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1. Philosophy and aims of the Paediatric Unit.

Providing health care to children is a privilege allowed to us by parents. We recognize the trust that families place in us to provide safe and effective care for their children.

The Paediatric Unit at Caboolture Hospital aims to provide care that is responsive to the needs of children and families. We should be flexible in how we deliver services according the circumstances of each family.

2. Permanent staff and Unit Description

The Paediatric Unit comprises a 12 bed inpatient paediatric unit, a 5 bed Paediatric Emergency Short Stay Unit (PESSU), a 12 cot Special Care Nursery and an 6 consultation room children’s outpatient department.

The children’s ward has 17 physical beds but this is to allow cohorting and the unit is only funded for 12 inpatients. Adults are sometimes admitted to a 4 bed bay in the children’s ward according to the "Adult admission criteria to the paediatric ward" procedure.

Medical

- 8 Consultants.
  - Dr John Waugh, Director of Paediatrics and Conjoint deputy head of the Northside Clinical School at Caboolture. Child protection advisor.
  - Dr Salil Gandhi fulltime Paediatrician. Attends Diabetes clinic.
  - Dr Brian Patten, 0.6 FTE Paediatrician
  - Dr Prasanna Shirkhedkar 0.7 FTE Paediatrician
  - Dr Lisa Kane 0.5 FTE Paediatrician plus works in ED on Wednesdays.
  - Dr Sudeep 0.5 FTE. Dr Sudeep is a paediatric endocrinologist. Covers Diabetes and endocrinology, as well as general paediatrics.
  - Dr Laurel Teoh fulltime Paediatrican and Paediatric respiratory physician.
  - Dr Manuel Bautista-Morales Fulltime Paediatrician

- Full establishment is 8 registrars/PHOs work a 24 hour roster.
- 1 discipline SHO (dSHO) who has similar responsibilities to the PHO/REGs but is always rostered with a more senior person present and does not work nights. The SHO requires assistance and supervision by the registrar or PHO who is rostered to work the same shift. The dSHO may work a weekend day shift, when the consultant will provide morning supervision until the evening Registrar starts.
- 1 RMO. These are rotating SHOs or JHOs who complete 10 week terms. There are often relievers and additional unallocated RMOs are sometimes sent to paediatrics.
Registrars/PHOs and dSHO may be required to provide orientation for short term RMO relievers.

- 1 Intern.
- 3-4 medical students. Students are final year (4\textsuperscript{th}) from UQ Clinical School, PCH-Northside Clinical Unit. During a 6 week term students. Medical students have set requirements for tutorials and assessments that Junior doctors may be requested to assist with.

The following staff list is not complete, but notes some names that you may become familiar with.

**Nursing**

- NUM of Children’s ward and PESSU is Michelle Hutch
- Clinical Nurses in the Children’s ward/PESSU, Michelle Brand, Danielle Briese, Julie Edwards, Kirsty Haley, Leeta Parker, Lee Baillie, Deepa Karolson, Maxine Torrance, Kylie Devcich.
- Clinical Nurse in charge of the Special Care Nursery is Stephanie Webster.
- Clinical Nurse in charge of the Children’s Outpatients Department is Michelle Kilah.

**Allied Health**

- Paediatric Therapies team leader Hsien-Jin Teoh, Psychologist ph. 5316 5746
- Senior Dietitian: Amy Thompson ph. 5433 8796 and
- Dietician: Stacey O’Donnell 5316 5882
- Speech therapist: Emily Rounsefell ph. 5316 5740

**Administration**

- Dale Holcroft, ESO to Dr Waugh ph. 5433 8090. CabH_SupportOfficerPaeds@health.qld.gov.au
- Annette Warne, AO in the Children’s Ward ph. 5433 8884
- Shelley Newham, AO in the Maternity Ward ph. 5433 8629
3. Junior Staff Role Descriptions

3.1 Registrars.

Registrars and PHOs see referred patients from the ED, the maternity unit, Home Midwifery Service (HMS) or GPs. Children referred from the ED may be seen by the registrar in the ED or they may be directly admitted to the Children’s Ward or PESSU by ED staff and seen initially by the paediatric registrar in the ward/PESSU. Direct admissions of neonates from outside the hospital may be by request from GPs and Midwives. (Direct admission of neonates procedure) See section 4.3.

