The Philippine
Pediatric Society, Inc.

HOSPITAL ACCREDITATION BOARD 2019

ACCREDITATION AND CURRICULUM MANUAL OF PEDIATRIC RESIDENCY PROGRAM (2019)

SECTION ONE

BASIC

AND

QUALITY STANDARDS

OF THE PEDIATRIC RESIDENCY PROGRAM

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FOREWORD

The Philippine Pediatric Society Inc. Hospital Accreditation Board (HAB) has revised the 2013 HAB Accreditation and Training Manual and changed the Competency Based to Outcome Based Education Curriculum.

Modern medical education and higher education training has taken the trend of moving towards demonstration of "intended or desirable outcomes". An "outcome" refers to high quality culminating observable demonstration of significant learning that occurs after a set of learning experiences. Through the years, its meaning has evolved from one that emphasizes knowledge through concepts, theories and methodologies (content based) to one that integrates knowledge, skills and attitude into an attribute called "competency" (competency based) to one that demands that competency be performed in real world situations judged using authentic assessment tools (outcomes based).

The Philippine medical education system which largely serves as the foundation of offshoot clinical training programs like internship, residency and even fellowship must make the shift to outcome based teaching-learning models because of the following reasons: (1) it focuses on outcomes enabling our current higher education systems to address concerns on accountability and effectively pairs legislative control with institutional autonomy; (2) it lays down intended learning outcomes of an institution and commits its educational resources until goals are achieved; (3) it is the benchmarking concept in higher education and training and; (4) it aims to organize a work-integrated education at the program level.

It is about time the PPS reorients its training program to that which is "trainee centered, clear, designed with the end in mind, expanded with numerous opportunities for consistent achievement of success". The shift from a training syllabus to a training learning program, from mostly summative to more frequent formative assessments is all constructively aligned horizontally and vertically.

Allow me to congratulate the Hospital Accreditation Board (2018-2020), our dedicated, passionate and skilled Dr. Melinda M. Atienza, HAB secretary, our "compleat medical educator", former Chancellor Ramon L. Arcadio and the Committee on Curriculum chaired by Dean Madeleine Grace M. Sosa for bringing into fruition this milestone endeavor intended to raise the bar of excellence in the practice of pediatric medicine in the Philippines.

The PPS sincerely wishes that our training institutions and their deeply committed pediatrician-mentors find genuine use and productivity in the utilization of this document.

Mabuhay ang PPS!

SALVACION R. GATCHALIAN, MD
President
Philippine Pediatric Society, Inc.

PREFACE

The Hospital Accreditation Board (HAB) of the Philippine Pediatric Society is mandated to develop and regularly update the basic and quality standards of the pediatric training programs nationwide. As of 2020, there are **110** accredited pediatric residency training programs: **56** level I, **36** level II, **14** level III and **4** level IV.

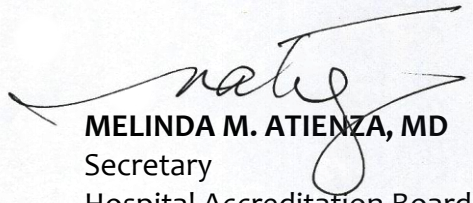
There is a need to continuously revisit, review and revise the existing standards on the implementation and evaluation of the training programs in accordance with the directive of the Commission on Higher Education (CHED) using the World Federation of Medical Education (WFME) framework for Postgraduate Medical Education.

The HAB and its members and the Committee on Curriculum reviewed and revised the 2013 Accreditation and Curriculum Manual of Pediatric Residency Training. We have added another Accreditation Area, that of TRAINEES, hence there are now a total of eight (8) evaluation areas. We have improved the self-assessment instruments to make it relevant and effective. Likewise, weight values of the different evaluation areas and the computation instruments were revised.

In Section 2 of the Manual, the Outcome-Based Education Pediatric Residency Curriculum based on CHED, AGME, WFME and PRC was included. A template of the instructional design in general pediatrics and subspecialties was made to guide the departments to draft their own OBE curriculum.

My sincere appreciation and gratitude go to the hardworking and dedicated members of the HAB (2018-2020) and the Committee on Curriculum who have worked hard in coming up with a Manual our Society can be proud of. Their passion, wisdom, commitment and vision have brought into fruition this revised 2019 HAB Manual.

I encourage all PPS-HAB accredited hospitals to use this revised Manual to guide them in their mission to come up with the best training program they can offer their trainees.



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THE PHILIPPINE PEDIATRIC SOCIETY HOSPITAL ACCREDITATION BOARD (HAB)

1. Composition: The members of the Hospital Accreditation Board (HAB) shall be sixteen (16) Fellows of the Philippine Pediatric Society who have been in good standing for at least the five preceding (5) years.
    - 1.1 President – as Chair
    - 1.2 Vice President - as Co-chair
    - 1.3 Immediate Past President
    - 1.4 The HAB Secretary, a voting member, is a Fellow appointed by the President and approved by the BOT with a term of two (2) years.
    - 1.5 The following members shall be appointed by the President and approved by the BOT
        - 1.5.1 Four (4) members from the Specialty Board
        - 1.5.2 Four (4) Past Presidents
        - 1.5.3 Four (4) appointees with a tenure of one (1) year each with an academic rank of at least associate professor, past chair of accredited residency training program, or past chapter president:
            - 1.5.3.1 two (2) from Luzon
                - 1.5.3.1.1 one (1) from the North of NCR
                - 1.5.3.1.2 one (1) from the South of NCR
            - 1.5.3.2 one (1) from the Visayas
            - 1.5.3.3 one (1) from Mindanao

    - 1.6 The Assistant Secretary of the BOT, a non-voting member assists the Board Secretary

    - 1.7 When deemed necessary, the president shall appoint hospital accreditation deputies to assist the HAB in site visits and evaluations. Deputies shall consist of Fellows who shall meet any of the following requirements.
        - 1.7.1 A past president
        - 1.7.2 A previous member of HAB
        - 1.7.3 A current or past chapter president
        - 1.7.4 A current or past chair of a department of pediatrics with at least level II accreditation.

2. Functions of the Board are as follows:

    - 2.1 Develop and regularly update the basic and quality standards of the HAB for Pediatric Residency Training Programs.

    - 2.2 Develop and regularly update the basic and quality standards of the Subspecialty Fellowship Training Programs in coordination with the Council on Subspecialties and Sections.

    - 2.3 Accredit/Reaccredit the Departments of Pediatrics for residency training programs.

    - 2.4 Recognize Subspecialty Fellowship Training Programs that are accredited by the respective Subspecialty Societies and Sections

2.5 Offer training seminars, workshops and lectures for Pediatric Teaching Consultants.

2.6 Assist Departments of Pediatrics in developing innovative strategies in implementing the Department-selected curriculum.

2.7 Administer formative Written In-Service Examinations (WISE) for residents-in-training.

3. The HAB Fund shall consist of accreditation and WISE fees paid by institutions to PPS.

GENERAL GUIDELINES FOR THE ACCREDITATION OF A PEDIATRIC RESIDENCY PROGRAM

1. The PPS-HAB Accreditation

1.1 The PPS Accreditation is a status granted to a pediatric residency program as recognition that it has met the standards of quality and excellence set by the Hospital Accreditation Board.

1.2 It is founded on the concepts of self-regulation focused on evaluation and the continuing improvement of educational quality and services.

2. The Three Stages of the PPS-HAB Accreditation Process

2.1 Departmental self-assessment of the pediatric residency program

2.1.1 This is an essential aspect of the PPS accreditation process. This is where the department does a critical review and assessment of its organization and program, and how these align with those of the PPS and the HAB. The self-assessment is an analysis of the department's educational resources and effectiveness by its own consultants and residents. It demonstrates a responsibility inherent in education and in the continuing development of a department of pediatrics offering a postgraduate residency program. The activities include a thorough self-examination based on the evaluation instruments provided by the HAB.

2.1.2 Accreditation documents must **be received by the HAB** not later than six (6) months before the expiration of the Program's current accreditation

2.2 The Formal Accreditation Visit

2.2.1 The Accreditation Team is composed of at least two members of the HAB and/or deputies.

2.2.2 The primary task of the accrediting team is to validate claims and statements in the self-assessment report and confirm alignment with the PPS and HAB Standards through the following activities:

2.2.2.1 Dialogue with the representatives of the consultant staff
2.2.2.2 Dialogue with the residents
2.2.2.3 Separate or joint interviews with the department chair, vice-chair, training officer, chief resident and other officials of the hospital
2.2.2.4 Observation of any ongoing clinical conference, lecture or training activity
2.2.2.5 Inspection of physical facilities

2.2.2.6 Examination of exhibits, documents, publications, logbooks, minutes of departmental meetings, manual of standard operating procedures (SOP), development plan, research papers, etc.

2.3 Evaluation by the Hospital Accreditation Board (HAB)

2.3.1 The accrediting team submits a formal assessment of the accreditation visit and the Summary Report Form to the HAB, to include recommendations for improvement when deemed appropriate and necessary. (See Appendix 8 & 9)

2.3.2 The HAB evaluates the report and makes a decision on whether or not to grant accreditation.

3. **Areas to be evaluated**

3.1 Vision-Mission
3.2 Training Program
3.3 Trainees
3.4 Consultants
3.5 Administration
3.6 Patient Services & Facilities
3.7 Research
3.8 Community Involvement
(see Appendix 1 – PPS HAB Visitation Guide)

4. **Levels of Accreditation**

For purposes of receiving benefits and progressive deregulation, Pediatric Residency Programs are classified by the HAB in one of four (4) accredited levels.

4.1 **Level I accredited/re-accredited status**: Residency programs which have been granted initial accreditation or re-accreditation effective for a period of three (3) years based on the appraisal of the HAB. These programs have met the minimum requirements for a 3-year residency program. They have also met the following additional criteria:

4.1.1 The Neonatal Unit is classified as Level II by the HAB, based on standards set by the Philippine Society of Newborn Medicine.

4.1.2 The Pediatric Intensive Care Unit (PICU) is classified as level I PICU based on the standards of the Society of Pediatric Critical Care Medicine Philippines (SPCCMP)

4.1.3 A creditable performance in the PPS specialty board certifying examination over the last three (3) years as determined by the HAB. All graduates must take the examination within two (2) years of graduation and at least fifty percent (50%) must pass.

4.1.4 The department applying for initial accreditation must have been in existence for at least one (1) year. Once the program starts, it is given five (5) years to achieve the above (section 4.1.2) at which time it is expected that there will be graduates of the program for the last three (3) years.

4.1.5 Twice weekly community service must be rendered by the trainees.

4.1.6 A Level I Program must meet the standards and be promoted to Level II within 12 years of its commencement.

4.2 **Level II re-accredited status**: Residency programs which have been re-accredited effective for a period of three (3) years based on the appraisal of the HAB. In addition to the criteria in Level I, these programs have met the following additional criteria:

4.2.1 A creditable performance in the PPS specialty board certifying examination over the last three (3) years as determined by the HAB. All graduates must take the examination within two (2) years of graduation and at least sixty percent (60%) must pass.

4.2.2 A reasonably high quality of instruction in general pediatrics as evidenced by:

4.2.2.1 a significant number of general pediatric admissions
4.2.2.2 a variety of clinical/teaching activities in general pediatrics
4.2.2.3 a daily (Monday to Friday) general pediatric service clinic for indigent patients.

4.2.3 Thrice weekly community service must be rendered by the trainees.

4.2.4 A Level II PICU based on standards of Society of Pediatric Critical Care Medicine Philippines (SPCCMP)

4.2.5 A Level II NICU based on NEOHAB classification

4.3 **Level III re-accredited status**: Residency programs which have been re-accredited effective for a period of four (4) years based on the appraisal of the HAB. In addition to the criteria in Level II, these programs must satisfy the first five (5) of the following additional criteria (4.3.1 to 4.3.5), and at least one (1) of the remaining three (4.3.6 to 4.3.8):

4.3.1 A high quality of instruction as evidenced by the presence of four (4) subspecialty programs for residents. The in-patient services and outpatient clinics are functioning.

4.3.2 The Neonatal Unit is classified as Level III by the HAB based on standards set by the Philippine Society of Newborn Medicine.

4.3.3 A Level II Pediatric Intensive Care Unit. (See Appendix 6)

4.3.4 A highly creditable performance in the PPS specialty board certifying examinations over the last four (4) years as determined by the HAB. All graduates must take the examination within two (2) years and at least eighty percent (80%) must pass.

4.3.5 Daily community service must be rendered by the trainees. Existence of integrated programs or linkages with other pediatric agencies including schools, to include memorandum of agreement, description of the nature, mechanism, and other details must be submitted as documentary evidence.

4.3.6 A highly visible research achievement. The following must be observable over a reasonable period of time:

4.3.6.1 reasonable budget
4.3.6.2 quality of research output
4.3.6.3 number published or given awards
4.3.6.4 number read in scientific conferences or conventions
4.3.6.5 visible, tangible and measurable impact on the community

4.3.7 A strong faculty achievement as evidenced by lectures delivered in scientific conferences, research output, awards received, training conferences attended, and other details.

4.4 **Level IV re-accredited status**: Residency programs which have been re-accredited effective for a period of five (5) years based on the appraisal of the HAB. They are highly respected as very high quality training programs in the Philippines and carry the prestige and authority comparable to similar programs in excellent foreign medical centers. In addition to the criteria in Level III, these programs must have met the following additional criteria:

4.4.1 A high quality instruction as evidenced by the presence of seven (7) subspecialty programs for residents. The corresponding in-patient services and outpatient clinics are functioning.

