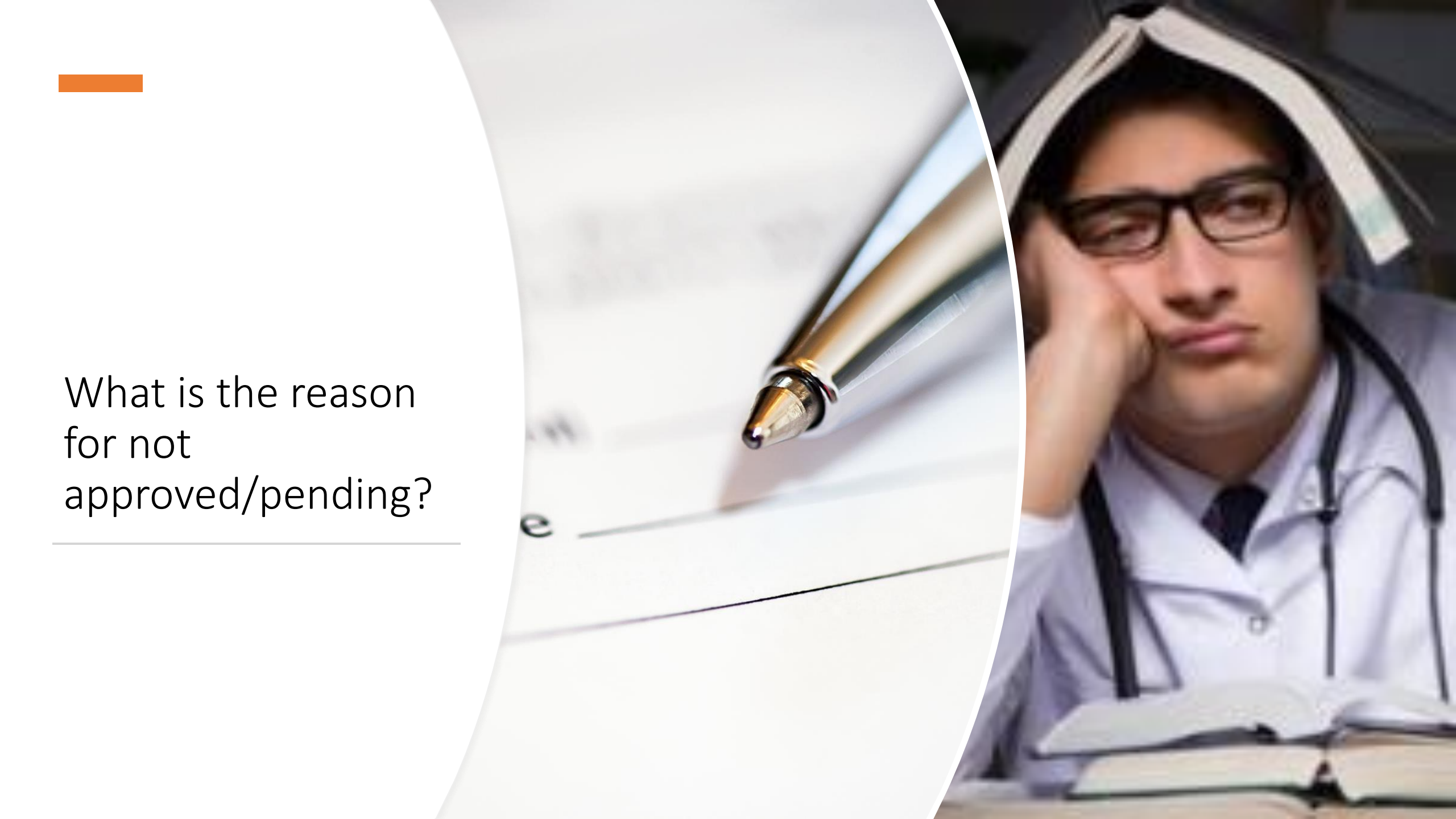
- Improve the record, ie missing information such as normal values, percentiles, lab results).
- Please correct by hand, and hand in again



Not approved

- Please take notes of remarks/suggestions and take a new record

What is the reason for not approved/pending?



Not using the template!!

TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2024

Remove sensitive information

In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination. Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in your record. The **record is a legal document** that must describe your thinking and action with the precision and completeness necessary in a courtroom, including negative results – what is not there has not been asked about or examined. Be as precise as possible: In the history: Use dates or "x many days ago", not weekdays. In the status praesens: *Describe what you **observe**, **not** your interpretation of it!* Avoid spelling mistakes if possible.