Registrars and PHOs are expected to assess and manage patients initially and liaise with the paediatric consultant. Emergency management should be commenced if required prior to discussion with the consultant. The timing of discussion with a consultant will depend on the severity and complexity of illness and the level of experience of the registrar. All paediatric ward inpatient admissions should be discussed with a consultant within 12 hours of admission. Consider updating the on call consultant regarding new ward admissions before 9 pm in order to adhere to the 12 hour rule while avoiding unnecessary overnight phone calls.

Registrars/PHOs are encouraged to call the consultant at any time. Even if you are comfortable with your diagnosis and management, consider if the severity or complexity of the case means the consultant needs to be informed, particularly early in your term when we do not know each other well. Informing the consultant of a complex case is important to manage professional risk, even if you are confident to manage the case.

Registrars/PHOs may be rostered to outpatient clinics to see new and review patients. All outpatients seen must have a letter dictated or typed. Check with the clinic consultant whether they wish to see your letter before it is sent and if so how they would like to receive it (email or hard copy). Letters dictated in Winscribe will be emailed to you for correction. DO NOT USE OWA email access to correct letters, you must be logged in to a computer using intranet email for the letter correction process to work. You cannot attach corrected letters to emails, you must use the “reply with corrections” button in the word document attached to the typist’s email. Ask for a demonstration of how to do this if you are unsure.

Registrars/PHOs maintain the handover sheet that is updated and saved at every handover (see section 4.2). The sheet is currently saved to a computer in the handover room. It should be saved with a filename in date format as “day month year am or pm” (eg “06022017 am” for 6 February morning handover). It should be updated by the night registrar prior to morning handover (with a change to the day’s date and to am) and again prior to handovers in the afternoon and evening (changing to pm in the file name). The sheet includes all inpatients in PESSU, children’s ward, SCN, Maternity as well as expected patients from transfers or births, patients requiring follow up and notes about transferred patients.

Registrars/PHOs are expected to participate in quality assurance processes through presentation at Morbidity and Mortality meetings, audits and specific quality assurance projects as they arise.
Registrars/PHOs are expected to present at unit educational activities including journal club, RMO teaching (Monday afternoon SCBU registrar) and may be asked to present at Grand Rounds.

Registrars will be supported according to their college training requirements for exam preparation and supervision. Please ensure your supervisor is aware of your requirements.

3.2 Discipline SHO (dSHO)

The aim of the dSHO role is to build experience in acute paediatrics and enable transition to a more senior role in paediatric training if desired.

The day to day role will be to support the consultant and registrar with ward rounds in the children’s ward, PESSU and special care nursery. The discipline SHO will be required to undertake admissions and other tasks similar to the Registrar/PHO responsibilities as above but will only be rostered when there is a registrar/PHO present to support them. The discipline SHO will mainly be rostered to acute inpatient and emergency work. The discipline SHO may be rostered to weekend and evening work with consultant and registrar support but will not be rostered to do nights.

Discipline SHOs will be required to participate in unit educational and quality assurance activities and may be requested to present at meetings.

3.3 RMOs (rotating term SHOs and JHOs)

RMOs on rotating 10 week terms are offered a paediatric term to gain familiarity with paediatric presentations and the management of acute paediatric inpatients. A focus of the RMO term is to gain familiarity with the range of normal newborn examination findings and management of low acuity neonatal conditions.

RMOs commence in the Maternity ward at 0700 to do normal newborn discharges and then attend handover at 0800. RMOs must be familiar with normal newborn examination and this will be revised on the first day of term. All RMOs should assist with the newborn discharges from 0700 and after the handover RMOs will be allocated to attend either the acute wards or the maternity ward for the week. RMOs and interns will alternate between the children’s ward and maternity.

See handover section below for specific instructions on handover role.

Each RMO will have an identified consultant supervisor and meet with them in the first week to discuss educational goals. RMOs should indicate their interest in learning procedures such as IVs/neonatal resuscitation/lumbar puncture and will be given opportunities depending on clinical availability and the training needs of more advanced junior staff.

**Result Clinics**

RMOs are required to arrange follow up for elective investigations that we arrange such as follow up hip or renal ultrasounds on infants. Results that should be available within 1 week should be noted in the “Follow up” section on the registrar handover sheet for follow up. Results that will take longer than 1 week should be booked into the RMO result clinic. This requires an EDS to be completed and in the “follow up” section an “RMO result clinic”
should be requested for the appropriate number of weeks hence. The EDS will be forwarded to the OPD who will arrange an appointment time.