4.4.2 A Level III Neonatal Unit and a Level II Pediatric Intensive Care Unit carry state-of-the-art equipment and facilities. (See Appendices 5 & 6)

4.4.3 A highly creditable performance in the PPS specialty board certifying examinations over the last five (5) years as determined by the HAB. All graduates must take the examination within two (2) years and at least ninety percent (90%) must pass.

4.4.4 Excellent outcomes in research as seen in the number, scope, and impact of scholarly publications in refereed national and international journals.

4.4.5 Excellent outcomes in community involvement using the model selected or developed by the department.

4.4.6 Excellent outcomes in the demonstration of the program's social accountability in teaching, service, and research using the WHO criteria of relevance, quality, equity, and cost-effectiveness.

4.4.7 Excellent outcomes in international linkages and consortia as evidenced by existing memoranda of agreement, resident and consultant exchange program, joint researches, visiting lecturer program.

5. The accreditation report is subject to deliberation and the decision of the HAB is final.

SPECIAL BENEFITS CORRESPONDING TO ACCREDITATION LEVELS

1. Level I
   1.1. Official recognition by PPS as accredited training program for three (3) years
   1.2. Residency graduates may apply to take immediately the written part (Part 1) of the Specialty Board Examinations, and the oral examination (Part II) after two (2) years of pediatric practice, subject to the approval of the Specialty Board

2. Level II
   2.1. Official recognition by PPS as accredited training program for three (3) years
   2.2. The department is eligible to apply for a PPS research grant
   2.3. Residency graduates may apply to take the written part (Part I) of the Specialty Board Examinations and oral examination (Part II) after two (2) years of pediatric practice, subject to the approval of the Specialty Board
   2.4. The department may offer one scientific forum every two (2) years

3. Level - III
   3.1. Official recognition by PPS as accredited training program for three (3) years
   3.2. The department is eligible to apply for a PPS research grant.
   3.3. The department is eligible to apply one general CME/scientific –forum course and one subspecialty post-graduate course annually.
   3.4. The Chief Resident may apply for written examination (Part I) immediately and oral examination (Part II) after one (1) year of pediatric practice subject to the approval of the Specialty Board.
   3.5. The other residency graduates may apply for written Specialty Board examination (Part 1) immediately and oral examination (Part II) after two (2) years of pediatric practice subject to the approval of the Specialty Board.

4. Level - IV
   4.1. Official recognition by PPS as accredited training program for five (5) years
   4.2. The department is eligible to apply for several slots of PPS research grants.
   4.3. The department is eligible to offer one general CME/postgraduate course and several subspecialty CME courses annually.
   4.4. The Chief Resident may take the written and oral (Part 1 & II) Specialty Board examinations immediately subject to the approval of the Specialty Board.
   4.5. The other residency graduates may apply for written examination (Part I) immediately and oral examination (Part II) after one (1) year of pediatric practice subject to the approval of the Specialty Board.

GUIDELINES FOR GRANTING RE-ACCREDITATION

1. For any hospital to be accredited, the areas of Training Program, Trainees and Consultants must have a rating of at least three (3) in all components. A rating of three (3) is considered good and passing.

2. Progress Report
   If only one (1) area other than the Training Program, Trainees and Consultants is rated below three (3), the hospital is granted accreditation but is required to submit a progress report within three (3) months **except** for community.

3. Interim Visit
   If two (2) or three (3) areas other than the Training Program, Trainees and Consultants are rated below three (3), an interim visit will be required within six (6) months. After two (2) interim visits and there is no improvement, the Accreditation status will be downgraded.

4. Deferment

   4.1. If one or two of the three (3) items in either the Training Program, Trainees or Consultants is/are rated below three (3), the accreditation will be deferred.
   4.2. If all the three (3) areas ---Training Program, Trainees and Consultants--- are rated below three (3), the accreditation will be revoked. They may reapply after a year.

All other cases are subject to deliberations of the HAB. The decision of the HAB is final.

THE SELF-ASSESSMENT PROCESS

1. Advantages of the Self-Assessment Process

1.1. It serves to point out the strengths of the department of pediatrics and its residency program.

1.2. It helps to diagnose difficulties, weaknesses or gaps in the department of pediatrics and its residency program, provides a basis for making decisions about needed improvements, and assists in setting up priorities for such improvements.

1.3. It leads to the realization by all those involved that the department of pediatrics has many component parts— administration, trainees, consultants, nursing and paramedical personnel, a residency training program, services, research activities, resources and facilities—each of which relates to or affects the others, so that decisions and revisions affecting any one of component parts will affect, to varying degrees, some or all of the parts.

1.4. It enables a department of pediatrics to see itself objectively.

1.5. It can assist the department of pediatrics in identifying new problems, opportunities and threats in developing consensus or future departmental priorities in step with the times, and in proposing strategies not yet included in other plans.

2. **The Self-Assessment Process Step-by-Step**

2.1 **STEP ONE:** Write a letter of application for re-accreditation to the PPS Hospital Accreditation Board six (6) months before expiration of current accreditation.

Write: The President
President, Philippine Pediatric Society
52 Kalayaan Avenue
Diliman, Quezon City

Telephone: 8 926-6758 to 59; 8 922-2435
Fax: 8 926-2381
Email: ppsinc@pps.org.ph

For first-time applicants, a letter must be sent to PPS HAB c/o the PPS President (see above) citing the cogent need to offer a residency training program. Following due deliberation, the Board either approves or denies such application. If approved, the new applicant will be instructed to proceed with the Self-Assessment Process (STEP TWO).

2.2 **STEP TWO:** Organize a Self-Assessment Committee / Staff

2.2.1 The PPS HAB recommends that the entire department of pediatrics---administration, consultant staff, trainees, nurses and paramedical personnel—participate in the process.

2.2.2 The department chair shall organize a Self-Assessment Committee or Staff composed of a chair, vice-chair, secretary and two (2) members (consultant and resident) for each area to be evaluated, namely:

a. Vision-Mission
b. Training Program
c. Trainees
d. Consultants
e. Administration
f. Patient Services/Facilities
g. Research
h. Community Involvement

2.2.3 The Self-Assessment Committee/ Staff will organize, plan and manage the departmental self-assessment in all the areas.

2.2.4 The Self-Assessment Committee/ Staff secretary shall keep a record of all meetings and accomplishments. These minutes should be available among the exhibits to be viewed by the HAB accreditors during the formal visit.

2.3 **STEP THREE:** Formulate /Reformulate / Reaffirm the department's vision-mission statement.

2.3.1 The self- assessment exercise begins with the vision-mission. This must be accomplished before the evaluation begins, since all other areas will be surveyed in view of the vision-mission of the department. The consultant assigned to evaluate the vision-mission should complete his/her work first and make a presentation to the whole department assembled in a plenary session.

2.3.2 If there is no departmental statement of its vision-mission (which is unlikely), then it has to be FORMULATED at this point. If the vision-mission statement is outdated or unclear, then it has to be REFORMULATED. If the vision-mission is updated, clearly stated and still relevant, then a REAFFIRMATION by the whole department is all that is needed.

2.3.3 For the purposes of this self –assessment the following definitions may be adopted. "VISION" refers to the long-term picture of what the department will be in the future. It is a statement of being. A statement of the long-term aspirations and dreams of the members of the departmental staff. On the other hand, "MISSION" is a statement of doing. It is the department's commitment. It is a declaration of how to achieve the vision.

2.3.4 A department of pediatrics should determine its vision-mission in receiving resident trainees and offering them instruction. The vision-mission should be determined in consideration of the stakeholders which it intends to serve and the needs of the community in which it exists. An agreement between the actual practices of the department of pediatrics should be apparent.

2.3.5 Based on the vision-mission statement, write the goals and objectives for the department's key result areas. The vision-mission statement will also guide the preparation of the long term and short-term development plan of the department of pediatrics.

2.3.6 After the vision-mission has been accepted by the whole departmental consultants and residents, the concerned personnel shall prepare the organizational charts, and needed guides on departmental policies such as: Standard Operating Procedures (SOP) for each pediatric area, job descriptions, department manual, handbooks, etc.

2.3.7 The department of pediatrics' vision-mission is not something that has to be revised with each PPS-HAB accreditation cycle or with every appointment of a new department chair. The vision-mission statement is a long-term aspiration that successive department chairs should look up to and translate into development programs during their term as department chair. The department's vision-mission is "carved in stone" and ideally should be relevant for many decades. New and/ or revised short term goals and objectives however may be formulated with each new administration. These should be in consonance with the department's long-term vision-mission.

2.4 **STEP FOUR:** Answer the eight (8) Evaluation Instruments and compute the ratings for each of the eight (8) areas

2.4.1 Each Evaluation Instrument has a brief description which forms the basis for evaluation. This describes the concept behind the criteria for each of the eight (8) evaluation areas.

2.4.2 This is then followed by the main Evaluation Instrument. The Instrument consists of a series of statements delineating traits, provisions, conditions or characteristics found in good pediatric departments and its residency programs.

2.4.3 Evaluations represent the best judgment of those making the evaluation after all the evidence has been considered. The following rating scale will be used:

5- Excellent Compliance : Meets all provisions of the standards
4- Very Good Compliance : Meets most provisions of the standards
3- Good Compliance : Meets some provisions of the standards
2- Fair Compliance : Meets few provisions of the standards
1- Poor Compliance : Fails to meet provisions of the standards

2.5 **STEP FIVE:** Prepare the appendices to the Self-Assessment Report and the exhibits for the formal visit.

2.5.1 The preparation of the appendices should be done throughout the self-assessment process. Appendices are evidences of the fulfillment of requirements. These should form part of the Self-Assessment Report. The PPS-HAB secretariat will provide a checklist of required appendices.

2.5.2 The exhibits required during the formal accreditation visit should also be prepared throughout the Self-Assessment process. The PPS-HAB secretariat will provide a checklist of required exhibits.

2.6 **STEP SIX**: For each of the eight (8) areas, describe the "ACTION TAKEN" on all "RECOMMENDATIONS" during the last accreditation visit.

2.6.1 The "HAB Recommendations" should be listed on the left column and the "ACTION" taken (implemented, partially implemented, not implemented) should be described on the right column as follows:

HAB RECOMMENDATIONS/ACTION TAKEN (Implemented; Partially Implemented, Explanation; Not Implemented, Explanation)	**ACTION TAKEN**
1.	1. Implemented
2.	2. Partially implemented/Explanation
3.	3.Not implemented/Explanation

2.7 **STEP SEVEN:** For each of the eight (8) areas, formulate the "BEST FEATURES" (strengths of the area) and the "RECOMMENDATIONS" (weaknesses of the area).
The format is as follows:

BEST FEATURES (strengths of the area)
The committee commends:
1.
2.

RECOMMENDATIONS (weaknesses of the area)
The committee recommends:
1.
2.

2.8 **STEP EIGHT:** Compute the Statistical Rating.
The computation formula is indicated in the Evaluation Instrument

See Appendix 10 – PPS Statistical Rating (Self-Assessment Form)

2.9 **STEP NINE:** All the eight (8) area reports are presented by the Self-Assessment Committee/ staff to the departmental consultants and residents in a formal meeting.

2.9.1 A plenary meeting of all the departmental consultants, residents, nurses, paramedical and administrative personnel should be called. The eight (8) area reports are then presented by the consultants assigned.

2.9.2 Further corrections, additions, changes are given and taken in good spirit and are integrated into the report.

2.9.3 The Self-Assessment Committee/ Staff resolve any conflict that may arise.

2.10 **STEP TEN:** Prepare the final Report of the Department's Self-Assessment of the Pediatric Residency Program. The Self-Assessment Committee/ Staff shall prepare the final report for submission to the PPS Hospital Accreditation Board. The contents of the final report are as follows:

2.10.1 Chairperson's Report

This report must discuss:

a. An exposition of the "state-of-the-department" considered especially in light of the departmental vision-mission and goals.

b. An overall interpretation of the self-assessment, succinctly evaluating the status of the department in view of its vision-mission, goals and its potentials.

c. A brief summary report of the self-assessment process including:
   - Composition of the Self-Assessment Committee/ Staff
   - Starting and terminal dates of the self-assessment
   - The schedule of work followed

2.10.2 History of the department and the mother institution

2.10.3 Departmental vision and mission statements

2.10.4 Goals for the Key Result Areas

2.10.5 Development Plan (both Long Term and Short Term)

2.10.6 The eight (8) area reports. Each area report shall include:

- The accomplished Evaluation Instrument and Area Rating
- The previous "HAB Recommendations" and the "Action Taken"
- The "Best Features" and "Recommendations"
- The relevant appendices

2.10.7 The overall Statistical Rating Sheet

3. **Submission of the Departmental Self-Assessment of the Pediatric Residency Program**

   Two compiled copies of the Departmental Self-Assessment report along with other appendices and requirements should be submitted to the PPS HAB Secretariat six (6) months prior to the visit.

4. **Conclusion:** The self-assessment process serves as a great incentive for the self-improvement of the department of pediatrics and its residency program. The prospect, however, of an accreditation visit is an even more powerful incentive to self-improvement.

BASIC AND QUALITY STANDARDS
FOR A PEDIATRIC RESIDENCY PROGRAM

1. GOAL

The Pediatric Residency Program shall provide the opportunity for the acquisition of knowledge, skills and attitudes in the preventive, promotive and curative aspects of the practice of pediatrics for Filipino children, their families and communities.

2. GENERAL OBJECTIVES

The Pediatric Residency Program shall:

2.1 Provide the pediatric residents with the knowledge, skills and attitudes in consonance with the concept of a general pediatrician.

2.2 Prepare pediatric residents for post-residency subspecialization, research, teaching and other postgraduate studies (i.e., masters, doctoral courses).

2.3 Reaffirm the profound importance of the vital and long-standing role of pediatricians in promoting the health and well-being of all children in the families and communities they serve (community dimension of pediatric practice).

