Pediatric patient records and case meetings: Practical information and advice

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The basics – 4 patient records in total

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

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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**

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 - 2023

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 birthweight and gestation. Nutritional state (length of breastfeeding). Health centre check-ups and **immunization status** (reasons if not vaccinated).

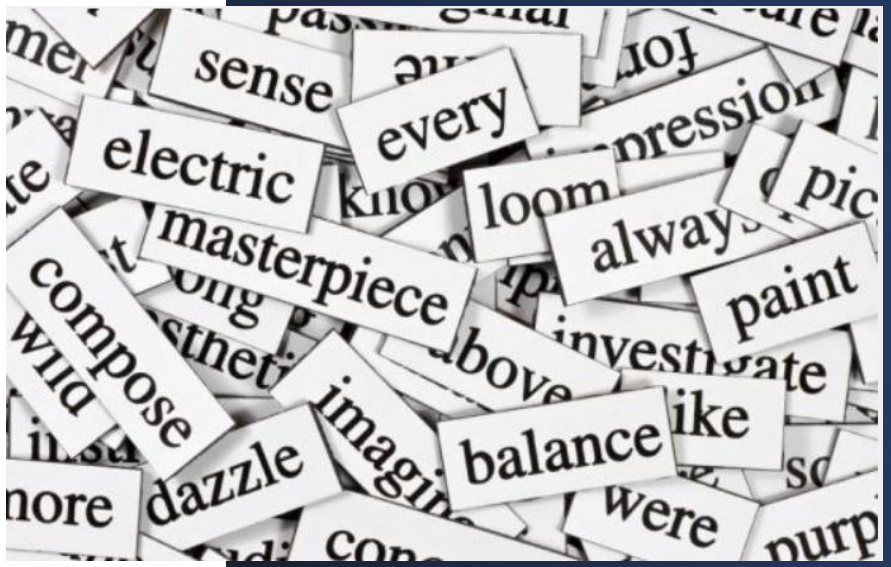
The purpose of the records and the template/standard is:

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

Look at is as a golden opportunity for learning ☺

A few important words for the exchange students to learn

- **Barnemottak** – emergency room – ER
- **Helsestasjon** – maternal/child health care center or well baby clinic
- **Fastlege** – the general practitioner – usually not a pediatritian



How to…

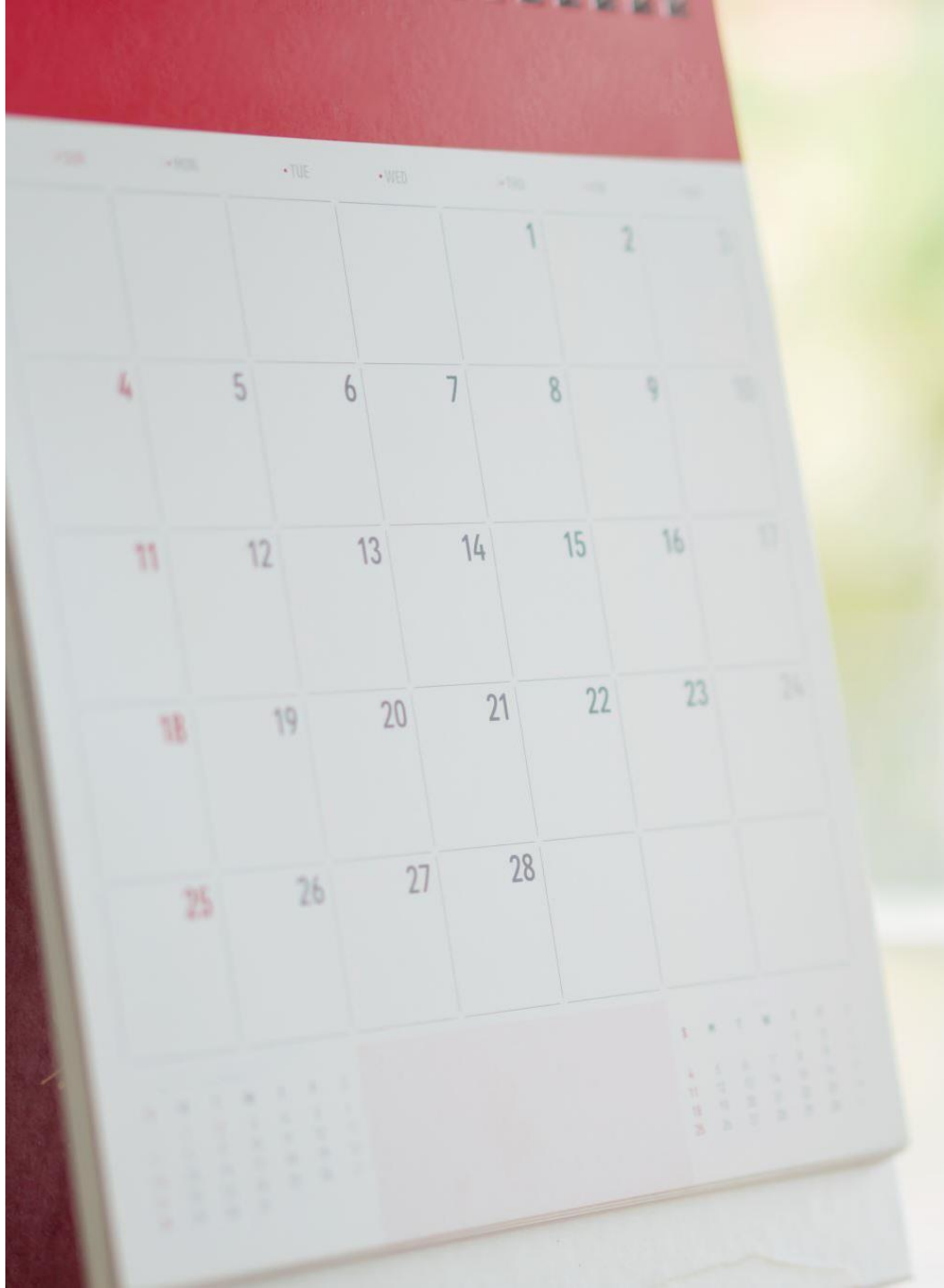
1. Organize a calender and book yourself a time slot - maximum 2 students at one time – and maximum 2 slots per student
2. Go to the ER at the booked time – cancel early if you cannot come
3. Make contact with the doctor on call
4. Ask whether there is a suitable patient for you (most, but not all patients 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
   - 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 doctor 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