RMOs attend the RMO Result Clinic on Tuesday 1pm (JHO or SHO attends as the intern is at Intern training), Thursday at 1 pm (Intern attends) in the children’s OPD. The charts are available and results should be checked and parents notified by telephone. If you are unable to get them on the phone you may dictate a letter using Winscribe or send the parent a text message from outlook.

SMS Text messages are sent by opening your email account, start a new email and in the 'to' field type the mobile number@smsmessages.health.qld.gov.au eg 0412345678@smsmessages.health.qld.gov.au The message is only in the subject line of the email, no information in the body of the email will be sent.

Record all attempts at contact with the parents in the medical notes in the outpatients section. If you are unable to contact the parent with a normal result it is sufficient to attempt a phone call and then send a text or a letter. If there is an abnormal result please discuss the result with a registrar or consultant prior to contact so that you know what to say. Notify a registrar or consultant if you are unable to contact a family about an abnormal result. Significant results require at least 3 documented attempts to contact the family by at least 2 different methods.

If the result is significant and requires further contact with the family then rebook the chart to return to another RMO result clinic.

3.4 Interns

Interns have the responsibilities of the rotating RMOs above but have additional requirements for supervision, goal setting and release to attend specific educational obligations.

Interns will commence at 0700 and assist the RMO with newborn discharges. In the first week of the term interns will be allocated to work in the children’s ward and PESSU following handover but will be allocated to Maternity following initial familiarization.

Interns will have an educational supervisor allocated to them at the start of the term. Please ensure that you have met with your supervisor and have completed the required supervision paperwork including educational goals.

Interns will be released for Intern specific training on Tuesdays and for RMO training on Fridays. Interns attend the RMO result clinic on Thursdays at 1 pm.

Interns will usually not be given opportunities to do procedures on children unless they are already proficient in the procedure (eg IV or venepuncture) on adults.

3.5 Students

The unit has 4 medical students during the term. Medical students should attend the handover at 0800 every day. Students change at times during the term and have different teaching and assessment requirements each week. Students are responsible for writing their first names and contact phone numbers on the white board in the handover room, so that they can be called for clinical opportunities as they arise. Ideally students will also
note which week of the rotation is current and what Polie and assessments are due that week. This information is used at the end of the handover to allocate tasks to medical staff that day.

Students should sit at the back during handover if the room is full, so that doctors participating in the handover can be at the table facing each other.

If you are allocated to the acute ward, you may record in the notes on ward rounds and you may be asked to see a patient and present their progress on the round. Students should be active participants in the acute care wards.

If you are in the outpatient department you will usually be invited to sit in. Do not be late to outpatients. The first patients are often the new patients and you will not be able to enter the room once the consultation has started. This may mean an hour sitting outside because you arrived 5 minutes after the consultant. If you are allocated to outpatients you should leave the handover early enough to be at OPD no later than 0830.

4. Unit Organization

4.1 Rosters and Leave.

a. Rosters are released as far in advance as possible, but are not “published” as a fixed roster until 2 weeks prior to the start of the pay period. While a roster may be issued in draft form 3 months in advance if possible, new leave applications or other factors may require a change in the roster. You will be notified of changes that occur in as much time as possible. Changes after the roster is “published” require negotiation and agreement and must be notified on AVAC forms to the payroll department.

b. Proposed changes to the roster must be approved by Dr Waugh. Junior doctors are not to undertake roster swaps without approval as this may affect MOCA compliance or anticipated skill mix or clinical continuity. Requests for particular days or weekends off should be made to Dale well in advance. Requests will be accommodated if possible, and late requests are more difficult to accommodate.

c. Registrar/PHO and discipline SHO leave applications should be lodged as early as possible. Leave may not be approved if applied for within 6 weeks of the intended dates as this may require cancelling outpatients who have already been notified of their appointments. At least one registrar should be on leave at all times. We will rarely have 2 registrars. Leave may not be approved if a registrar is already on leave and it is a peak activity period. **Do not pay for holidays, courses or airfares without first having written approval for your leave.** Your leave will not necessarily be approved just because you have made a financial commitment. Most registrars/PHOs seek leave at the end of term, but unfortunately this can only be granted to a limited number of people.