2.4 Promote the integration of existing public health services into the training of pediatric residents.

2.5 Develop in pediatric residents habits and attitudes to practice their profession with integrity and ethical conduct.

2.6 Develop in the pediatric residents the attitude of engaging in lifetime continuing pediatric education responsive to changing needs and issues.

3. PROFESSIONAL ROLES FOR THE PEDIATRIC TRAINEES

The graduates of a Pediatric Residency Program may assume any or all of the following roles:

3.1 Clinician

a. Given an emergency situation, the pediatrician, utilizing holistic approach and critical thinking, shall recognize the emergency situation, identify the cause, and apply corrective or definitive measures.

b. Given a non-emergency situation, the pediatrician, utilizing holistic approach and critical thinking, shall arrive at a logical impression, plan and implement the therapy, provide psychological support to the family, and emphasize preventive measures.

3.2 Educator

a. Given a patient and his/her family in a clinical situation, the pediatrician, utilizing holistic approach and critical thinking, shall determine their knowledge and attitude about the clinical problem, address issues to be resolved, and institute the proper health education strategies.

b. Given a population group in a community (i.e., barangay health workers, school staff, parents, adolescents, and other groups), the pediatrician, utilizing holistic approach and critical thinking, shall plan, implement, and evaluate the appropriate educational activity.

c. Given a group of pediatric students/residents in a learning situation, the pediatrician, utilizing holistic approach and critical thinking, shall plan, implement, and evaluate an appropriate instructional design for a module.

3.3 Researcher

a. Given a diagnostic or therapeutic dilemma, the pediatrician, utilizing holistic approach and critical thinking, shall formulate appropriate questions, critically appraise selected journal articles, and make a clinical decision based on evidence and appraisal.

b. Given a non-emergency situation, the pediatrician, utilizing holistic approach and critical thinking, shall arrive at a logical impression, plan and implement the therapy, provide psychological support to the family, and emphasize preventive measures.

3.4 Leader/Manager

a. Given a pediatric health care facility in the community, the pediatrician, utilizing holistic approach and critical thinking, shall plan, implement, and evaluate the operations of the pediatric health care facility.

b. Given an area to start a pediatric project for families and communities, the pediatrician, utilizing holistic approach and critical thinking, shall plan, implement, and evaluate the project.

3.5 Social Advocate

Given families or communities with pediatric issues of concern, the pediatrician, utilizing holistic approach and critical thinking, shall:

a. Act as advocate of people empowerment and self-reliance.

b. Encourage the people to be involved in the affairs of their own community.

c. Participate in community organization.

d. Promote people participation in identifying problems of the community, developing and implementing solutions to the problems.

e. Contribute to the building of partnerships and collaborations among different institutions, agencies, and groups.

4. LEARNING OUTCOMES

PPS LEARNING OUTCOMES FOR PPS PEDIATRIC RESIDENCY TRAINING PROGRAM

The Philippine Pediatric Society formulated its learning outcomes which are congruent with the ten (10) learning outcomes of CHED but with an addition of community – based practice.

PPS Program Outcomes	Competencies
1. Clinical competence	Patient care
	Medical knowledge
	Technical procedural skills
	Attitudes and values
2. Communication and interpersonal skills	Inter-personal relationships
	Oral, written and para-verbal skills
3. Leadership and management skills	Organizational skills
	Problem-solving and decision-making skills
4. Evidence-based practice (Practice-based learning)	Critical appraisal of evidence
	Self-assessment and reflection
	Production of relevant quality research
5. Inter-professionalism	Collaboration with other health professionals
	Teamwork
6. Health system-based practice	Awareness of health systems
	Knowledge of societal needs
	Ability to call on other resources to improve patient care
	Cost-effective health care practice
7. Continuing professional development	Self-directed lifelong learning PPS

8. Professionalism	Adherence to ethical and legal principles
	Compliance to existing laws, rules and regulations that govern the medical profession
	Compassionate responsibility and accountability to patient welfare
9. Nationalism and internationalism	Awareness of global health care challenges
	Awareness of cultural and religious diversity
10. Social accountability	Knowledge of the concept of social accountability and its values
	Knowledge of the priority health needs in terms of pediatrics and the national objectives for health of the nation
11. Community – oriented practice	Awareness of important characteristics of and needs of the community that might impact on patient care
	Applies the understanding of these features to improve the management of the patient's population
	Awareness of social determinants of health
	Knowledge of resources available in the community and effective use of these resources
	Knowledge of the principles of preventive pediatric health care

EVALUATION INSTRUMENTS

Area 1: VISION-MISSION-OBJECTIVES

MINIMUM BASIC STANDARDS

1. The vision-mission-objectives must be aligned with the vision-mission of the Philippine Pediatric Society (PPS) and the hospital / institution.

2. The vision-mission-objectives must be specific, attainable and clearly stated.

3. The department must make its vision-mission-objectives known to its constituency.

4. The vision-mission-objectives of the department must be defined by its stakeholders which include:
   - 4.1. PPS
   - 4.2. Hospital, local government units, and other external agencies (governmental / non-governmental)
   - 4.3. Consultants, administrative staff, trainees (undergraduates, junior interns, senior interns, residents, and fellows), and patients

5. The objectives of the training program must be aligned with the program outcomes set by the PPS.

QUALITY STANDARDS

1. The vision-mission-objectives should encompass quality:
   - 1.1 Training and continuing pediatric education (professional and personal development of faculties and trainees, exposure to subspecialties, and readiness for lifelong self-directed learning)
   - 1.2 Research
   - 1.3 Patient care and social responsibility

2. The vision-mission-objectives should include governance (inclusion of internal quality audit in the department's organizational chart, ethics, and professionalism).

3. The objectives of the training program should address the development of habits and attitudes necessary to practice the profession with integrity and ethical conduct.

ANNOTATIONS

1. If there is no departmental statement of its vision-mission (which is unlikely), then it has to be FORMULATED. If the vision-mission statement is outdated or unclear, then it has to be REFORMULATED. If the vision-mission is updated, clearly stated, and still relevant, then a REAFFIRMATION by the whole department is all that is needed.

2. The department should determine its vision-mission in receiving resident trainees and offering them instruction. It should be determined in the light of the stakeholders which it intends to serve and the needs of the community in which it exists.

3. Based on the vision-mission statements, the goals and objectives for the department's key result areas should be written. It will guide the preparation of the long- and short-term development plans of the department.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. VMO of the institution
2. VMO of the department

EVALUATION INSTRUMENT

The accreditors should use the vision-mission-objectives as guideposts in evaluating the different areas of the department. Since these analysis statements are not weighted, their scores are not included in the overall computation. The following symbols should be used:

E	The statement or condition is clearly evident.
N	The statement or condition is not clearly evident.
M	The statement or condition is missing or not evident.

INSTRUCTIONS: Evaluate each statement using the scale provided. Write the assessment inside the parenthesis. A numerical rating is NOT needed for this area.

( ) 1. The vision-mission-objectives are aligned with the vision-mission-objectives of the PPS and the institution.

( ) 2. The vision-mission-objectives are clearly stated.

( ) 3. The vision-mission-objectives are made known to its constituency through various means.

( ) 4. The vision-mission-objectives encompass quality training, research, patient care, and social responsibility.

( ) 5. The vision-mission-objectives include governance.

( ) 6. The objectives of the residency program are aligned with the program outcomes set by the PPS.

( ) 7. The objectives of the training program are clearly specified and attainable.

( ) 8. The objectives of the training program address the development of habits and attitudes necessary to practice the profession with integrity and ethical conduct.

AREA 2: TRAINING PROGRAM

MINIMUM BASIC STANDARDS

1. The department must have its own unique institutional formal written residency program which shall include:

    1.1. General objectives
    1.2. Intended Learning Outcomes (ILOs) at the end of each year level for general pediatrics
    1.3. Intended Learning Outcomes (ILOs) of a general pediatrician in each subspecialty rotation
    1.4. Curricular content
    1.5. Teaching/Learning activities (TLA)
    1.6. Assessment Tasks (ATs)
    1.7. Policies for admission of residents
    1.8. Duties of residents per year level
    1.9. Duties of the chief resident
    1.10. Other unique features of the residency program

2. The minimum number of staff required for the opening of a residency program must be: Three (3) core board certified pediatricians and three (3) trainees. The consultant to trainee ratio should be at least 1:2.

3. The curriculum content must include:

    3.1. Growth and development
    3.2. Nutrition and nutritional disorders
    3.3. Community, ambulatory and preventive pediatrics
    3.4. Genetics / Dysmorphology
    3.5. Fetus, newborn, EINC, breastfeeding policies
    3.6. Allergy, immunology and related disorders
    3.7. Infectious diseases
    3.8. Respiratory disorders
    3.9. Gastrointestinal disorders
    3.10. Fluid, electrolytes and acid-base
    3.11. Renal and urinary tract disorders
    3.12. Cardiovascular disorders
    3.13. Collagen, vascular and other multisystem disorders
    3.14. Metabolic and endocrine disorders
    3.15. Disorders of the blood/neoplasms
    3.16. Genital system disorders
    3.17. Neurologic disorders
    3.18. Musculoskeletal disorders
    3.19. Skin disorders
    3.20. Disorders of the eye, ear, nose and throat
    3.21. Adolescent medicine / Gynecology
    3.22. Child abuse

3.23. Behavioral disorders
3.24. Critical care
3.25. Emergency care
3.26. Poisoning
3.27. Sports medicine
3.28. Pharmacology
3.29. Environmental health
3.30. Ethical issues in pediatrics
3.31. Care of children with special needs

4. The curriculum content must also include the Common Acute, Complex and Chronic Childhood Conditions.

4.1. **Common Acute Childhood Illnesses:**
- 4.1.1. Sore throat: Pharyngitis, Peritonsillar abscess and Infectious mononucleosis
- 4.1.2. Cough:
  - 4.1.2.1. Acute cough (< 2 weeks): AURI, asthma w/o exacerbation and pneumonia, minimal/low risk
  - 4.1.2.2. Acute cough in distress: bronchiolitis, pneumonia, moderate risk, foreign body, laryngotracheitis (croup), epiglottitis, tracheitis or asthma with exacerbation
  - 4.1.2.3. Subacute (2-4 weeks): bronchitis, TB and atypical respiratory infections (chlamydia/mycoplasma pneumonia), and rhinosinusitis
- 4.1.3. Headache: migraine, tension headache, acute sinusitis
- 4.1.4. Eye pain and discharge: conjunctivitis, orbital cellulitis
- 4.1.5. Diarrhea: viral & bacterial gastroenteritis, protozoan and parasitic infections, toddler's diarrhea and pseudomembranous colitis
- 4.1.6. Constipation: functional
- 4.1.7. Fever: URI, otitis media, bacterial sinusitis, bronchiolitis, pneumonia, viral syndromes, and UTI, DF/DHF, typhoid fever, leptospirosis
- 4.1.8. Ear pain: otitis media/externa and foreign body
- 4.1.9. Weight gain: obesity and Cushing disease
- 4.1.10. Dysuria: UTI, trauma, STD/child abuse and vulvovaginitis
- 4.1.11. Fever and rash: viral exanthems, meningococcemia, Henoch-Schonlein purpura, toxic shock syndrome, Kawasaki disease and acute rheumatic fever
- 4.1.12. Anemia: iron deficiency anemia, G6PD deficiency, thalassemia, lead poisoning and physiologic anemia of infancy
- 4.1.13. Neonatal fever: sepsis, UTI, meningitis or encephalitis
- 4.1.14. Seizures: febrile seizure, CNS infection, metabolic & electrolyte disturbances, trauma, toxic ingestions
- 4.1.15. Skin and soft tissue infections: cellulitis, abscess, necrotizing fasciitis, erysipleas, impetigo, and scrofula
- 4.1.16. Limping child: trauma, child abuse, osteomyelitis, synovitis and septic arthritis
- 4.1.17. Neonatal jaundice: physiologic jaundice, sepsis, ABO hemolytic disease, G6PD deficiency and breastfeeding/breastmilk jaundice
- 4.1.18. Abdominal pain: appendicitis, intussusception, malrotation with midgut volvulus, gastroenteritis, mesenteric adenitis, constipation, incarcerated hernia and UTI

4.1.19. Allergic disorders: eczema, urticaria/angioedema/anaphylaxis
4.1.20. Common viral illnesses: measles, mumps, rubella, roseola infantum, erythema infectious, varicella-zoster, Hepatitis A/B/C/D/E/G, rotavirus, rabies, adenovirus, Norwalk agent, influenza, enteroviruses, RSV, cytomegalovirus, herpes simplex, HIV, Epstein-Barr virus and arbovirus (H-fever).
4.1.21. Common bacterial infections: TB, diphtheria, tetanus, pertussis, pneumonia, salmonella, staphylococcal aureus, N. gonorrhea, N. meningitides, shigellosis, E. coli, Treponema pallidum, H. influenza type B, streptococcal group B and D, campylobacter jejuni, yersinia enterocolitidis, chlamydia.
4.1.22. Fungal infection: candidiasis
4.1.23. Parasitic infections: Giardia lamblia, toxoplasma gondii, trichomonas, visceral larva migrants, ascaris lumbricoides, enterobius vermicularis, E. histolytica, plasmodium sp.
4.1.24. Colds: common colds, allergic rhinitis
4.1.25. Renal disorders: UTI, AGN, nephrotic syndrome
4.1.26. Genital disorders: undescended testes, retractile testes, hernia, hydrocele, imperforate hymen, ovarian torsion and vulvovaginitis

