

## Pediatric Case Log System Update

The Residency Review Committee for Pediatrics (RRC) has made modifications to the Resident Case Log System based on feedback from users and APPD. The following changes will be in effect for the July 1, 2004 rollout.

1. The list of procedures tracked in the System has been further refined and narrowed. Residents will only be asked to enter those procedures for which the RRC needs to capture national level data. As a result, the procedures have been grouped and listed in three categories. The first group contains procedures that need to be tracked throughout training (endotracheal intubation, umbilical artery catheter, umbilical vein catheter, and lumbar puncture). The second group contains procedures tracked until competence is achieved (arterial puncture, placement of intravenous line, venipuncture, suturing of laceration, splinting of simple dislocation, and bladder catheterization). The last group is the listing of additional procedures. These are procedures that the RRC is not currently requiring be entered, but are listed and available for tracking.
2. Additionally, the System has been changed so that programs/residents can indicate the name of the specific individual who supervised the resident during the procedure/encounter. The previous list of supervisors (attending, other, other supervising resident, PL-2, PL-3, or subspecialty resident) will remain, but programs will have the option of adding the specific names of the various potential supervisors. While the System requires a supervisor to be indicated, it is the program's choice as to whether they want their residents to use the generic options or enter the individual.

If your program wants to add the supervisor's names, go to the "Program Setup" tab in the Case Log System when logged in as the program director or administrator. Using the "Add/Update" link the names can be entered and residents will be able to select them from the dropdown list when entering a patient encounter.

3. Also, an additional field has been added to the System so the resident can indicate the appropriate competence level for the procedure entered. The options are: N/A, practice independently, and practice with supervision. The N/A option is available because the System has been deliberately designed to allow residents the capability to enter patient encounters other than just procedures (i.e. diagnoses) and the competence level would not necessarily apply in these instances.
4. Finally, remember that there is an export function available within the Resident Case Log System. At any time, a program or resident can request a tab-delimited ASCII file containing all of the data entered into the System. The request can be for a particular timeframe or for all data entered up to that point. Also, the program can get the data for an individual resident or all residents in

the program. You can use this file for whatever you need, including running customized reports or loading into another database.