Introduction to Pediatrics, modul 6.

Practical information and advice

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Lecture overview:

I. Clinical teaching this semester – general information

II. Pediatric admission notes and case presentation

III. Pediatric patient – is not «just a smaller adult» in medicine

I. Clinical teaching this semester:

1. **Introductory course in paediatrics** (Wed 4th Feb), goal: learn practical pediatrics tools to use in the clinic.

2 .**Clinical small group teaching** at Ahus, Rikshospitalet and Ullevål – total 10 sessions

i. Pediatric ward x 2 each hospital (total 6)

ii. Newborn / neonatal x1 each hospital (total 3)

iii. Voksentoppen centre for asthma and allergy x1

3. **Completing hospital admission notes** (innkomstjournal)

4. **Case meeting**

5. **Paediatric CPR training** (session in May)

II. Pediatric admission records and case meeting



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 4 approved admission records, you have what is required to take your exam

Our template and standard

TEMPLATE FOR PATIENT RECORDS – PAEDIATRICS - 2026

Remove sensitive information

"In a consultation, begin with the medical history and end with the physical examination (which is often 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? Is it obtained from the medical record?

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). Are the parents married/living together/divorced? Is there any consanguinity between the parents? 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. 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 as well as percentiles for all measurements. Nutritional state (length of breastfeeding).

Immunization status (reasons if not vaccinated).

Growth and development: Health centre check-ups. 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 and health problems in childhood.

Present situation: Reason for consultation this time. Initiation and description of symptoms (gradual or

The purpose of the records and the template standard is:





Admission notes – booking in the calender

Locations:

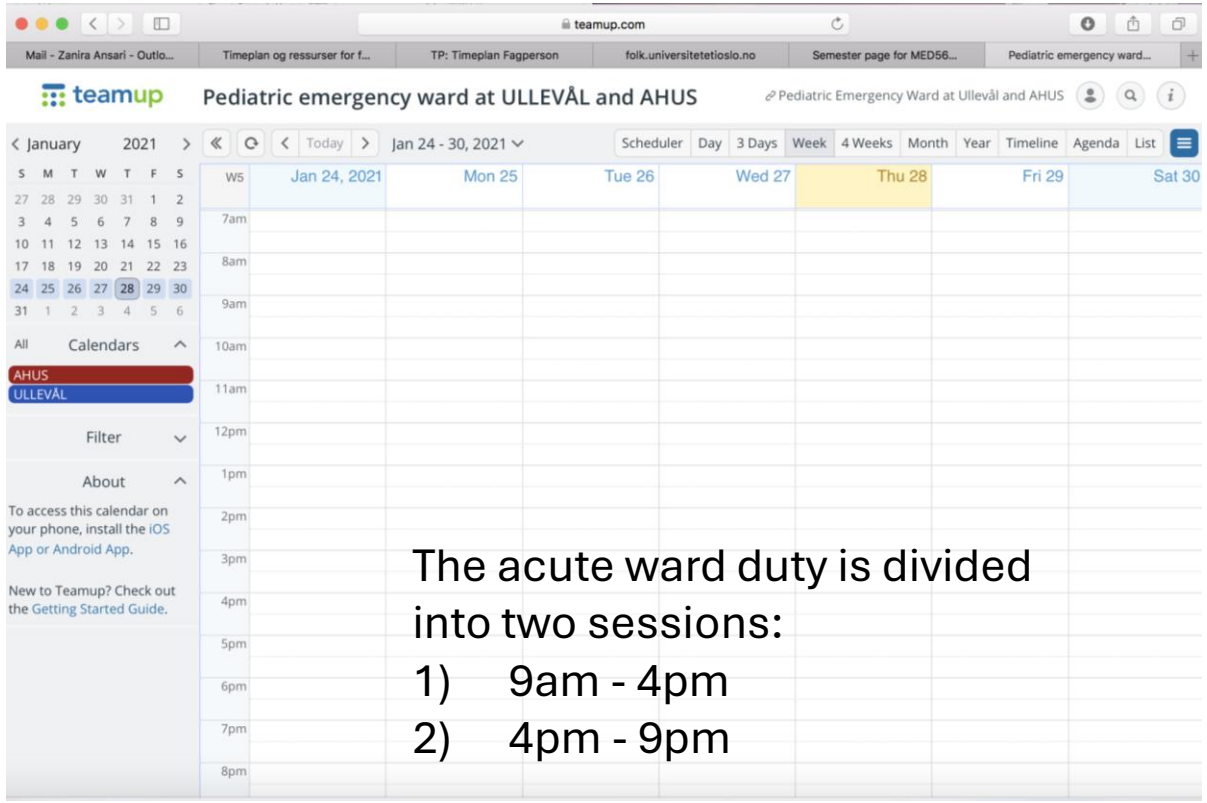
Group 1-10 at Ahus

Group 11-30 at Ullevål

Sign up for the acute ward using the TeamUp Calender;

https://teamup.com/ksk7kstfqk6236anj4

Maximum of **two students** at the same time in the acute assessment wards.



The acute ward duty is divided into two sessions:

1) 9am - 4pm
2) 4pm - 9pm

* Until the end of next week (15th Feb), students are only allowed to book two sessions each

Admission records, 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. Write in Norwegian.
- 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.

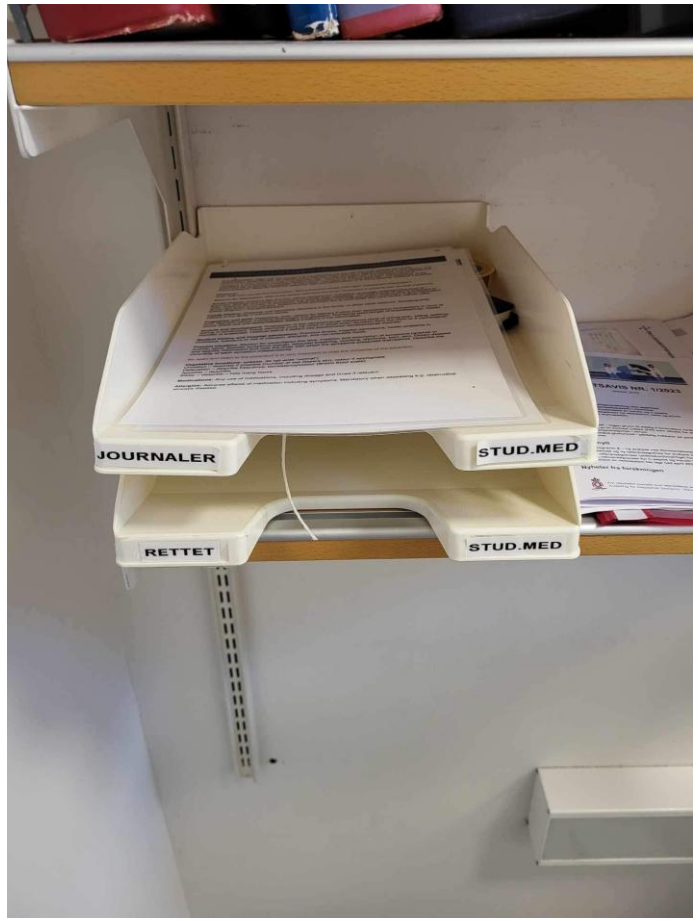
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Growth and development: Progression of key developmental milestones (time of rolling over, sitting, walking, talking in sentences). These elements must be noted in detail when deviation from the norm or a neurological disorder is suspected. Habitual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