4.2. **Complex Pediatric Conditions:**

4.2.1. Acute cough in distress: pneumonia, high risk, ARDS and status asthmaticus
4.2.2. Headache: brain tumor; pseudotumor cerebri
4.2.3. Diarrhea: malabsorption and Inflammatory bowel disease
4.2.4. Constipation: Hirschsprung disease, hypothyroidism, spinal cord abnormalities and lead poisoning
4.2.5. Fever: occult bacteremia, CNS infections, PFAPA syndrome and FUO.
4.2.6. Weight gain: Prader-Willi syndrome and hypothalamic obesity
4.2.7. Dysuria: urolithiasis
4.2.8. Anemia: anemia of chronic disease
4.2.9. Seizure: epilepsy, status epilepticus, and brain tumor
4.2.10. Prolonged jaundice: biliary atresia, choledochal cyst
4.2.11. Respiratory distress in newborn: RDS, meconium aspiration syndrome, pneumonia, air leak syndrome, congenital diaphragmatic hernia, TE fistula
4.2.12. Delayed meconium passage: meconium ileus/meconium plug syndrome, Hirschsprung disease
4.2.13. Heart murmur: congenital heart diseases (cyanotic/acyanotic) and acquired heart disease (rheumatic fever/RHD)
4.2.14. Abdominal distention: NEC
4.2.15. Raised intracranial pressure: hydrocephalus, brain tumor, CNS infection, and intracranial hemorrhage
4.2.16. Arrthymia: sinus tachycardia/bradycardia, SVT, heart block and VT
4.2.17. Shock: Hypovolemic, distributive, obstructive and neurogenic shock
4.2.18. Diabetic ketoacidosis, Acute Adrenal Crisis
4.2.19. Trauma: traumatic brain injury
4.2.20. Heart failure: congestive heart failure, myocarditis/pericarditis, cardiomyopathy
4.2.21. Chest pain: muscle strain, costochondritis, contusion, pleural effusion, GERD, esophagitis, rhythm disturbances, ischemia and anxiety/stress
4.2.22. Child abuse

4.2.23. Pediatric poisoning
4.2.24. Animal bite
4.2.25. Short stature: growth hormone deficiency, failure to thrive, hypothyroidism, malnutrition
4.2.26. Common bacterial causes of nosocomial infections: Klebsiella, enterobacter, pseudomonas, CONS
4.2.27. Renal disorders: urolithiasis, renal TB, renal tubular acidosis, acute and chronic renal failure
4.2.28. Hypertension: renal, vascular, endocrine and neuroblastoma
4.2.29. Collagen and vascular disorders: rheumatic diseases, SLE, JRA, dermatomyositis, scleroderma, ankylosing spondylitis, post-infectious arthritis, arthritis of IBD, Henoch-Schoenlein purpura and Takayasu arteritis.
4.2.30. Metabolic disorders: IEM
4.2.31. Endocrine disorders: adrenal disorders, disorders of gonads & puberty, disorders of parathyroid
4.2.32. Musculo-skeletal disorders: developmental dysplasia of hip, skeletal dysplasia, osteogenesis imperfecta, fractures, torticollis, Legg-Calve-Perthes disease, Osgood-Schlatter disease
4.2.33. Skin disorders: Hemangiomas, Scabies, SSSS, Pediculosis, Molluscum contagiosum, Steven-Johnson syndrome

4.3. **Common Chronic Childhood Conditions:**

4.3.1. Chronic cough (>4 weeks): pertussis, GERD, airway anomaly (TEF, tracheal ring, tracheomalacia, laryngeal cleft)
4.3.2. Newborn dysmorphology
4.3.3. Children with Chronic Illnesses: congenital neuromuscular disorders, HIE, static encephalopathy, BPD/chronic lung disease, diabetes mellitus type 1 & 2
4.3.4. Malformations: trisomies, Turner syndrome, Fragile X
4.3.5. Children with special needs: autism, ADHD, cerebral palsy, intellectual disability, learning disability, mental health disorders
4.3.6. Palliative care for cancer patients
4.3.7. Medical Home Initiative

5. The training rotation must be practice-based involving the personal participation of the resident in the services and responsibilities of patient care in various settings. The sequence of rotation must include:

5.1. **First Year**

Ward	6 months
OPD / ER	4 months
NICU	2 months

5.2. **Second Year**

Ward	4 months
OPD / ER	3 months
***Subspecialties / Electives	2 months [1 month subspecialty preferably PICU, ½ month research, ½ month radiology]
Community	1 month
NICU	2 months

5.3. **Third Year**

Ward	3 months
OPD / ER	2 months
NICU	2 months
Subspecialties /Electives	4 months [1 month PICU, 2 months subspecialty of choice, 1 month research]
Community/CPU	1 month

***** Subspecialty rotation includes rotation in subspecialty clinics in their hospitals, preceptorship in clinic of certified subspecialist, or outside rotation to other HAB hospitals or accredited ******specialty hospitals (RITM, PHC, Lung Center, NKTI)

****** Requirements for Accredited Subspecialty Hospitals

1. There should be an accredited fellowship program of a subspecialty society/societies recognized by the PPS-HAB.
2. Seventy percent (70%) of the patients are subspecialty patients.
3. There should be periodic accreditation visits by the subspecialty society/societies using their own assessment instruments. For subspecialty society/societies with no self-assessment instruments, the PPS HAB Fellowship Program Assessment instrument can be used.

(see Appendix 2 for summary)

6. The learning activities must encompass integrated practical and theoretical instruction (competency-based approach, problem-oriented strategies, evidence-based medicine, and practice-based training including values formation, bioethics, and community orientation).

   The learning activities should include:

   6.1. Bedside rounds with the chair, training officer, or consultants
   6.2. Supervised ER and OPD clinics
   6.3. Supervised lectures/journal critic & appraisal/chart reviews
   6.4. Clinical conferences
      6.4.1. Case presentations (grand rounds, case discussions, diagnostic / management conferences, and bioethics conferences)
      6.4.2. Morbidity and mortality conferences
      6.4.3. Endorsement conferences / rounds
   6.5. Conferences with family members

6.6. Research workshops/presentations
6.7. Mentoring activities

7. The following pediatric procedures must be included in the technical skills training part of the program:

7.1. Office procedures
  7.1.1. Anthropometric studies
  7.1.2. Vital signs measurements
  7.1.3. Subcutaneous injection
  7.1.4. Intramuscular injection
  7.1.5. Intradermal injection
  7.1.6. Oral administration
  7.1.7. Nebulization
  7.1.8. Fever control
  7.1.9. Cord care
  7.1.10. Incision and drainage

7.2. Eye procedures
  7.2.1. Topical drug administration
  7.2.2. Foreign body removal (assist or observe)
7.3. Ear procedures
  7.3.1. Foreign body removal (assist or observe)
  7.3.2. Cerumen removal
7.4. Nose procedures
  7.4.1. Foreign body removal (assist or observe)
  7.4.2. Control of epistaxis
7.5. Endotracheal intubation
7.6. Thoracentesis (assist or observe)
7.7. Nasogastric tube placement
7.8. Genitourinary procedures
  7.8.1. Urethral catheterization
  7.8.2. Supra-pubic bladder puncture
7.9. Lumbar puncture
7.10. Bone marrow aspiration
7.11. Exchange transfusion
7.12. Vascular procedures
  7.12.1. Percutaneous peripheral venous access
  7.12.2. Peripheral venous access by cut down
  7.12.3. Umbilical vessel cannulation
  7.12.4. Blood extraction
    - capillary blood sampling
    - arterial blood sampling
  7.12.5. Intra-osseous infusion
7.13. Bedside sedation for procedures
(See Appendix 3)

8. The latest editions of the HAB-required textbooks, journals, and PPS publications outlined in Appendix 3 must be available at the department's library. (Appendix 4)

9. Each trainee must be certified by the PPS to have satisfactorily completed the following courses:
   9.1. Pediatric Resuscitation
   9.2. Neonatal Resuscitation Program Plus

10. Formative evaluations must be done at regular intervals. The residents must take the WISE yearly. A summative evaluation must be done at the end of each year level of training.

11. A variety of evaluation strategies must be used to evaluate clinical competence including:
   11.1. Clinical conferences and oral reports
   11.2. Written examinations
   11.3. OSOE / OSCE

QUALITY STANDARDS

A. Curriculum and Educational Program (Instructional Design)

1. The objectives and content should be appropriate to the national and regional health needs (leading causes of morbidity and mortality) and expectations / demands of the Filipino population.

2. The department should have its own unique institutional formal written residency program focused on primary care. There must be a well written instructional design in general pediatrics and the subspecialties, according to year level, using the template provided in Section 2.

3. The instructional design should address the different professional roles of a pediatrician: (a) healthcare provider with emphasis on primary care, (b) health educator, (c) researcher, (d) healthcare manager, and (e) social mobilizer.

B. Instructional Materials, Delivery, and Resources

1. The curriculum content should include the common acute, complex, and common chronic childhood conditions.

2. The program should include Child Protection in the curriculum as follows:
   2.1. Level 1 – lectures or workshops
   2.2. Level 2 – lectures or workshops and exposure in a Child Protection Unit (CPU) in the second year of residency
   2.3. Level 3 – should have a CPU desk
   2.4. Level 4 – should have an organized CPU

C. Evaluation

1. The program should include a process of evaluation that measures clinical competence, promote learning, and document adequacy of training, including the criteria for passing assessments.

2. The following areas of clinical competence should be evaluated:
   2.1. Knowledge
   2.2. Clinical skills / decision making
   2.3. Technical skills
   2.4. Interpersonal skills
   2.5. Professional attitudes and habits

3. The trainees should receive regular constructive feedback about their performance.

4. The program should be evaluated and monitored regularly to ensure the attainment of program outcomes and assess the progress of the trainees.

5. The results of program evaluation should be utilized to enhance and revise the curriculum.

D. Program Outcomes

1. All graduates during the accreditation period must take the SB examinations within two (2) years of graduation.

2. Residency programs granted level I & II accreditation status must be reaccredited after three (3) years, level III status after four (4) years and level IV after five (5) years.

3. The program should have a creditable performance in the PPS certifying examinations.
   2.1. Level I – at least fifty percent (50%) must pass
   2.2. Level II – at least sixty percent (60%) must pass
   2.3. Level III – at least eighty percent (80%) must pass
   2.4. Level IV – at least ninety percent (90%) must pass

4. There should be a creditable performance in the PPS Written-In-Service-Examination (WISE)

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Brief description of the training program, including its unique features
2. Instructional design in general pediatrics
3. Instructional designs in the subspecialties
4. Schedule of rotations of trainees
5. Monthly and weekly schedules of activities
6. List of books and references indicating the years of publication
7. Evaluation tools for:
   a. Different conferences and activities
   b. Monthly or quarterly clinical evaluation
   c. Annual summative evaluation

d. Program evaluation

8. List of graduates in the past accreditation period with the results of their performances in the PPS certifying examinations.
9. Yearly performance report on the WISE indicating the number of examinees per year level and the percentage of successful examinees

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Curriculum and Educational Program (Instructional Design)

( ) 1. The objectives and content are appropriate to the national and regional health needs, and expectations / demands of the Filipino population.

( ) 2. There are well written instructional designs in general pediatrics and the subspecialties according to year levels.

3. The instructional designs address the different professional roles of a pediatricians:

( ) 3.1. Healthcare provider with emphasis on primary care

( ) 3.2. Health educator

( ) 3.3. Researcher

( ) 3.4. Healthcare manager

( ) 3.5. Social mobilizer

( ) MEAN

Instructional Materials, Delivery, and Resources

( ) 1. The rotations follow the HAB recommendations outlined in Appendix 2.

( ) 2. The learning activities encompass integrated practical and theoretical instruction (competency-based approach, problem-oriented strategies, evidence-based medicine, and practice-based training including values formation, bioethics, and community orientation).

( ) 3. The learning activities include the must-have activities recommended by the HAB:
   3.1. Bedside rounds with the chair, training officer, or consultants
   3.2. Supervised ER and OPD clinics
   3.3. Supervised lectures and journal reviews
   3.4. Clinical conferences
      3.4.1. Case presentations (grand rounds, case discussions, diagnostic / management conferences, and bioethics conferences)
      3.4.2. Morbidity and mortality conferences
      3.4.3. Endorsement conferences / rounds
   3.5. Conferences with family members

( ) 4. The pediatric procedures are included in the technical skills training part of the program.

( ) 5. Child Protection is included in the curriculum.
   5.1. Level 1 – lectures or workshops
   5.2. Level 2 – lectures or workshops and exposure in a CPU
   5.3. Level 3 – CPU desk
   5.4. Level 4 – CPU unit

( ) 6. The latest editions of the HAB-required textbooks, journals, and PPS publications are available at the department's library.

( ) 7. Each trainee has satisfactorily completed the following courses:

   7.1. Basic life support

( ) 7.2. Cardio-Pulmonary Resuscitation / Pediatric Advanced Life Support

( ) 7.3. Neonatal Resuscitation Program

( ) MEAN

Evaluation

1. The program includes a process of evaluation that measures clinical competence, promote learning, and document adequacy of training, including the criteria for passing assessments.

( ) 2. The following areas of clinical competence are evaluated:

2.1. Knowledge

( ) 2.2. Clinical skills / decision making

( ) 2.3. Technical skills

( ) 2.4. Interpersonal skills

( ) 2.5. Professional attitudes and habits

( ) 3. A variety of evaluation strategies is used to evaluate clinical competence including:

3.1. Clinical conferences and oral reports

( ) 3.2. Written examinations

( ) 3.3. OSOE / OSCE

( ) 4. Formative evaluations are done at regular intervals.

( ) 5. A summative evaluation is done at the end of each year level of training.

( ) 6. The trainees receive regular constructive feedback about his performance.