History:

First, note how you got the information. Who's present? Direct interview? Telephone? Interpreter?

Reason for admission: Why is the patient admitted this time? (important in patients with several problems)

Social History: Patient's age and sex. Ethnic background, birthplace, language-understanding level of parent(s). Siblings and home environment (smoking, pets, carpeting). The child's level of care is important to note, including the number of caretakers, the work situation including occupation (important to give information at the right level) of the parents, childcare while parent(s) are at work (child day-care centre, school, after-school program – friends/hobbies?).

Family History: Diseases and hereditary disorders in the family, or other close relatives. Consanguinity. Deaths in the family if unknown cause.

Pregnancy and birth: Pregnancy, birth, reason for delivery if other than spontaneous contractions in mum at term. Neonatal period, including gestation, birthweight/- length and head circumference Neonatal period, as well as percentiles for all measurements. Nutritional state (length of breastfeeding). Health centre check-ups.

Immunization status (reasons if not vaccinated).

Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual status if patient has psychomotor developmental disorder.

Medical history and hospital admissions: Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies, and non-tolerable foods.

Goal: Improve between the records





Good to know



The doctor on call is always fully responsible for diagnosis and treatment of the patient

You have the opportunity to learn a lot by «playing» doctor first without responsibility!



Not every doctor in the ER knows everything about your role, what you know, what you should know



Sometimes (hopefully, not too often), not everyone has a lot of time or energy for you, or seem unwelcoming. The reason is usually that a lot may be happening, and other responsibilities. Try not to let this stop you. Your job is also important.

If you have unpleasant experiences, please let us know as soon as possible.

Important

- Act politely, professionally and humble
- The patient record is a legal document
  - Professional language
  - Grammar
  - Precision
- Do not be afraid to ask questions to us, or to the doctors on call
- We ask you to hand in your best work ☺



Case meeting



- 2 students cooperate and do one record
- Choose an interesting patient at one of the wards at Rikshospitalet, Ullevål, or Ahus .
- Write as Word document
- Follow our template/standard when you take the record
- **Hand the printed copy/email of the record directly to your case meeting teacher** for correction