Ideally please look at the leave planner and identify available weeks for leave and apply. Please talk with Dale to get access to the current leave planner.
4.2 Handover

Handover occurs at 0800 every day except Wednesday, when it starts at 08:45 following QCH grand rounds. On Wednesday the QCH grand rounds is video conferenced, commencing at 07:45 am.

The night registrar prepares the handover sheet and prints the required number of copies for all attendees, including students. (Usually around 12 copies).

Handover is a registrar to registrar handover, with consultant supervision. It is not intended to be a defacto ward round and should be efficient with the aim to complete in 30 minutes.

ISBAR is the handover format. Please use this explicitly. Identify (name and age), Situation (=diagnosis/differential), Background (brief history), Assessment (current status) and Recommendation/Read back. Please try to avoid long narrative histories. Use appropriate medical terminology and commit to a provisional diagnosis and differential. It is better to be clear and wrong than vague and imprecise.

Handovers also occur in the afternoon when the day registrar/SHO leaves and at night when the evening registrar leaves. The time should be around 30 minutes prior to the end of the shift. There should be a handover with sharing of tasks and responsibilities at the start of the evening shift at 2 pm.

The handover sheet should be updated prior to each handover. The doctor giving the handover is responsible for this. The sheet should have accurate information and minimum required details. Please be pedantic to ensure accuracy of numbers (UR, ages, date of birth etc).

During the morning handover the main participants (night reg, day reg and dSHO, DOW consultant) should have places at the table.

One RMO should sit at the left side computer and call up pathology and radiology results on the large monitor as patients are discussed.

4.3 Admission processes

See admission procedures. Admission Criteria Paeds Ward, Admission criteria PESSU, Neonate direct admission, Direct admission procedure (all are appended at the end of this manual). All patients require a medical admission, including elective admissions for overnight oximetry. All patients should have a weight and height documented in the children’s ward. ED weights should be checked on admission.

Children are exposed to significant risk of witness trauma in Caboolture Emergency Department, because of crowding and the lack of a separate area for children. There is also a strong community expectation that children will be placed in a child-appropriate environment quickly when in hospital.

Children should be moved rapidly from the ED to either PESSU or the ward. Direct admission is supported by the paediatricians at Caboolture and our expectation is that
registrars will not slow transfers by requesting that children wait in the ED for review prior to transfer unnecessarily. Please be active in facilitating transfer of children out of the ED.

For children who have not been seen by the paediatric registrar, safe transfer requires that an ED registrar or ED consultant has reviewed the child within the 30 minutes prior to the child leaving the ED. Children admitted to the ward should come with sufficient orders (IV, Medications, observations) so that the nurses are able to continue care for up to 4 hours. However, our expectation is that direct admissions will be seen within 2 hours of arrival.

Children admitted to PESSU may be eligible for Criteria Led Discharge (see PESSU procedures). If the ED has completed the criteria, there is no requirement for an admission paediatric medical review and the patient can be admitted and discharged directly by the nurses in PESSU. Discharge criteria should be completed by the ED for minor head injuries, post sedation observation, post anaphylaxis and for some children having an oral fluid trial for gastroenteritis. Paediatric registrars may use criteria led discharge for the patients you see in PESSU, and the nurse can then discharge the patient without further medical review if appropriate. This is useful to allow nursing discharge in the morning prior to the medical ward round.

4.4 Ward Rounds

The unit is organized around the consultant schedules. This is currently a 4 week repeating cycle. Each day the acute wards are covered by the “Day Consultant” (also previously known as the “doc of the week” = DOW) and overnight by the consultant on call. A second consultant will do the morning Special Care Nursery (SCN) round and hand over to the DOW consultant around lunchtime.

Handover will be registrar to registrar and supervised by the Day consultant will attend the handover each morning at 0800. Ideally the on call consultant for that night will also attend but this may not always be possible. The overnight on call consultant will attend handover in the afternoon if possible or will obtain a handover from the day consultant.

At the end of the handover the Day Consultant will assign tasks and arrange to complete a ward round.

Special Care Nursery babies are reviewed daily or more frequently if required. Babies requiring oxygen or CPAP for acute respiratory illness should be reviewed at least 4 hourly, and more frequently if unstable.

Babies in SCN requiring IV fluids or antibiotics should be examined at least daily. Babies who are stable premature infants waiting to grow and establish feeds may be examined twice weekly, and should have head circumferences measured weekly on Tuesdays.