( ) 7. The program is evaluated and monitored regularly to ensure the attainment of program outcomes and assess the progress of trainees.

( ) 8. The results of program evaluation are utilized to enhance and revise the curriculum.

( ) MEAN

Program Outcomes

A. SB Examination

Total number of trainees during the accreditation period

Total number of trainees who took the SB written examinations (1st takers) _____

Percentage of trainees who took the SB written examinations _____

Total number of successful examinees _____

Percentage of successful examinees _____

Score _____

< 10% ---------- 0

10 – 29% ------ 1

30 – 49% ----- 2

50 – 69% ----- 3

70 – 89% ----- 4

≥ 90% --------- 5

B. 3-Year Performance in the WISE

Number of residents who took the WISE _____

Number of residents who passed the WISE _____

Percentage of successful examinees _____

Score _____

< 10% ---------- 0

10 – 29% ------ 1

30 – 49% ----- 2

50 – 69% ----- 3

70 – 89% ----- 4

≥ 90% --------- 5

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Curriculum and Educational Program		20	
Instructional Materials, Delivery, and Resources		40	
Evaluation		20	
Program Outcome a. SB Examination b. WISE		 15 5	
AREA MEAN		100	

Area 3: TRAINEES

BASIC STANDARDS

Residency is a vital step of post-medical school training. After completing medical school, those interested in child health are highly encouraged to apply for residency.

1. The trainees are important indicators of the success of a program. To ensure that the trainees maintain a certain standard of quality, attention must be given to the screening process, teaching-learning activities, and retention and promotion process.

2. A minimum of three (3) trainees is required to start a residency training program. Sixty percent (60%) of the total number of trainees per year level must be Filipino citizens.

3. The selection process of prospective trainees must be clearly described including the:
   - 3.1. Criteria for selection
   - 3.2. Admission process
   - 3.3. Persons responsible for the admission process
   - 3.4. Policies on transferees from other accredited programs
   - 3.5. Policies on foreign medical graduates

4. The number of trainees must be proportionate to the:
   - 4.1. Adequacy of clinical materials
   - 4.2. Availability of consultants
   - 4.3. Other available resources

5. A resident's quarter/call room must be provided to the trainees.

6. The duties and responsibilities of trainees per year level, including the chief resident, must be clearly described.

QUALITY STANDARDS

A. Admission Policies

1. The selection of trainees should be harmonized with the institutional and departmental vision-mission-objectives. Transparency and equity should be observed in the selection process.

2. The trainees should have a high level of understanding of the basic biomedical sciences achieved at the undergraduate level before starting the training program.

3. The trainees should be oriented on the program content of the PPS-approved residency training program and the aligned institutional training manual. Promoted trainees should be reoriented prior to the next year level.

4. The admission policy should be periodically reviewed.

B. Performance

1. There should be a system to monitor the progress of trainees in the form of formative and summative assessments, including reported unintended incidents.

2. Each trainee should have a training portfolio that is regularly monitored and evaluated by the supervising consultants. The portfolio should contain the cases seen, procedures done, certificates of attendance to workshops / conventions, and results of evaluations.

3. Awards & recognition should be available for outstanding performances.

4. The trainee should have taken the PPS National Written In-Service Examination (WISE) at least twice during the residency period.

5. There should be a mechanism to ensure the trainees' representation and participation in the following activities:
   5.1. Formulation of the mission, goals, and program outcomes
   5.2. Design and planning of the training program
   5.3. Evaluation of the training program

6. The graduates should take the PPS Specialty Board Examination within two (2) years after completing the program.

C. Support Services for Trainees

1. There should be a system for academic counseling, including career and guidance planning for trainees, with utmost confidentiality in handling counseling.

2. The training program should provide available support addressing professional, psychological, social, material, and personal needs of the trainees.

3. The department should provide appropriate and equitable remuneration and benefits, including legally mandated training interruptions (pregnancy, sickness, bereavement, and others).

4. There should be a mechanism to consider safeguarding the welfare of residents in the structuring of duty hours and clinical workload.

5. The department should implement a mentoring program for residents.

D. Promotion, Retention, and Dismissal

1. There should be clear policies on the promotion, retention, and dismissal of trainees. These policies should be made known to them.

2. The department should provide a mechanism for grievance and appeal against decisions involving:
   2.1. Admission to the program
   2.2. Disciplinary sanctions
   2.3. Retention
   2.4. Dismissal from the program

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Departmental policies on the selection process of prospective trainees including:
   1.1. Criteria for selection
   1.2. Admission process
   1.3. Persons responsible for the admission process
   1.4. Transferees from other accredited programs
   1.5. Foreign medical graduates
2. Number of slots available per year level
3. Duties and responsibilities of trainees per year level, including the chief resident
4. Description of the assessment process of trainees indicating the formative and summative evaluation methods
5. Salaries, benefits, and other incentives for trainees
6. Policies on the promotion, retention, and dismissal of trainees
7. Guidelines on disciplinary sanctions
8. Description of the mechanism for grievance and appeal against departmental decisions
9. Description of the mentoring program

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Admission Policies

( ) 1. The selection process of prospective trainees should be clearly described including the:
   1.1. Criteria for selection
   1.2. Admission process
   1.3. Persons responsible for the admission process
   1.4. Policies on transferees from other accredited programs
   1.5. Policies on foreign medical graduates

( ) 2. The admission policies of the department are consistent with governmental and institutional regulations and conform with the vision-mission-objectives of the institution and the department.

( ) 3. The criteria for selection of trainees are effective in identifying individuals capable of undergoing pediatric residency and includes:
   3.1. Undergraduate performance (class rank)
   3.2. Aptitude examination
   3.3. Interview
   3.4. Other qualities

( ) 4. The number of trainees is proportionate to the:
   4.1. Adequacy of clinical materials
   4.2. Availability of consultants
   4.3. Other available resources

( ) 5. The trainees are oriented on the program content of the PPS-approved residency training program and the aligned institutional training manual. Promoted trainees are reoriented prior to the next year level.

( ) MEAN

Performance

( ) 1. The duties and responsibilities of trainees per year level, including the chief resident, are clearly described.

( ) 2. There is a system to monitor the progress of trainees in the form of formative and summative assessments, including reported unintended incidents.

( ) 3. Each trainee has a training portfolio that is regularly monitored and evaluated by the supervising consultants.

( ) 4. There is a mechanism to ensure the trainees' representation and participation in the following activities:
   4.1. Formulation of the mission, goals, and program outcomes
   4.2. Design and planning of the training program
   4.3. Evaluation of the training program

( ) MEAN

Support Services for Trainees

( ) 1. There is a system for academic counseling, including career and guidance planning for trainees.

( ) 2. The training program provides available support addressing professional, psychological, social, material, and personal needs of the trainees.

3. The department provides appropriate and equitable remuneration and benefits, including legally mandated training interruptions (pregnancy, sickness, bereavement, and others).

( ) 4. There is a mechanism to consider safeguarding the welfare of residents in the structuring of duty hours and clinical workload.

5. The department implements a mentoring program for residents

( ) MEAN

Promotion, Retention, and Dismissal

( ) 1. There are clear policies on the promotion, retention, and dismissal of trainees. These policies are made known to them.

2. The department should provide a mechanism for grievance and appeal against decisions involving:
   2.1. Admission to the program
   2.2. Disciplinary sanctions
   2.3. Retention
   2.4. Dismissal from the program

MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Admission Policies		15	
Performance		40	
Support System for Trainees		30	
Promotion, Retention, and Dismissal		15	
AREA MEAN		100	

AREA 4: CONSULTANTS

BASIC STANDARDS

1. All consultants must be board certified (Diplomate or Fellow) by the Philippine Pediatric Society.

2. There must be a formal mechanism for the recruitment and selection of consultants.

3. The consultants and residents must observe the Code of Ethics of PMA and PPS.

4. The department/hospital must have on their staff:

    4.1. For NICU
        HAB Level I – a board certified pediatrician as head
        HAB Level II – a board certified neonatologist,
            a board eligible neonatologist but must be certified within 2 years after graduation
        HAB Level III – a board certified neonatologist
        HAB Level IV – same as Level III
    4.2. For PICU – a board certified pediatric intensivist
    4.3. pediatric surgeon (approved/recognized by their society; not necessarily part of active staff)
    4.4. three (3) PPS certified subspecialists
        - A PPS subspecialty Fellow may be a section chief of only 2 subspecialty sections.
        - A PPS Fellow may be a chair of only one PPS-HAB accredited department of pediatrics.

QUALITY STANDARDS

A. Recruitment and Selection

1. There should be a formal mechanism for the recruitment and selection of consultants.

2. The selection of consultants should be a cooperative process involving the administration, department heads, and other institutional members.

B. Academic Qualifications

1. The qualifications of each group of consultants (active vs visiting, or any other distinction present) should be clearly specified.

2. Attention should be given to their teaching ability, character / integrity, professional competence, research expertise, and communication skills.

C. Performance

1. The duties and responsibilities of each group of consultants (active vs visiting, or any other distinction present) should be clearly specified.

2. The consultants should participate in the different activities of the department including training activities, service, research, formulation of policies, and evaluation of trainees.

3. There should be an annual performance evaluation, acceptable to consultants, considering teaching competence, patient care, research, and administrative involvement.

4. There should be harmonious relationships between the administration and the department, and within the department.

D. Benefits

1. There should be incentives for the consultants' participation in the teaching program (decking of private walk-in admissions, offices, parking spaces, and others).

2. There should be provisions for recognition and reward for meritorious activities of consultants (plaques of recognition, citations, gifts, and others).

3. The department should have a staff development program to enhance their professional roles, and provisions to attend teacher training seminars and participation in scientific conferences.

4. There should be activities that promote the consultants' well-being and welfare.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Flowchart of recruitment and selection process of consultants
2. Qualifications and duties / responsibilities of each group of consultants (active vs visiting, or any other distinction present)
3. List of consultants based on grouping (to include academic background, PPS and subspecialty status, and professional affiliations)
4. Staff development program
5. Incentives for consultants
6. Consultants' evaluation tool

EVALUATION INSTRUMENT

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard

2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Recruitment and Selection

( ) 1. There is a formal mechanism for the recruitment and selection of consultants.

( ) 2. The selection of consultants is a cooperative process involving the administration, department heads, and other institutional members.

( ) MEAN

Academic Qualifications

( ) 1. The qualifications of each group of consultants (active vs visiting, or any other distinction present) are clearly specified.

( ) 2. The process of consultant selection considers:
- 2.1. Teaching ability
- 2.2. Character / integrity
- 2.3. Professional competence
- 2.4. Research expertise
- 2.5. Communication skills

( ) MEAN

Performance

( ) 1. The duties and responsibilities of each group of consultants (active vs visiting, or any other distinction present) are clearly specified.

( ) 2. The responsibilities of consultants include participation in:
- 2.1. Training activities
- 2.2. Service
- 2.3. Research
- 2.4. Formulation of policies
- 2.5. Evaluation of trainees

( ) 3. There is an annual performance evaluation that is acceptable to consultants.

( ) 4. The consultants observe the Codes of Ethics of the PMA and PPS.

( ) 5. There are harmonious relationships between the administration and the department, and within the department.

( ) MEAN

Benefits

( ) 1. There are incentives for the consultants' participation in the teaching program.

( ) 2. There are provisions for recognition and reward for meritorious activities of consultants.

( ) 3. The department has a staff development program to enhance their professional roles, and provisions to attend teacher training seminars and participation in scientific conferences.

( ) 4. There are activities that promotes the consultants' well-being and welfare.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Recruitment and Selection		20	
Academic Qualifications		25	
Performance		30	
Benefits		25	
AREA MEAN		100	

AREA 5: ADMINISTRATION

BASIC STANDARDS

1. The department must have an administrative organization which facilitates the attainment of its vision, mission, and objectives. The governance structures and functions of the department should be defined including the relationship with the hospital and / or university.

2. The administrative structure must include appropriate officers, sections and committees, and should reflect the representation of consultants and residents.

3. The chair and training officer must be Fellows of the PPS. A Fellow must chair only one (1) HAB-accredited training program.

QUALITY STANDARDS

A. Administrative Organization

1. The department should have an organizational structure defining the training, service, and research functions, as well as governance (including its relationships with the hospital administration and / or university).

2. The qualifications and job descriptions of the following departmental officers should be defined:
   - 2.1. Chair
   - 2.2. Training officer
   - 2.3. Section chief
   - 2.4. Committee heads

3. The staffing pattern in all pediatric patient care areas should be described including:
   - 3.1. Number of beds per service area
   - 3.2. Number of personnel per service area
     - 3.2.1. Residents
     - 3.2.2. Nurses
     - 3.2.3. Midwives
     - 3.2.4. Other healthcare providers

4. There should be open communication lines among the hospital and / or university, department, consultants, trainees, and other healthcare providers.

5. The department should have working linkages with other institutions involved in child healthcare.

6. A Bioethics committee (departmental or hospital level) should be organized and functioning.

B. Planning and Financial Management

1. The department should have regular or periodic planning sessions.

2. The planning sessions should involve the consultants and residents with provisions for the participation of the alumni in the affairs of the department.

3. The department should have immediate (5 years) and long-range (10 years) plans.

4. The hospital and / or university should allocate resources to implement the programs of the department.

C. Recording and Documentation

1. The records of departmental meetings, planning sessions, data of consultants and residents, official rules and policies, and reports should be kept on file.