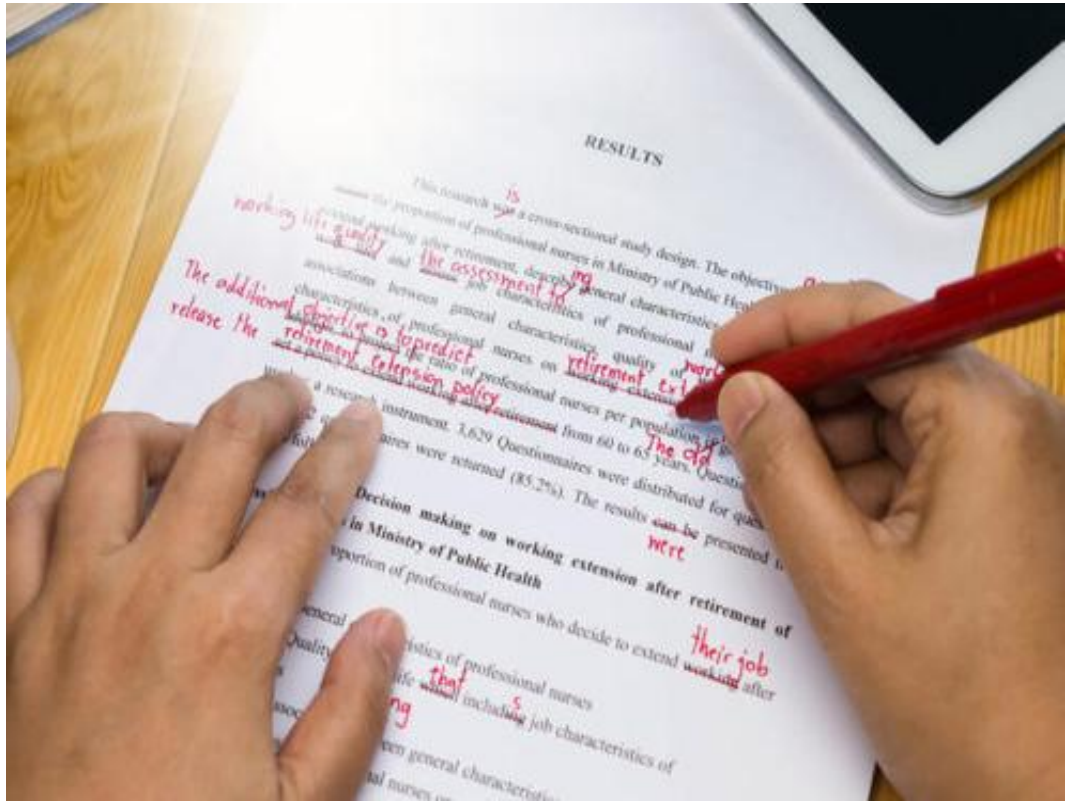
If the patient`s ID is not removed;

- 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

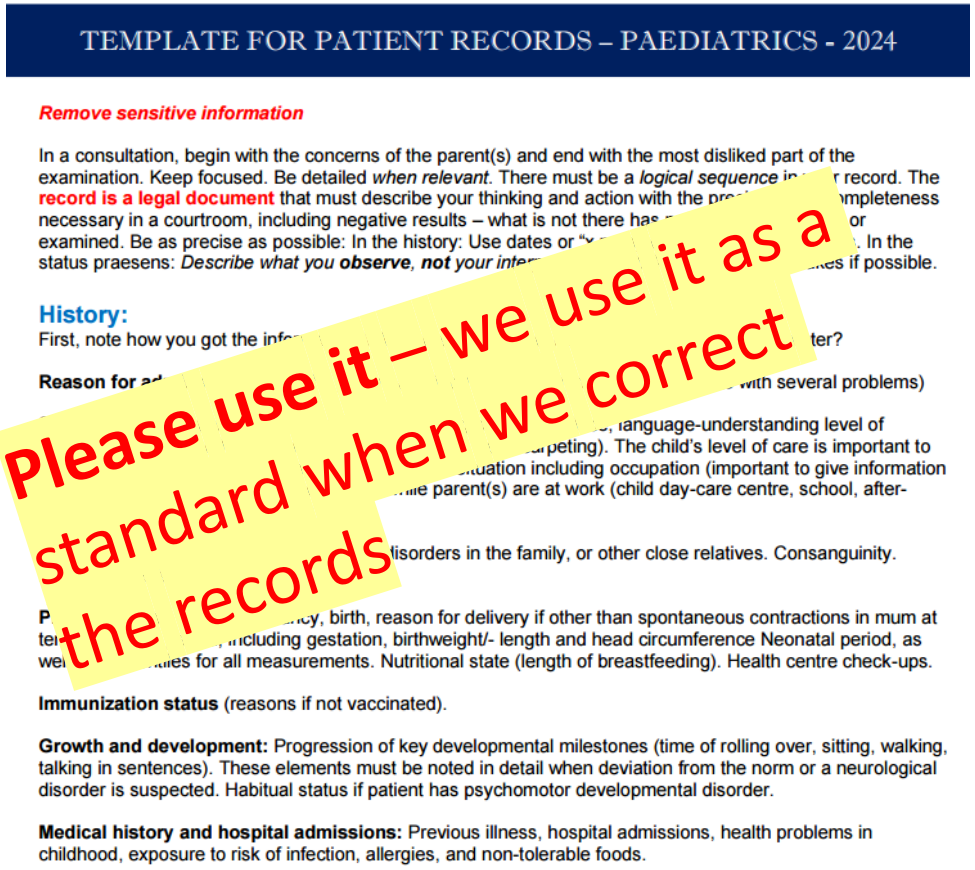
- Please take notes of remarks/suggestions and take a new record

Goal: Improve between the records





Our template /standard - highlights



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…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-…

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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!**

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, how to..?