On Tuesdays in week 1 there is a consultant meeting at 12 pm followed by a Morbidity and Mortality meeting at 1 pm. Junior doctors are encouraged to attend this Quality Assurance activity.

Weekend handovers are at 0800 and usually the consultant will attend and then conduct a ward round.
4.5 Discharge Processes

**EDS**

Follow up appointments are only made with a completed electronic discharge summary (EDS). All ward inpatients require an EDS to be completed prior to leaving the ward. This should be partially completed on ward rounds if possible and then finalized at discharge. Current medications should be completed accurately in the EDS for discharge. EDS should be brief, and do not require narrative history or irrelevant detail from the admission. It is not a detailed record of the admission, it is a brief handover note to allow the next doctor sufficient information to carry on management.

All EDS should have the follow up field completed as either GP follow up or to return to outpatients. If the consultant requires an OPD appointment the EDS should specify how many weeks or a desired month, and whether the appointment should be with “Paediatrician” (meaning any paediatrician) or with a specific named consultant. Generally follow up will be with “paediatrician” unless the consultant specifies that it should be with a particular paediatrician. In the follow up session, a note is needed to be put if the patient needs a longer appointment for review.

PESSU patients may also have an EDS completed but this is not required if a GP letter has been completed by the ED staff using EDIS. The red sheet at the front of the admission does need to have a brief descriptor of the diagnosis and be signed for coding.

Neonates who are well and “unqualified” (never admitted to SCN) do not require an EDS. If a result check is required then an EDS should be completed to inform the GP and arrange the RMO result clinic appointment.

Newborns who have been “qualified” by admission to SCN or intervention on the maternity ward will require an EDS. This should be done quickly as the chart will be removed for use by the home maternity service and then return for an EDS weeks later if it has not been completed.

Babies who have had complex or prolonged admissions to the SCN should have the EDS done by a registrar or dSHO prior to discharge from SCN to Maternity. Babies who have had very brief admissions for unproven sepsis or minor temperature instability or tachypnea that settles quickly may have the EDS completed by an RMO or Intern.

**Newborns**

Newborns may be discharged by RMOs but should be discussed with a registrar if they are less than 12 hours old. RMOs should not make any referrals without discussion with a registrar.

All newborns should have pulse oximetry prior to discharge (right hand and a lower limb – pre- and post-ductal saturations). Normal results are >= 95%. Please review Appendix A in the “Routine Newborn Assessment” guideline.
4.6 Non-current Patients

The handover sheet will record details for transfers or births awaited and for patients who require phone call follow up. Generally, if results are anticipated within a week, or if the result is likely to be significant/complex, the patient should remain on the handover sheet. Please record a parent’s name and phone number to facilitate contact. A doctor’s name should be associated with follow up patients so it is clear who has the responsibility. Information provided over the phone should be recorded in the chart.

If advice is given to GPs over the phone should be recorded in the book provided in the handover room. The patient’s name and DOB should be recorded along with the advice given.

4.7 Pathology

During morning handover pathology results are viewed in Auscare on the large monitor (the view is enlarged to facilitate reading the results). This facilitates signing off the results as they are viewed at handover.

Junior doctors are expected to sign off pathology in Auscare. Please ensure you are aware of how to do this. Your pathology list that is generated from the start of the term will be monitored by your supervising consultant to ensure that results are viewed and signed off. There are no printed results for inpatients in the children’s ward so please ensure that you are compliant with this by signing off results every shift and as you see results. You should not only sign off the results that you ordered. If you have seen and acted on the result for a test ordered by the registrar on the previous shift, sign it off.

Each junior doctor in Paediatrics is informed of their Caboolture Auslab code. This is a 4 letter shortening of your name, possibly with a number. It is essential that you write this in the appropriate place on the request form whenever you order pathology, along with the correct consultant’s name. Failure to do so means that pathology results will not be allocated correctly and there will be a delay before they eventually find their way to you, when you may no longer remember the patient.

4.8 Outpatients

Registrars/PHOs may be required to attend outpatient clinics. These clinics will be supervised by nominated supervisor.

The registrar allocated for clinic will be identified on the registrar roster.