2. The departmental records should be filed systematically.

3. The department should follow proper policies and procedures to ensure the confidentiality of the trainees' records.

4. The department should be up to date in the submission of the ICD 10 report requirements to PPS.

    a. The report should be submitted on time (on the third Friday of the following month)
    b. The report should be accurate as assessed by a Clearing-House Committee headed by either the Training Officer or Research Committee Chair created for this purpose. The department chair should sign the submitted report.
    c. The acknowledgement of the submission of ICD 10 reports should be kept on file.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Hospital organization chart
2. Departmental organizational chart
3. Qualifications and job descriptions of departmental officers
4. Staffing pattern in all pediatric service areas
5. MOA with other institutions involved in child healthcare, if any.
6. Composition and functions of the hospital or departmental bioethics committee
7. Immediate (5 years) and long-range (10 years) plans
8. Acknowledgment report of ICD 10 submission.

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Administrative Organization

( ) 1. The hospital and / or university has an organizational structure which details and relationships and governance of the different departments.

( ) 2. The department has an organizational structure defining the training, service, and research functions, as well as governance (including its relationships with the hospital administration and / or university).

( ) 3. The qualifications and job descriptions of the departmental officers are defined.

( ) 4. The staffing pattern in all pediatric patient care areas is described including the number of beds and personnel per service area.

( ) 5. There are open communication lines among the hospital and / or university, department, consultants, trainees, and other healthcare providers.

( ) 6. The department has working linkages with other institutions involved in child healthcare.

( ) 7. There is a functioning Bioethics committee.

( ) MEAN

Planning and Financial Management

( ) 1. The department has regular or periodic planning sessions.

( ) 2. The planning sessions involve the consultants and residents with provisions for the participation of the alumni in the affairs of the department.

( ) 3. The department has immediate (5 years) and long-range (10 years) plans.

( ) 4. The hospital and / or university allocates resources to implement the programs of the department.

( ) 5. The records of departmental meetings, planning sessions, data of consultants and residents, official rules and policies, and reports are kept on file.

( ) MEAN

Recording and Documentation

( ) 1. The records of departmental meetings, planning sessions, data of consultants and residents, official rules and policies, and reports are kept on file.

( ) 2. The departmental records are filed systematically.

( ) 3. The department follows proper policies and procedures to ensure the confidentiality of the trainees' records.

( ) 4. The department submits an accurate ICD 10 report on time assessed by the Clearing-House Committee and signed by the department chair.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Administrative Organization		50	
Planning and Financial Management		20	
Recording and Documentation		15	
ICD 10		15	
AREA MEAN		100	

AREA 6: PATIENT SERVICES AND FACILITIES

BASIC STANDARDS

1. The hospital must be Philhealth accredited and certified as a Mother-Baby Friendly Institute.

2. There must be written policies and procedures for the admission, care and discharge of pediatric patients for each pediatric area of care (Standard Operating Procedures or Manual of Operations).
   - 2.1. Neonatal unit
   - 2.2. Inpatient wards
   - 2.3. Emergency room
   - 2.4. Outpatient unit
   - 2.5. PICU
   - 2.6. Adolescent wards

3. Ten percent (10%) of the total bed capacity must be identified for service patients.

4. The minimum equipment for pediatric patient care must be available. (Appendix 3)

5. There should be physical plant facilities for:
   - 5.1. Separate pediatric emergency area
   - 5.2. Oral rehydration area
   - 5.3. Reverse isolation room
   - 5.4. Outpatient care (sick and well patients)
   - 5.5. NICU
   - 5.6. Rooming-in wards
   - 5.7. Pediatric wards
   - 5.8. Adolescent wards
   - 5.9. Isolation ward for communicable diseases
   - 5.10. Treatment room at each pediatric floor
   - 5.11. PICU

6. Attending physicians for patients aged 0-18 yrs. must be board certified pediatricians (Diplomate or Fellow).

7. All patients at the emergency room aged 0-18 yrs. must be evaluated by the pediatric resident.

8. All newborn babies shall be under the care of a board certified pediatrician (Diplomate or Fellow). High-risk newborns must be referred to a board certified or board-eligible neonatologist.

9. The pharmacy, laboratory, radiology and central supply room must render 24-hours service.

10. There must be an updated formulary.

QUALITY STANDARDS

1. The neonatal unit should meet the standards set by the HAB and the Philippine Society of Newborn Medicine.
   1.1. Levels I and II – Neonatal Unit Level I & II respectively
   1.2. Levels III and IV – Neonatal Unit Level III & IV respectively
   See Appendix 5 – PPS Neonatal Unit Level Requirement

2. The Pediatric Intensive Care Unit must be Level II for Level III and IV HAB accredited hospitals.

3. The pharmacy, laboratory, radiology, and central supply room should render 24-hour services.

4. The physical plant should provide for safety, cleanliness, comfort, and space provisions for patient care and training activities.

5. There should be a written safety / disaster management plan.

6. There should be a process to evaluate facilities, equipment, and supplies.

7. The physical facilities used by consultants and trainees should include:
   7.1. Conference room
   7.2. Department office
   7.3. Call room for trainees
   7.4. Multimedia resources (computer, internet facilities, and LCD projector)

A. Patient Services

1. There should be a sufficient number of patients to satisfy the training objectives. The minimum number of patients per area per month should be:

1.1.	ER consultations	120 – 150
1.2.	OPD consultations	90 – 100
1.3.	Well baby / child consultations	50 – 60
1.4.	Deliveries	20 – 30
1.5.	In-patient admissions	50 – 60
1.6.	Adolescents (in- and out-patients)	20 – 30

2. The service areas should have a sufficient case-mix of patients.

3. The minimum equipment for patient care outlined in Appendix 3 should be available.

4. There should be an updated formulary available in all service areas.

B. Human Resources

1. The attending physicians for all patients aged 0 – 18 years should be managed by board-certified pediatricians.

2. All patients aged 0 – 18 years at the emergency room should be evaluated by the pediatric resident.

3. All newborns should be under the care of a board-certified pediatrician. High risk newborns should be referred to a board-certified or board-eligible neonatologist.

4. The PICU should be headed by a board-certified pediatric intensivist.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Certificates of accreditation from: PhilHealth, MBF, NBS, and HS
2. Breakdown of number of beds per service areas: ER, OPD, NICU, rooming-in ward, in-patient wards, adolescent services (in- and out-patient), and PICU
3. SOPs at the: ER, OPD, NICU, rooming-in ward, in-patient wards, and PICU
4. Total census during the accreditation period (per year) in the: ER, OPD, NICU, rooming-in ward, in-patient wards, adolescent services (in- and out-patient), and PICU
5. Top 10 causes of morbidities during the accreditation period (per year) in the: ER, OPD, NICU, in-patient wards, adolescent services (in- and out-patient), and PICU
6. Bench marking data: infant mortality rate, case fatality rate of the most common morbidities and mortalities.
7. Checklist of minimum equipment for pediatric patient care
8. In- and out-patient census during the accreditation period (per year) for the subspecialty programs for Levels III and IV
9. Three (3) year departmental procurement plan for medicines, drugs, and equipment
10. Safety / disaster management plan
11. Self-assessment checklist of Society of Pediatric Critical Care Medicine Philippines (SPCCMP) and Philippine Society of Newborn Medicine (PSNbM) requirements

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Physical Facilities and Equipment

( ) 1. There are written policies and procedures for the admission, care, and discharge of patients for the following service areas:
   1.1. Emergency room
   1.2. Outpatient unit
   1.3. Neonatal unit
   1.4. Rooming-in ward
   1.5. In-patient wards
   1.6. PICU
   1.7. Adolescent wards

( ) 2. The neonatal unit meets the standards set by the HAB and the Philippine Society of Newborn Medicine.
   2.1. Levels I and II – Neonatal Unit Level I & II
   2.2. Levels III and IV – Neonatal Unit Level III & IV

( ) 3. The Pediatric Intensive Care Unit (PICU) meets the standards set by the SPCCMP
   3.1 Level I – PICU Level I
   3.2 Level II – IV – PICU Level II

( ) 4. The pharmacy, laboratory, radiology, and central supply room render 24-hour services.

( ) 5. There are physical plant facilities for:
   5.1. Separate pediatric emergency area
   5.2. Oral rehydration area
   5.3. Reverse isolation room
   5.4. Outpatient care (sick and well patients)
   5.5. NICU
   5.6. Rooming-in wards
   5.7. Pediatric wards
   5.8. Adolescent wards
   5.9. Isolation ward for communicable diseases
   5.10. Treatment room at each pediatric floor
   5.11. PICU

( ) 6. The physical plant should provide for safety, cleanliness, comfort, and space provisions for patient care and training activities.

( ) 7. There is a written safety / disaster management plan.

( ) 8. There is a process to evaluate facilities, equipment, and supplies.

( ) 9. The physical facilities used by consultants and trainees include:

9.1. Conference room
9.2. Department office
9.3. Call room for trainees
9.4. Multimedia resources (computer, internet facilities, and LCD projector)

( ) MEAN

Patient Services

( ) 1. There is a sufficient number of patients to satisfy the training objectives.

1.1. ER consultations	120 – 150
1.2. OPD consultations	90 – 100
1.3. Well baby / child consultations	50 – 60
1.4. Deliveries	20 – 30
1.5. In-patient admissions	50 – 60
1.6. Adolescents (in- and out-patients)	20 – 30

( ) 2. At least ten percent (10%) of the total bed capacity is identified for service patients.

( ) 3. The service areas have a sufficient case-mix of patients.

( ) 4. The minimum equipment for patient care is available.

( ) 5. An updated formulary is available in all service areas.

( ) MEAN

Human Resources

( ) 1. The attending physicians for patients aged 0 – 18 years are board-certified pediatricians.

( ) 2. All patients aged 0 – 18 years at the ER are evaluated by a pediatric resident.

( ) 3. All newborns are under the care of a board-certified pediatrician. High-risk newborns are referred to a board-certified or board-eligible neonatologist.

( ) 4. The PICU should be headed by a board-certified pediatric intensivist.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Physical Facilities and Equipment		30	
Patient Services		40	
Human Resources		30	
AREA MEAN		100	

AREA 7: RESEARCH

BASIC STANDARDS

1. The department should have a formal written research program.

2. Each resident must submit a completed, well designed research paper at the end of the 3-year residency program.

3. Consultants must be involved in research advising.

4. There must be venues for oral presentation or publication of residents' research papers. (Abstracts should be included in the PPS website)

QUALITY STANDARDS

A. Research Education and Policies

1. The research agenda should be relevant to the national or regional health needs. Research studies with social relevance in the community where the department is located should be encouraged.

2. The hospital / department should conduct annual research lectures, seminars, or workshops to include Evidence-Based Medicine (EBM) and Good Clinical Practice (GCP).

3. The residency program should have a protected time for research work.

4. Researches from Levels 1 – 3 programs should be submitted to the PPS Research Committee for final approval. Researches from Level 4 programs need not be submitted to the committee. The department's research committee will give the final approval.

5. All PPS-published research papers shall be the property of the society. Presentations in other scientific venues and publication in various journals will require permission from the PPS.

B. Resources – Human, Physical, and Financial

1. There should be a designated coordinator for research. The trainees should be given a consultant-adviser (co-author) who will supervise them from the development of a proposal to the completion of research.

2. All research proposals should be evaluated by the research coordinator or the research committee of the department.

3. All researches should be approved by an ethics review committee or accredited institutional review board.

4. The trainees should be given sufficient statistical assistance by the hospital or departmental staff, or outside personnel.

5. The trainees should avail of various research funding sources including the government, PPS, and other private funding organizations.

C. Research Outputs

1. The researches should be submitted for publication in various peer-reviewed journals.

2. The research papers should be filed in the department's library.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Composition, duties, and responsibilities of the department's research committee to include statistician
2. Departmental research agenda
3. Research program of the department
4. Research seminars, workshops, and lectures conducted by the department / hospital during the accreditation period
5. Research output per year during the accreditation period to include authors, source of funding, venues / fora presented, citations / prizes won, and publication details

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Research Education and Policies

( ) 1. The department has a formal written research program.

( ) 2. The research agenda is relevant to the national or regional health needs. Research studies with social relevance in the community where the department is located is encouraged.

( ) 3. The hospital / department conducts annual:
   3.1. Research lectures, seminars, or workshops
   3.2. EBM
   3.3. GCP

( ) 4. The residency program has a protected time for research work.

( ) 5. There are venues for oral presentations organized by the department, hospital, the PPS, or other organizations.

( ) MEAN

Resources – Human, Physical, and Financial

( ) 1. The trainees are given a consultant-adviser (co-author) who supervise them from the development of a proposal to the completion of research.

( ) 2. All research proposals are evaluated by the research coordinator or the research committee of the department.

( ) 3. All researches are approved by an ethics review committee or accredited institutional review board.

( ) 4. The trainees are given sufficient statistical assistance by the hospital or departmental staff, or outside personnel.

( ) 5. The trainees avail of various research funding sources.

( ) MEAN

Research Outputs

( ) 1. Each trainee submits a completed research paper at the end of the 3-year residency program.

Total number of residents during the accreditation period _____

Total number of completed researches _____

Percentage _____

Scoring

< 10%	0
10 – 29%	1
30 – 49%	2
50 – 69%	3
70 – 89%	4
≥ 90%	5

( ) 2. The completed researches are submitted for publication in various peer-reviewed journals.

( ) 3. The research papers are filed in the department's library.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Research Education and Policies		30	
Resources – Human, Physical, and Financial		30	
Research Outputs		40	
AREA MEAN		100	

Area 8: COMMUNITY INVOLVEMENT

For purposes of accreditation, a community is defined as a political group (purok, barangay, town or province), institution, school, agency, or any population group outside the hospital identified by the department for its community involvement program.

BASIC STANDARDS

1. The department must have a formal written community program that includes objectives, content, learning strategies, and evaluation criteria.

2. The community involvement program must be a family-centered, community-based partnership approach to provide high quality healthcare services that are affordable, accessible, continuous, coordinated, comprehensive, compassionate, and culturally effective.