Here we want you to write 1 admission record and to present the case in a case meeting:

- 2 students cooperate and do one patient record
- Choose ***an interesting patient*** at one of the wards at Rikshospitalet, Ullevål, or Ahus .
- Write the admission record as Word document
- **Hand the printed copy of the record directly to your case meeting teacher** for correction. *Do not* send it by email.

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



III. Pediatric patient – is not «just a small adult»





Tips for infants 0 – (8-)10 months

- Usually not sceptical to strangers
- **Very good understanding of non-verbal language and moods**



Tips for toddlers and preschool children 10 months – 4-5 years

- Most children of this age **evaluate strangers through their parents' attitude to them**, and require **«warm-up-time»**
- In most cases, **greet the parents first** (but do communicate with the child, like a kind smile)
- The child will often «warm up» to you through the relation between you and the parent
- Little understanding of irony



Tips for children (4-)5-12 years old

- Requires you to **sense the situation** – some children are very shy, others are extremely outgoing
- Generally, **greet and talk to the patient first**
- The parents should usually stay in the room, anamnesis often given by them



Tips for teenage patients

- **Greet the patient first**
- Independent beings, not just children of their parents
- Children 12-16 years should be offered a **chat without the parents present**
- The parents should also be heard out!



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



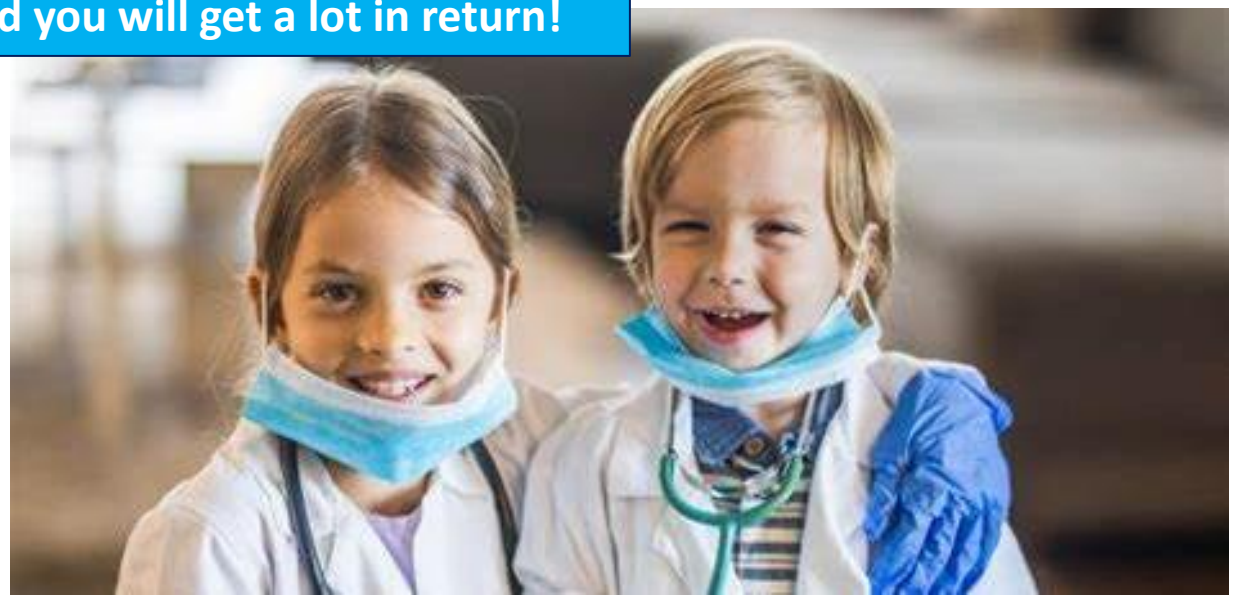


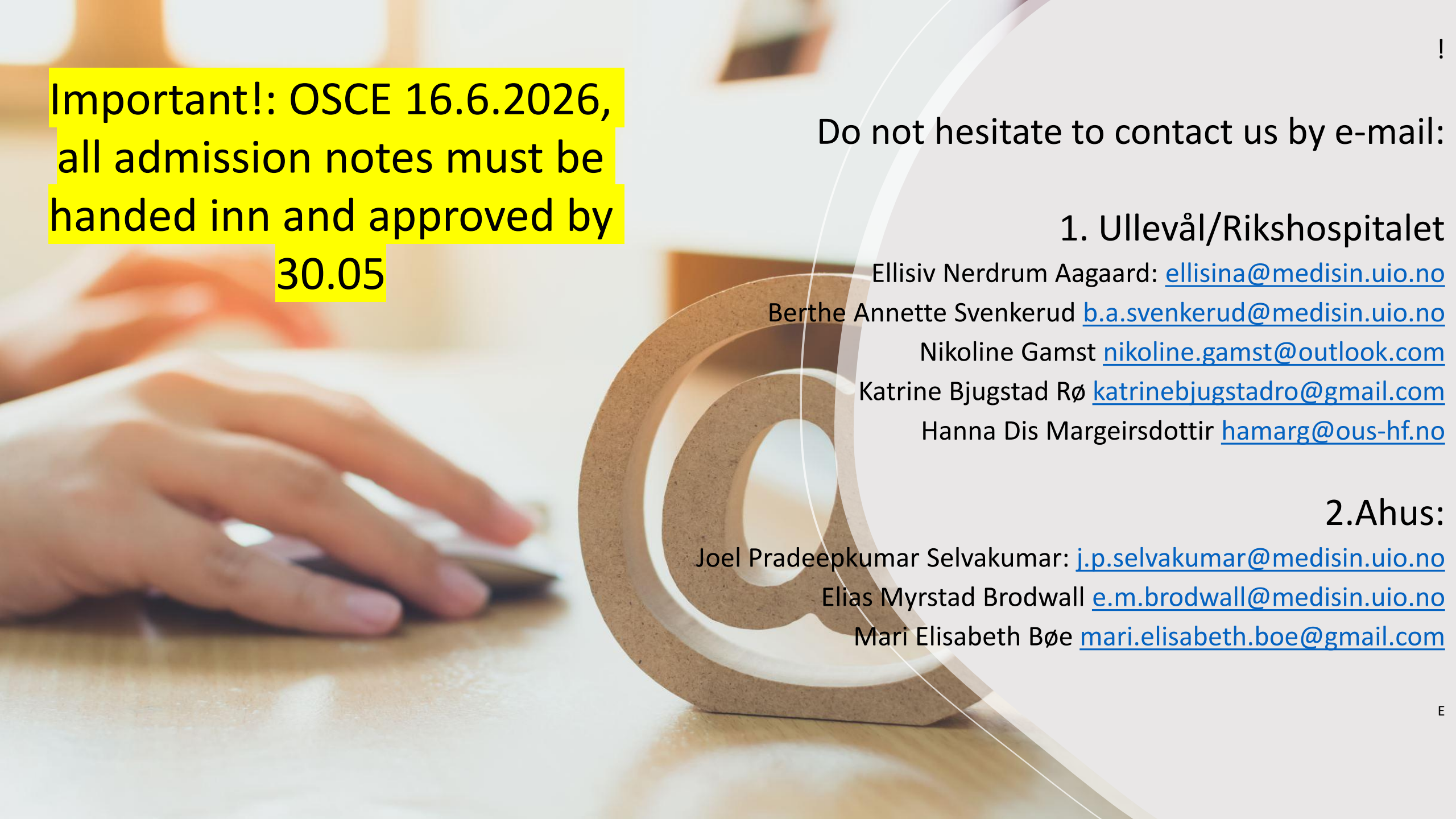


The visits to the ER might be the highlight of the semester – fun, a lot to learn, the closest you get to trying pediatrics!

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







Important!: OSCE 16.6.2026, all admission notes must be handed inn and approved by 30.05

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