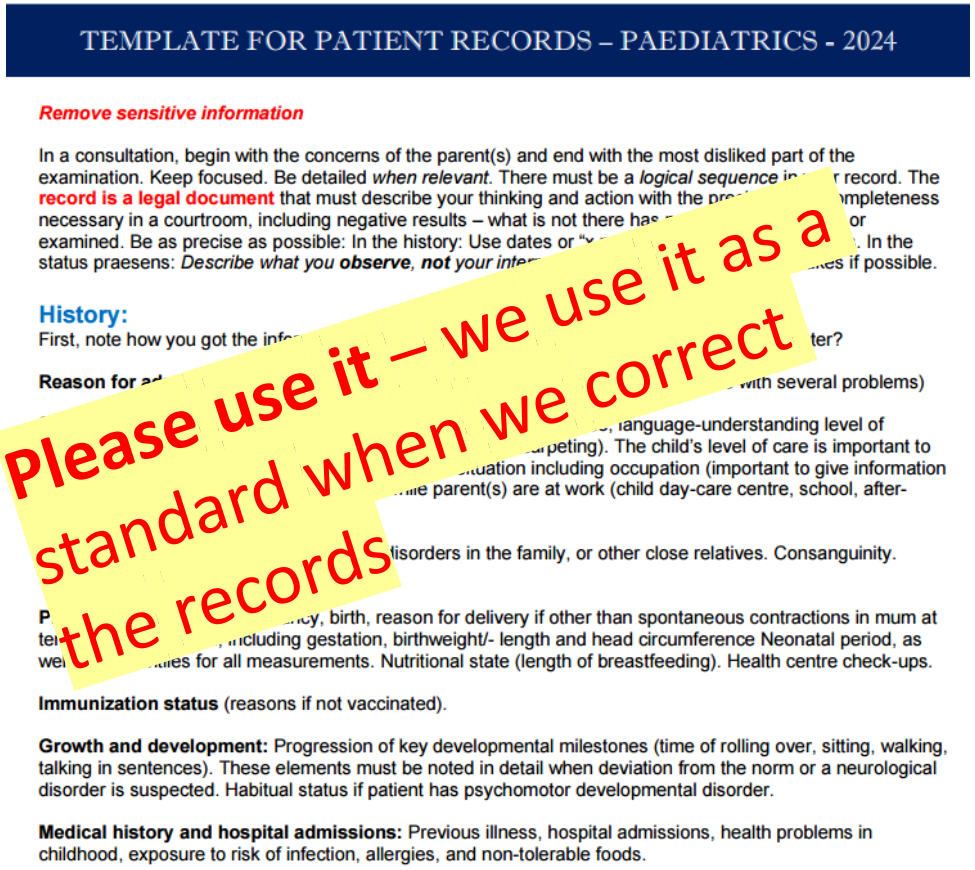
Case meeting

Powerpoint (or similar) presentation for the rest of the students

- The case – 5 mins
- Facts about the disease - 5 mins
- Discussion – 5 mins



Our template /standard - highlights



TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2024

Remove sensitive information

In a consultation, begin with the concerns of the parent(s) and end with the most disliked part of the examination. Keep focused. Be detailed *when relevant*. There must be a *logical sequence* in … record. The **record is a legal document** that must describe your thinking and action with the pr… ompleteness necessary in a courtroom, including negative results – what is not there has … or examined. Be as precise as possible: In the history: Use dates or "… . In the status praesens: *Describe what you* ***observe***, ***not*** *your inter…* …kes if possible.

History:
First, note how you got the inf… …ter?

Reason for ad… …with several problems)

…language-understanding level of …peting). The child's level of care is important to …situation including occupation (important to give information …ile parent(s) are at work (child day-care centre, school, after-…

…isorders in the family, or other close relatives. Consanguinity.

P… …ncy, birth, reason for delivery if other than spontaneous contractions in mum at te… …including gestation, birthweight/- length and head circumference Neonatal period, as we… …ities for all measurements. Nutritional state (length of breastfeeding). Health centre check-ups.

Immunization status (reasons if not vaccinated).

Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual status if patient has psychomotor developmental disorder.

Medical history and hospital admissions: Previous illness, hospital admissions, health problems in childhood, exposure to risk of infection, allergies, and non-tolerable foods.

Please use it – we use it as a standard when we correct the records

Much more comprehensive than records taken by the ER doctors

- i.e. we want you to include every time
  - Normal values for vitals
  - Percentiles for measured weight and length, head circumference if below two years of age
  - Results from <u>all</u> workup ordered at admission
- This is a **conscious choice to maximize your learning!**

Some important differences from adult history:

- Whether the child lives with both or only one of the parents, whether the parents live together, foster-care
- Any kind of disease in the closest *family*
- Immunizations
- Growth (with percentiles if possible) until now
- Psychomotor development
- Daycare/school
- Thorough information on urination and defecation is relevant in almost every record (frequency, amounts, colour, Bristol stool scale...)



Some important differences from adult examination:

- Vital signs with normal range!
- Percentiles - almost always highly relevant in pediatrics!
- Detailed description of respiratory symptoms
  - Retractions
  - Nasal flaring
  - Forced respiration ++++
- Puberty with Tanner stages ** if the child are at puberty/age were puberty should start*
- Inspection of the diaper area – and inspection of genitals
- Rectal exam only on indication



General points

- There are three (four) sections in a medical record:
  - **History** = what the patient and/or parents tell you
  - **Examination** = what you find/see
  - **Workup** = results from diagnostic workup
  - **(Summary and) assessment** = brief summary with *no new information*, and then you have to explain the thoughts about why it could be disease X and not Y, and why you chose treatment Z. The most important and difficult part
- If anything is omitted, i.e. a specific exam not performed, state why
- If there are significantly deviating values or significant findings, you need to comment on them in the assessment



Usefull pediatric tools:

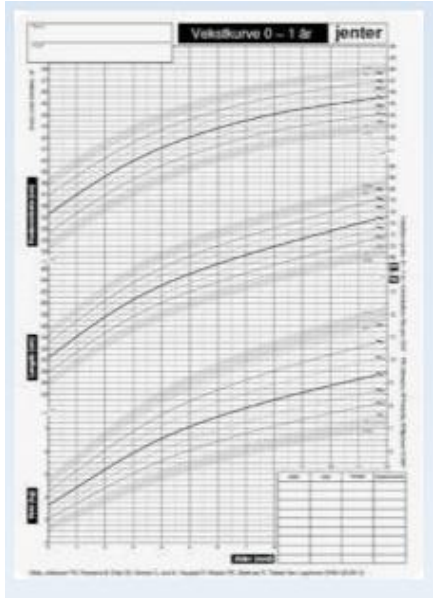
- Template for patient record 2024

- Pdf file for PEVS form and PEDSAFE pocket size. www.pedsafe.no.

