Pediatric patient records and case meetings:
Practical information and advice

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The basics

- Do a total of **three** admission records («innkomstjournaler») at either the Ahus or Ullevål ER

  and

- Do **one** record (at one of the wards at Ullevål, Rikshospitalet or Ahus) to present at a **case meeting** with other students
  - Make a presentation – 5 min history/examination
  - The diagnosis in general – 5 min
  - Discussion – 5 minutes

Our template and standard

Template for patient records - Paediatrics | 2022

Below is a template for writing a complete paediatric patient record. 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.
Present history -> background history -> status praesens -> supplementary investigations -> interpretation/diagnosis -> management
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!*

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?

Social History:
Age and sex of the patient. Ethnic background, birthplace, language-understanding level of parent(s). Siblings and home environment (smoking, pets, carpeting).

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

Solely to give you the opportunity to learn as much as possible!

Admission records at the Ullevål or Ahus ER (Barnemottak)

1. Organize a calender and book yourself a time slot
2. Go to the ER at the booked time
3. Make contact with the resident on call
4. Ask whether there is a suitable patient for you (most, but not all patients are!)
5. Take a full history and perform an examination
   - *Tip*: See one, do one... You will learn more if you jump in and try history+exam yourself before the doctor on call
   - You should in any case try to make up your own mind before discussing with and getting the «answers» from the doctor on call. Present the history and examination results to the resident on call and discuss findings, diagnosis and treatment
6. The doctor on call will always examine the patient themselves, and probably take a supplemental history

Admission records at the Ullevål or Ahus ER (Barnemottak)

8. Write the admission record in accordance with our template/standard
   - Norwegian students: Create «Innkomstjournal SO» in DIPS. This will be the principal admission record for the patient
   - Exchange students: Write the admission record in a Word document or similar. The doctor will have to produce the document themselves.
9. Send the document to the doctor on call for formal approval (Norwegian students only)
10. Print the document before you leave regardless of whether the doctor on call has approved it/checked it or not The doctor on call will not always have time to check everything in your record before you leave. We want to see <u>your</u> «product», not one by the doctor on call
11. Use a pair of scissors to remove the patient's name and personal information from the record
12. 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
13. **Voilá!** Hand in the record in designated box!

Admission records at the Ullevål or Ahus ER (Barnemottak)

After correction

1. Pick up your corrected admission record at the message box – allow us 1 week (+) to correct it ☺
2. Now there are three options:
   a) Your record is **approved**. Please take notes of our remarks/suggestions/praise – we will look for development in your next record.
   b) We ask you to make certain **corrections/improvements** to the record (i.e. missing information such as normal values, percentiles, lab results). Please correct by hand, and hand in again
   c) Your record is **not approved**. Please take notes of remarks/suggestions and take a new record.
3. When you have three approved records + 1 case meeting, you have what is required to take your exam

Good to know

- **The doctor on call is always fully responsible** for diagnosis and treatment of the patient
  - Thus, 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

Case meeting

- Two students cooperate
- Take record at either the ER or one of the pediatric wards at Rikshospitalet, Ullevål, or Ahus
- Write as Word document
- The ward staff probably do not know anything about the concept of case meeting. Follow our template/standard when you take the record
- **Powerpoint (or similar) presentation for the rest of the students**
  - The case
  - Facts about the disease
- **The record should be handed in directly to your case meeting teacher** either physically or by e-mail
- The case meeting teacher will contact every student by e-mail prior to the meeting about practical details (i.e. how much time per presentation)

Our template / standard - highlights

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

- **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 height and length, head circumference if below two years of age
    - Results from all 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, especially atopy
- Immunizations
- Growth (with percentiles if possible) until now
- Psychomotor development
- Daycare/school
- Thorough information on urination and defecation relevant in almost every record (frequency, amounts, colour, Bristol stool scale...)

Some important differences from adult examination:

- Vital signs with normal range!
- Percentiles of your measured height and length
  - Almost always highly relevant in pediatrics!
- Detailed description of respiratory symptoms
  - Retractions
  - Nasal flaring
  - ++
- Forced respiration
- Puberty with Tanner stages
- Inspection of the diaper area
- Usually no rectal exam

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

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!

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