How to…

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. Norwegian students send document to the doctor on call for formal approval
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 the scissors provided to remove the patient's ID 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!

After correction… then what..

1. Pick up your corrected admission record from 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 3 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

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

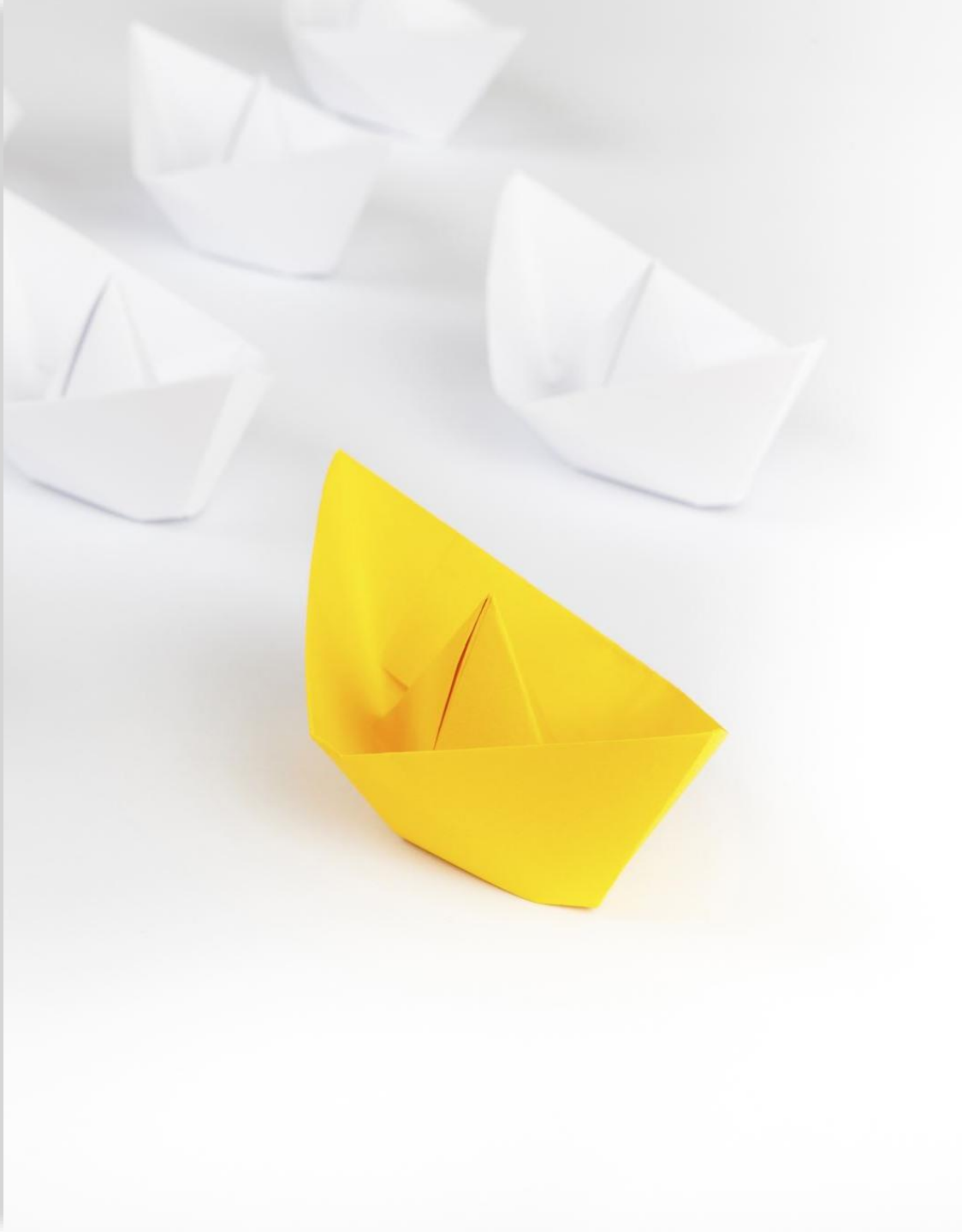
Not every doctor in the ER knows everything about your role, what you know, what you should know

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
- The ward staff mights 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 – 5 mins
  - Facts about the disease - 5 mins
  - Discussion – 5 mins
- **Hand the printed copy/email of the record directly to your case meeting teacher** for correction
- The case meeting teacher might contact the students 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

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 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 – 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

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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