- Growth Percentile Chart, age 0-1yr (M/F), 1-5yr (m/f), 4-19yr (m/f) www.vekststudien.no
- Pediatric nevrological exam: https://www.spesialisthelsetjenesten.no/lis/nyheter/videopakke-med-fullstendig-barnenevrologisk-undersokelse-er-lansert/

  https://kursbygger.ihelse.net/?startcourseid=2301&tracking=

- Youtube, Newborn physical examination:
  - Newborn Physical Examination med.uio.no – YouTube, av neonatology og prof. Thor Willy Ruud Hansen https://www.youtube.com/playlist?list=PL230CE83048F52B06
  - "Newborn Exam" by Nina Gold for OPENPediatrics (youtube.com) , https://www.youtube.com/watch?v=cracmPo3iYo







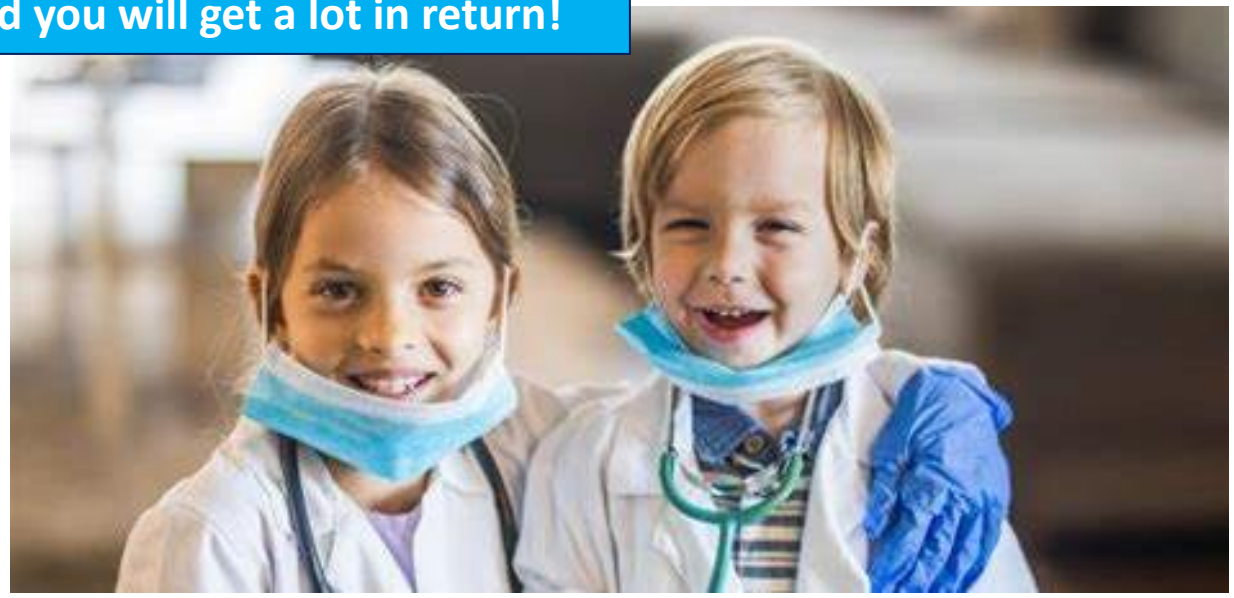




The visits to the ER might be the highlight of the semester – fun, a lot to learn, the closest you get to trying pediatrics!

So – invest in this work and you will get a lot in return!







!

Do not hesitate to contact us by e-mail:

1. Ullevål/Rikshospitalet

Ellisiv Nerdrum Aagaard: ellisina@medisin.uio.no

Åsbjørn Westvik: a.s.westvik@medisin.uio.no

Christina Elisabeth Bjerring Opheim: c.e.b.opheim@medisin.uio.no

Linn Oftenes Lie: liolie@ous-hf.no

Hanna Dis Margeirsdottir: hamarg@ous-hf.no

2.Ahus:

Joel Pradeepkumar Selvakumar: j.p.selvakumar@medisin.uio.no

Zarah Farnes:

z.e.h.f.farnes@medisin.uio.no

Zanira Yaquib Ansari:

z.y.ansaru@medisin.uio.no