3. A specific consultant must supervise the community involvement program.

4. There must be an identified health team or point person in the community.

QUALITY STANDARDS

A. Community Programs and Policies

1. The community involvement program should provide opportunities for trainees to develop skills in community and ambulatory pediatrics, health planning, and providing health services.

2. The department's vision-mission, projects and services must be made known to the community. (i.e., general assembly, meeting with leaders, newsletter, etc.)

3. Secondary data on the community should be available including:
   - 3.1. General characteristics (geography, demography, socio-economic data, religious and cultural data, and others)
   - 3.2. Resources (natural, technological, educational, civic, religious, charitable, industrial, government, health, and others)
   - 3.3. Needs (health, socio-economic, environmental, and others)

4. At least one (1) strategy should be implemented to give the trainees an opportunity to know the conditions and needs of the community (build community awareness). Examples are:
   - 4.1. Meetings with community leaders
   - 4.2. Research studies
   - 4.3. Community projects
   - 4.4. Field practicum
   - 4.5. Community surveys
   - 4.6. Interviews of key persons in the community

5. There should be evidence of measurable outcomes/impact of the programs/strategy.

6. There should be an active and functioning referral system between the community and the hospital.

7. There should be a Memorandum of Agreement (MOA) between the department / hospital and the community to provide safety measures for the trainees.

8. The community involvement should be periodically evaluated by the beneficiaries of the program.

9. The community program should be evaluated regularly by the department based on the expected outcomes.

B. Community Involvement

1. Service should be rendered through at least one of the following or similar strategies:
   1.1. Providing regular ambulatory clinic services for well and sick children
   1.2. Participation in the work of government and non-government organizations, schools, civic, and religious groups
   1.3. Conducting own community service projects (environmental health, *botika sa barangay*, training of barangay health workers, and others)
   1.4. Participation in the provision of primary health care services (EPI, CDD, CARI)
   1.5. Participation in public health education sessions (mothers' class)
   1.6. Participation in the services for the promotion of children's health (child safety, proper parenting and child care, reproductive health, school health, anti-smoking, alcohol and drugs, sports and other wellness programs, TB-DOTS, child protection)
   1.7. Participation in the provision of services for disadvantaged children (out of school youth, juvenile delinquents, homeless, street children)

2. The service in the community should be rendered following the frequency recommended by the HAB:
   2.1. Level I – at least twice weekly (half day)
   2.2. Level II – thrice weekly (half day)
   2.3. Levels III and IV – daily (whole or half day)

3. For residency training programs utilizing integrated (consortium) community projects, continuity should be assured by adopting a minimum of two projects shared by all members of the consortium.

4. The trainees, under the supervision of a consultant, should be involved in planning, implementing and evaluating community projects.

5. Health promotion and disease prevention should be emphasized in the program rather than care of the sick.

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Instructional design for community involvement
2. Departmental community team and health team (point person) in the community
3. MOA between the hospital / department and the community
4. Community profile indicating the duration of departmental presence in the community and the secondary data of the community.
5. Brief description of the strategies used to know the condition and needs of the community
6. Description of the public health projects of the department (include pictures and other forms of documentation)
   - 6.1 Include the schedule of clinics, services offered by the department, total number of recipients of each service during the accreditation period (per year), and top 10 causes of morbidities during the accreditation period (per year) – for regular ambulatory clinic services
   - 6.2 Include the inclusive dates of the project, background, objective, strategy, and results / evaluation for the following activities:
     - 6.2.1 Participation in the work of government and non-government organizations
     - 6.2.2 Own community service projects
     - 6.2.3 Participation in the services for the promotion of children's health
     - 6.2.4 Participation in the provision of services for disadvantaged children
     - 6.2.5 Participation in the provision of primary health care services (EPI, CDD, CARI)
   - 6.3 Include the topics discussed, materials used, participants, and results of evaluation and feedback – for participation in public health education sessions
7. Monthly schedule of trainees while on community rotation
8. Description of the referral system between the hospital and the community – including the number of beneficiaries during the accreditation period (per year)
9. Program evaluation by the community
10. Program evaluation by the department
11. Outcome measures of program intervention or impact to community.

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Community Programs and Policies

( ) 1. The department has a formal written community program that includes objectives, content, learning strategies, and evaluation criteria.

( ) 2. A specific consultant supervises the community involvement program.

( ) 3. The department's vision-mission, projects, and services are made known to the community.

( ) 4. There is an identified health team or point person in the community.

( ) 5. There are evidences of measurable outcomes of interventions (projects, activities and services).

( ) 6. At least one (1) strategy was implemented to give the trainees an opportunity to know the conditions and needs of the community. *Check the appropriate box.*

6.1. Meetings with community leaders _____

6.2. Research studies _____

6.3. Community projects _____

6.4. Field practicum _____

6.5. Community surveys _____

6.6. Interviews with key persons in the community _____

( ) 7. There is an active and functioning referral system between the community and the hospital.

( ) 8. There is a MOA between the department / hospital and the community to provide safety measures for the trainees.

( ) 9. The community involvement is periodically evaluated by the beneficiaries of the program.

( ) 10. The community program is evaluated regularly by the department based on the expected outcomes.

( ) MEAN

Community Involvement

( ) 1. Service is rendered through at least two of the following strategies (*Check the appropriate box)*:

1.1. Providing regular ambulatory clinic services for well and sick children _____

1.2. Participation in the work of government and non-government organizations, schools, civic, and religious groups _____

1.3. Conducting own community service projects (environmental health, *botika sa barangay*, training of barangay health workers, and others) _____

1.4. Participation in the provision of primary health care services (EPI, CDD, CARI) _____

1.5. Participation in public health education sessions (mothers' class) _____

1.6. Participation in the services for the promotion of children's health (child safety, proper parenting and child care, reproductive health, school health, anti-smoking, alcohol and drugs, sports and other wellness programs, TB-DOTS, child protection) _____

1.7. Participation in the provision of services for disadvantaged children (out of school youth, juvenile delinquents, homeless, street children) _____

Scoring		Score
Number of strategies:	2	1
	3	2
	4	3
	5	4
	≥ 6	5

( ) 2. The service in the community is rendered following the frequency recommended by the HAB:
   2.1. Level I – at least twice weekly (half day)
   2.2. Level II – thrice weekly (half day)
   2.3. Levels III and IV – daily (whole or half day)

( ) 3. The trainees, under the supervision of a consultant, are involved in planning, implementing and evaluating community projects.

4. Health promotion and disease prevention is emphasized in the program rather than care of the sick.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Community Programs and Policies		40	
Community Involvement		60	
AREA MEAN		100	

WEIGHT VALUES FOR THE OVERALL RATING

EVALUATION AREAS	MEANS		WEIGHT VALUE		PRODUCT
Training Program	5	X	**10**		50
Trainees	5	X	**10**	=	50
Consultants	5	X	**10**	=	50
Administration	5	X	**4**	=	20
Patient Services and Facilities	5	X	**6**	=	30
Research	5	X	**6**	=	30
Community Involvement	5	X	**4**	=	20
			50		250

Enter the means for each area of evaluation. *Supposing each area got a mean of 5, write 5 in each box under column 2.*
Multiply each mean by the WEIGHT VALUE to get the PRODUCT.

Get the sum of the products and divide it by 50 to get the average.
Sum of Products = Average
50

250 = 5 *(the highest possible rating if each area gets the highest possible mean)*
50

(See Appendix 7 – Summary of all documents to be submitted by hospital applying for accreditation/reaccreditation)

APPENDICES

APPENDIX 1

PPS HOSPITAL ACCREDITATION BOARD VISITATION GUIDE

Evaluation Area	Whom to Interview	Interview Coverage	Written Materials to Review	Facilities to Inspect
1. Training Program	Department Chair Training Officer Consultants (as many) Chief Resident Resident Physicians (as many)	Residency training program Supervision of training Innovations or electives for Residents Evaluation system Enrichment opportunities/Program Outside hospital rotation for Subspecialties Use of library and resource center/access to academic materials Community outreach program co-Curricular activities Participation in inter-hospital integrated program Issues encountered Grievance procedure	Residency training program Schedule of training activities, lectures, clinical conferences Evaluation system and forms Schedule of duties/rotation Schedule of outside hospital rotation Access to textbooks/journals Library acquisitions/holdings Patient records/charts Recommended incentive and sanctions Written procedure for infraction for academic & non-academic issues Communication from Committee on Education of the Hospital Accreditation Board of the WISE performance for the past three (3) years	Conference room Patient care areas Library Audio-visual equipment
2. Trainees	Chair Training officer Consultants Chief resident Residents	PPS HAB Manual Hospital Training Manual Resident admission process Supervision of trainees Formative and summative evaluation of residents Guidance and counselling Enrichment opportunities and professional development programs Feedback from specialty/subspecialty rotation (inhouse/external)	Policies on admission, promotion, completion, retention and dismissal Schedule of duties/rotation Residents' portfolio Performance evaluation sheets. Including WISE and feedback Policies on grievances and appeals Policies on safety in the workplace	Residents quarters and call room Library and resource center Community
3. Consultants	Consultants (as many) Department Chair Chief Resident Section Heads Committee Chairs	Selection process Consultant development program Evaluation and promotion Compensation, benefits, incentives Teaching assignment and workload Grievance procedure Issues & concerns	Consultants' manual Consultant development program (professional, personal, spiritual, social) Schedule of consultant workshops, conferences, and other professional activities Schedule of benefit, compensation & salaries Consultant evaluation by chair/peer/residents	Consultants' lounge/office

Evaluation Area	Whom to Interview	Interview Coverage	Written Materials to Review	Facilities to Inspect
4. Administration	Hospital Director Asst. Directors/ Chief of Clinics Department Chair Training Officer	Vision-mission of the hospital and department Organizational plan/chart Job description of section chiefs Staffing pattern in patient care areas Clerical support Department budget Sources/allocation of funds Department's short and long range plans Data privacy regulation Implementation of gov't mandated laws & policies	Vision-mission of the hospital and department Organizational plan/chart Job descriptions Development plans – long and short term Data privacy manual Compliance with DOH/Philhealth & other regulatory agencies Written plan for archiving	Offices
5. Patient Service and Facilities	Consultants-in-charge of various patient areas Department Chair Chief Resident Consultants Residents Pediatric area head nurses	Policies and procedures in the admission, care and discharge of patients in all pediatric cares of care: - Newborn services - Wards - Emergency Room - Outpatient - Pedia ICU - Subspecialty clinic - Medical equipment - Drugs and medical supplies Development and maintenance program for equipment and physical plant SOPs for use of various hospital facilities Disaster plan of hospital	Standard Operation Procedures or Rules and Policies in all pediatric areas of care: - Newborn services - Wards - Emergency Toom - Outpatient - Pedia ICU - Subspecialty clinic Formulary Patient records/chart Use of growth and other PPS recommended forms Development and maintenance program for equipment and physical plant Calibration of medical equipment	Newborn services Wards E.R. OPD Pedia ICU CPU Laboratory Radiology Equipment Supplies Library & resource center Conference room Call rooms Pedia office Restrooms
6. Research	Consultant-in-charge Department Head Chief Resident Consultants Residents	GCP Conduct of research IRB/Ethics review	Written plan for research Research papers of residents and consultants List of research in past years Consultants w/ GCP certification	Library & resource center

Evaluation Area	Whom to Interview	Interview Coverage	Written Materials to Review	Facilities to Inspect
7. Community Involvement	Consultant-in-charge Department Head Chief Resident Residents Consultants	Characteristics of the community (or the school, agency, institution or population group) Resources available in the community Socio-economic, environmental & health needs of the community Relationship of the hospital (Dept. Of Pediatrics) with the other sectors of the community (i.e. NGO's, government agencies, schools, church groups, business groups) The Department's contribution to the community's development The community's contribution to the growth of the hospital/ Department of Pediatrics Details of the Community Outreach Program	Basic data/ description of the community or population group The Community Outreach Program Researches done by residents concerning the community Updated MOA Outcomes/impact (Levels III and IV)	The actual community, agency institution of population group

APPENDIX 2

SUMMARY OF ROTATION OF RESIDENTS

Year Level	Areas of Rotation	Length of Rotation (Months)
First Year (12 months)	Ward	6
	OPD/ER	4
	NICU	2
Second year (12 months)	Ward	4
	OPD/ER	3
	Subspecialties and electives (1 month PICU ½ month Research ½ month Radiology)	2
	Community	1
	NICU	2
Third year (12 months)	Ward	3
	OPD/ER	2
	NICU	2
	Subspecialties and electives (1 month PICU 2 months Subspecialty of Choice 1 month Research)	4
	Community	1

APPENDIX 3

THE PPS MINIMUM EQUIPMENT REQUIREMENTS

TR	ER	OPC		N	
		WC	SC		
☐	☐	☐	☐	☐	Weighing scale, beam type
				☐	Clean N
				☐	Isolation N
☐	☐	☐	☐	☐	Infantometer/Stadiometer
☐	☐	☐	☐	☐	Sphygmomanometer with different pediatric cuffs
☐	☐	☐	☐	☐	Ophthalmoscope-otoscope set
☐	☐			☐	Laryngoscope
☐	☐			☐	Catheters
☐	☐			☐	Oxygen supply
☐	☐			☐	Tray with emergency drugs
☐	☐			☐	Suction apparatus
☐	☐			☐	Ambubag
☐	☐			☐	Resuscitator
☐	☐			☐	Cutdown set
☐	☐			☐	Lumbar puncture set
☐	☐			☐	Bililight
☐	☐			☐	Incubator / isolette
☐					Bone marrow needle/set
☐					Incubator / isolette
	☐	☐			Defibrillator
	☐	☐			Emergency cart

Legend:
TR- Treatment Room
ER- Emergency Room
OPC- Outpatient Clinic
WC- Well Child
SC- Sick Child
N- Newborn/NICU

APPENDIX 4

PPS REQUIRED TEXTBOOKS AND JOURNALS

(The list is updated regularly in separate communications to the accredited program/department)

The latest edition of the following books and journals must be available at all times:

A. Basic textbooks

1. Fundamentals of Pediatrics: Competency-Based Textbook of Pediatrics
2. Nelson's Textbook of Pediatrics (Latest Edition)
3. PALS/CPR Manual
4. NRP Manual
5. Bioethics
7. PE and Data Gathering
8. Pediatric Procedures

B. Main Journals

1. Philippine Journal of Pediatrics
2. One foreign pediatric journal (ex. The green or gray Journal of Pediatrics). On line subscription is acceptable.