All patients should have a letter dictated. When starting a dictation, state your name and “General Paediatrics for Dr …” naming the relevant consultant. You also need to state the patient’s name, DOB and UR number for correct identification. Letters from registrars should have the format below, using the bold words as headings in the letter. It is intentional to have the Diagnosis list/medications/Referrals/follow up plan at the start of the letter for ease of use by the GP.
Dear Dr (GP name)

Patient details. (name, DOB, UR.

Seen by (your name) in Dr (Name of consultant)’s clinic.

State age of the child and who attended the consultation.

**Diagnosis (Problem) List:**
1. a
2. b
3. c

**Medications:** include the current medications following the consultation, not what they were before the consultation. State “nil” if there are no prescribed medications.

**Follow up:** This should include when the patient is to be seen again, what referrals and investigations are planned and what referrals if any are requested from the GP.

**History**
Brief assessment or history. Be concise and use appropriate medical terminology.
4.9 Clinical Meetings

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5. Specific Presentations

5.1 Neonatal Presentations.

Please refer to the Maternal and Neonatal Guidelines on QHEPS.

Developmental Dysplasia of the Hip.

If you think that the hip is unstable or suspicious, an ultrasound should be ordered and a decision made about treatment before the baby is discharged from hospital. The outcome of DDH is better with early bracing.

Outpatient neonatal hip ultrasounds should be ordered when there is a chance that a hip that currently does not have DDH may develop dysplasia in future. Risk factors for this include previous infant with DDH, breech presentation, other significant compression (talipes, torticollis). If a hip was initially unstable and then stabilizes in the first few days of life a follow up scan should be ordered.

Renal Pelvis Dilation.

This is a common presentation from the antenatal ultrasound. An ultrasound after the first postnatal week should be done to confirm if the finding is still present. The delay is to ensure the baby has established feeds and is well hydrated.

In the postnatal scan, measurements up to 6 mm require no further action. Between 6-10 mm a follow up ultrasound should be done around 6-8 weeks. If it remains <10 mm and the baby is well no further action is required.

If a postnatal scan shows >or =10mm pelvis size, further investigation for ureteric obstruction may be required and the case should be discussed with a consultant.

This advice assumes that the baby is well and has not had a urinary tract infection.

5.2 Diabetes Service:

Our Team:
Diabetes Clinic Lead: Dr Sudeep
Paediatrician: Dr Salil Gandhi
Educators: Annette Keid, Marcus Kacprzak
Dieticians: Genevieve Mathieson and Gail Zammit
Psychologist: Vicky Green
Social Worker: Kim Gabriel
Exercise physiologist: Scott Quigg
There are approximately 110 children with Type 1 Diabetes being looked after by the Paediatric Diabetes Service.

The service runs an outpatient clinic on Monday afternoons from 12:30pm to 4:30pm. This is a multidisciplinary clinic with clinicians, diabetes educators, dietician, social worker and when required, a psychologist. These children also have access to an Exercise Physiologist. Each child has a designated case manager.

Type 1 Diabetes kids are followed up by Allied Health and Diabetes Educators in Community in between their clinic appointments.

Caboolture teams maintain electronic records of their consultation via a care plan called “My Plan’. Login and password are pasted on the computer in the Paediatric Hand Over Room. Registrars have an access to these plans for reviewing purposes only. Every child has two sets of case notes; Community and Hospital. Outpatient consultations are only documented in the Community Chart. These charts can be requested by calling the ESO on ext. 8350 during business hours Monday to Friday.

All newly diagnosed patients are admitted to Paediatric Ward for treatment and education. Please call the Diabetes Educator on ext. 8350 to organize for the Diabetes Team to review a patient. Please fill out, sign and fax a Community referral form for all hospital consultations.

There are separate protocols/guidelines for management. We follow the Australasian Paediatric Endocrine Group (APEG) guidelines which can be found at: http://www.apeg.org.au/Default.aspx?tabid=36
These are national evidence based clinical guidelines for Type 1 Diabetes in children, adolescents and adults.

Resources:
- DKA Guidelines
- APEG Guidelines
- Basic information for children diagnosed with Type 1 Diabetes
- Caring for diabetes in children and adolescents (A parents’ manual)

Hard copies of these resources can be found in the Paediatric Ward.

5.3 Child Protection

All paediatric medical staff should be familiar with reporting processes and resources available at Child Safety Reporting resources.

The Child Protection Liaison Advisor is Dr John Waugh with Dr Lisa Kane assisting.
The Child Protection Team at Caboolture consists of:
Katie Johnston - CN/CPLO
Julie Gould - CPU RN/CPLO
Rachael McCall – CPU SW/CPLO
Josephine (Jo) Hodgkinson - AO.

If you are concerned about the possibility of physical abuse an early discussion with the day consultant or on call consultant is required. You should have the following history if possible:

- Exact age of the child in years and months.
- Mechanism of injury and whether this is from a firsthand witness, or is a presumed mechanism. Who is a firsthand witness?
- Examination findings for the physical abuse.
- Developmental status of the child to give an indication of whether the mechanism is possible.
- Social history – who is in the house, other risk factors – new partner, mental health, drug and alcohol use if possible.

If there is an allegation of sexual abuse you should discuss with the consultant prior to any attempt at examination unless there is a history of severe pain or bleeding suggestive of an acute injury requiring urgent medical attention. Usually genital examinations can be deferred to be done electively. We generally do not do sexual abuse examinations without a request from the department of child safety or the police. These examinations are only performed by consultants.

5.4 Department of Child Safety requests for assistance

Sometimes the Department of Child Safety will request that a child be admitted overnight for protection. We resist this and will not agree to do so in almost all circumstances. It is an inappropriate use of health resources and may result in prolonged unintended admissions. Avoidance of emergency foster care allows families to stay in denial about the level of child safety intervention.

Registrars should never agree to “social admissions” without discussion with the consultant on call. The department of child safety is required to provide emergency foster placement. We will not consider ‘social admission” until after the department of child safety have explored other options.


Junior doctors should have learning objectives specified with their supervisor at the start of the term. This applies to all levels of junior doctor, although the content and format will depend on the junior doctor's level of training and college training obligations.

Below is a list of potential topics for use by Interns and RMOs. (acknowledgement to Redcliffe Hospital for permission to copy this from the Redcliffe manual.)
LEARNING OBJECTIVES

A term in paediatric medicine will provide Residents an opportunity to:

- Consolidate understanding of normal growth and development
- Develop confidence in dealing with sick children and their families
- Learn about disease processes largely confined to the paediatric population
- Improve paediatric clinical skills
- Experience differences between paediatric and adult medicine

Residents are expected to develop their own learning objectives for this rotation in consultation with the Unit Educational Supervisor during the first few days of the rotation using the Agreed Learning Objectives form (Appendix 3). You should refer to this form at your mid and end of term interviews where you can monitor your progress and set reviewed goals for further progress and development.

By the completion of this rotation, it is expected that you will be able to:

- Competently demonstrate appropriate skills in taking a paediatric history and performing an examination in children of all ages.
- Appropriately utilise and interpret growth charts.
- Recognise the importance of the physical, neurological and psychological development in children.
- Demonstrate ability to perform a screening developmental assessment.
- Competently demonstrate appropriate skills in emergency department assessment and consultation of paediatric patients.
- Recognise and manage the sick child including appropriate consultation and referral.
- Understand fluid and electrolyte management in paediatric patients.
- Appropriately manage fluid and electrolyte disturbances relevant to paediatrics.
- Correctly utilise and manage medications in children.
- Demonstrate well developed communication skills with parents and children.
- Demonstrate confidence in neonatal resuscitation.
- Demonstrated ability and confidence in the assessment of well newborn babies and be familiar with common 'normal' neonatal variations.
- Demonstrate competency in the diagnosis and management of common paediatric conditions including
  - Febrile child without an apparent focus of infection
  - Gastroenteritis
  - Asthma
  - Pneumonia
  - Bronchiolitis
  - Croup
  - Urinary tract infection
  - Febrile convulsions
  - Abdominal pain
  - Ingestion/poisoning
  - Behavioral problems
- Demonstrate an understanding of the principles of management of the following neonatal conditions (with appropriate supervision)
- Neonatal fever
- Jaundice
- Hypoglycemia
- Respiratory distress
- Problems associated with preterm/LBW infants e.g. temperature, feeding, infection
- Glucose homeostasis

- Demonstrate proficiency in the following practical skills and procedures (with appropriate supervision)
  - Insertion of IV catheters and collection of venous blood
  - Other paediatric procedures such as urinary collection
  - Insertion of a NGT
  - Lumbar puncture
  - Resuscitation (BLS)

- Learn how to recognise the sick child.
- Learn when to ask for help.