C. All PPS Publications

1. Anthropometrics PPS/FNRI
2. Standards of Child Care
3. Standards of Newborn Care
4. CCD Manual
5. Handbook of Pediatric Infectious Diseases
6. Handbook on Newborn Care
7. Core Pediatrics
8. Tuberculosis in Infancy and Childhood
9. National Consensus on Childhood TB
10. IMCI / CATT WHO
11. Preventive Health Care Manual
12. CPGs
13. Policy Statements
14. Proceedings of PPS Annual Convention
15. Undergraduate Pediatric Curriculum Manual and other UPEC teaching modules.
16. ICD 10
17. PPS Code of Ethics
18. PMA Code of Ethics
19. PPS Accreditation Manual
20. Child Protection Manual
21. Childhood Immunization Schedule
22. Other new PPS publications

D. The pediatric library shall have a book or reference on **ALL** pediatric subspecialties. In addition, books on the following topics shall be available.

1. Adolescent Medicine
2. Ambulatory Pediatrics
3. Child Development and Behavior Problems
4. Child Psychiatry
5. Critical Care
6. Diseases of the Newborn
7. Emergency Pediatrics
8. Genetics
9. Oncology
10. Pediatric Pharmacology and Therapeutics
11. Philippine National Drug Formulary
12. Poisoning and Toxicology
13. Fundamentals of Pediatrics: A Competency Based Approach
14. Red Book
15. Fe del Mundo Textbook of Pediatrics

Appendix 5

PHILIPPINE SOCIETY OF NEWBORN MEDICINE
NEOHAB CLASSIFICATION OF NEONATAL UNITS

A Neonatal Intensive Care Unit (NICU) is a unit with appropriate resources and staff skilled in the provision of newborn care, with higher level units deemed capable of managing premature babies and more critically ill newborns. A system of classification will enable the following:

1) Provide definitions for classification of NICUs based on the increasing complexity of neonatal care, which will be used for institutions with pediatric residency training programs
2) Provide the local standards for each level that facilities can aspire to achieve
3) Mapping of facilities in terms of their capacity to provide neonatal care, that will subsequently designate their role in the service delivery network in each region

The NEOHAB improves on the previous classification of newborn care services contained in 4th edition of the Philippine Society of Newborn Medicine's Standards of Newborn Care 2017 by the addition of protocols and procedures and statistical data collection. Identification of the capabilities of each facility will improve neonatal outcomes since it will allow recognition of high-risk neonates that need to be referred to higher level centers with the suitable resources and skilled personnel. The statistics will allow monitoring of neonatal morbidity and mortality and track outcomes for each facility.

The classification of levels of care is based on the evaluation of the following areas of concern:

I. Level of Care –therapies and services provided
II. Patient Category –based on gestational age, birth weight, severity of illness
III. Laboratory/ Ancillary Services Available – including but not limited to diagnostic, imaging and screening studies. Classification will be based on availability of the tests, and evaluations may be outsourced without downgrading the level of care
IV. Structural Requirement – recommendations for physical plant, with some being optional for a specific level
V. Functional Areas - some areas considered optional for a specific level
VI. Human Resources - medical, nursing and ancillary staff and their qualifications; may be visiting consultants
VII. Equipment – supplies and machines appropriate to the level of care provided
VIII. Records (Hospital Information System) – systematic documentation of each individual neonate cared for by the institution
IX. Protocols & Procedures – documents on the specific plan of management (protocol) and standard steps (procedure) done for common neonatal conditions
X. Statistical Report –indices on neonatal birth, morbidity and mortality
XI. Certifications – mandatory certifications relevant to newborn care required for licensing of health care facilities

NEOHAB CLASSIFICATION OF NEONATAL UNITS

REQUIREMENT	LEVEL I	LEVEL II	LEVEL III	LEVEL IV
I. LEVEL OF CARE	• Basic care of normal / low risk newborn • EINC 4 core steps • Neonatal resuscitation • Post-natal care for stable term newborns • Family Centered Care	<u>Level I plus the following:</u> • Acute care management of selected high risk and moderately ill newborns and monitoring of problems anticipated to resolve rapidly (not anticipated to need sub-specialty services on an urgent basis) • Convalescent care after intensive care • Ventilatory support (nasal CPAP) • Kangaroo Mother Care Note: Level II patients must be referred to a neonatologist	<u>Level II plus the following:</u> • Comprehensive high risk and intensive care for infants born at all ages and birth weights • Sustained critical care and full range of ventilator support • High Risk or Kangaroo Mother Care (KMC) Program with Follow up Clinic	<u>Level III plus the following:</u> • Provision for surgical repair of complex congenital conditions • Facilitation of transport and provision for outreach education
II. PATIENT CATEGORY	• Full term 37-42 weeks • Preterm 34 or more completed weeks AGA (birth weight ≥ 2000 gm) Note: If unstable, transfer to higher level of care	<u>Level I plus the following:</u> • Gestational age ≥32 weeks • Gestational ≥ 42 weeks • Stable NB > 32 weeks and > 1500 g for transfer • SGA • LGA	<u>Level II plus the following:</u> • Referral Center • Any sick infant up to 44 weeks post-conceptional age needing medical and surgical care • Infants < 32 weeks and <1500 g	<u>Level III plus the following:</u> • Infants with complex congenital anomalies • Infants requiring ECMO

III.	**LABORATORY/ ANCILLARY SERVICES AVAILABLE**	Available 24 hours: • Laboratory – CBC, CBG • Radiology • ENBS • OAE testing • CCHD screening	<u>Level I plus the following:</u> • Laboratory – Biochemistry • Radiology + trained staff • Blood Bank • Microbiology • Serology • Portable x-ray machine • Pharmacy	<u>Level II plus the following:</u> • Ultrasound (portable) • CT scan • MRI • Echocardiography (portable) • Ophthalmologic screening • Pharmacy with life-saving drugs, e.g. surfactant • Human Milk Storage Facility • Human Milk Bank - *optional*	<u>Level III plus the following:</u> • Drug levels determination
IV.	**STRUCTURAL REQUIREMENT**	• Proximity to Delivery Room • Good lighting • 1 Sink for every 6-8 patients • Electrical outlets (at least four per functional area) • Oxygen	<u>Level I plus the following:</u> • Oxygen & compressed air • Foot -knee/elbow or sensor operated scrub sink	<u>Level II plus the following:</u> • Piped-in oxygen and compressed air	Same as Level III
V.	**FUNCTIONAL AREAS**	• Handwashing Area • Resuscitation/ Admitting Area • Breastfeeding Area/ Kangaroo Care Area • Storage area for supplies & equipment • Nurses' Station/ Clerical Area • Utility Room (clean & dirty) • Staff Room/Quarters • Intermediate Room - *optional* • Conference Room - *optional*	<u>Level I plus the following:</u> • Intermediate Room (Special Care/Continuing Care/Step-down Area) • Intensive Care Room • Isolation Room • Conference Room - *optional*	<u>Level II plus the following:</u> • Conference Room • Bereavement Area	Same as Level III
Note: Lower units may re-admit patients from higher level units for continuing care					

VI. HUMAN RESOURCES				
1. Training	80% of staff in newborn care trained in: • NRPh+ • Lactation Management Training (LMT)	80% of staff in maternal & newborn care trained in: • NRPh+ • Lactation Management Training (LMT) • Care of the Small Baby (CSB)	Same as Level II	Same as Level II
2. Medical Staff				
a. Pediatrician/ Neonatologist	• Board Certified Pediatrician	• Board Certified Neonatologist • Board Eligible Neonatologist (in the absence of a board certified neonatologist) – *should be certified within 2 years after accreditation visit* • Board Certified Pediatrician	• Board Certified Neonatologist	Same as Level III
b. Pediatric Medical Subspecialists		• Cardiologist	<u>Level II plus the following:</u> • Neurologist • Hematologist • Infectious Disease specialist • Gastroenterologist • Pulmonologist • Endocrinologist – on call • Developmental Pediatrician – on call • Geneticist – on call	Same as Level III
c. Pediatric Surgery Subspecialists		• Pediatric Surgeon • Ophthalmologist • Otorhinolaryngologist (ENT)	<u>Level II plus the following:</u> • Pediatric Ophthalmologist/ Retina specialist • Cardiovascular Surgeon (TCVS) • Neurosurgeon • Orthopedic Surgeon • Urologist	Same as Level III

d. Other Pediatric Subspecialists		• Radiologist • Infection Control Committee	• Pediatric Radiologist • Infection Control Committee • Pediatric Anesthesiologist • Rehabilitation Medicine	Same as Level III
e. Pediatric Residents	• Year I	• Year II-III	• Year II-III	• Year II-III
3. Nursing Staff Registered Nurses Registered Midwives (NAs)	• Trained in perinatal care • Recognizes need for transfer or referral to higher level facility • Skilled in breastfeeding techniques	<u>Level I plus the following:</u> • Trained in O2 therapy, CPAP/ventilator use • Trained in caring for sick neonates (cardiopulmonary monitoring, maintenance of metabolic and thermal function) • Trained in advanced resuscitation • Can operate NICU equipment • Skilled in lactation management/with Lactation Nurse	<u>Level II plus the following:</u> • Can understand principles of mechanical ventilation	Same as Level III
4. Ideal Nurse to Patient Ratio	1:6	1:3-5	NICU 1:1-2 Special Care 1:3-5 Intermediate Care 1:5-6	Same as Level III
5. Support Personnel	• Laboratory Technician • Radiology Technician	<u>Level I plus the following:</u> • Social worker • Pharmacist • Biomedical engineer *- optional*	<u>Level II plus the following:</u> • Respiratory therapist • Nutritionist-Dietician • Biomedical engineer • Clinical Pharmacist *- optional*	Same as Level III
VII. EQUIPMENT	• Emergency Cart (with drugs and IVF) • Resuscitation set: Laryngoscope (straight blade 0,1, 2)	<u>Level I plus the following:</u> • Diagnostic set (otoscope & ophthalmoscope) • Syringe/infusion pumps • Neonatal incubator/	<u>Level II plus the following:</u> • Mechanical ventilator • ABG machine • Oxygen blender • Cardiac monitor/vital signs monitor	<u>Level III plus the following:</u> • High frequency ventilator • Nitric oxide machine - *optional*

	Neonatal resus. bag with preterm/term mask sizes Endotracheal tubes Fr 2.5, 3.0, 3.5, 4.0) • Resuscitation Table • Radiant warmer or secure overhead source of heat • Pulse oximeter • Stethoscopes • NIBP apparatus with neonatal cuff • Suction machines with pressure regulator • Phototherapy units • Clock or timer • Digital thermometers • Non-mercury room thermometers • Weighing scale, preferable digital	radiant warmer • Transport incubator • CPAP machine • Umbilical catheterization set • Exchange transfusion set • KMC reclining chair • Freezer for breast milk storage • Mechanical ventilator *- optional* • ABG machine *- optional* • Oxygen blender *- optional*	• PICC Line set • Thoracostomy set • Therapeutic hypothermia capability • High frequency ventilator *- optional*	• ECMO capability *- optional* • Research facility – with trained research staff and equipment
VIII. RECORDS (Hospital Information System)	• Individual Patient Records	• Individual Patient Records	• Individual Patient Records	• Individual Patient Records
IX. PROTOCOLS & PROCEDURES				
Protocols	• Prevention of preterm birth and its complications • Essential Intrapartum and Newborn Care • Neonatal resuscitation (NRPh+) • Criteria for admission to the	<u>Level I plus the following:</u> • Respiratory distress syndrome • Neonatal hyperbilirubinemia • Neonatal hypoglycemia • Neonatal hypothermia • Neonatal sepsis • Kangaroo Mother	<u>Level II plus the following:</u> • Anemia of prematurity • Intraventricular hemorrhage • Birth asphyxia • Therapeutic hypothermia • Kangaroo Mother Care (KMC) Program	Same as Level III

	NICU and admission set up and care guidelines • Breastfeeding/ Lactation Management	Care (KMC) Method • Infection Control (Antimicrobial surveillance – monthly monitoring/ hospital antibiogram)		
Procedures	• Neonatal resuscitation • Newborn metabolic screening (Expanded NBS) • Newborn hearing screening (Otoacoustic emissions testing) • Critical congenital heart disease (CCHD) screening • Red orange reflex (ROR) screening	<u>Level I plus the following:</u> • Lumbar tap • Blood transfusion • Retinopathy of Prematurity Screening • Phototherapy • Surfactant administration • Umbilical cannulation • Double volume exchange transfusion • Ventilatory support	<u>Level II plus the following:</u> • Endotracheal intubation • Peripherally Inserted Central Catheter (PICC) line insertion • Needling • Thoracentesis • Thoracostomy tube insertion	Same as Level III
X. STATISTICAL REPORT				
	1) Total number of live births 2) Manner of delivery (NSD, CS, etc.) 3) Total number of admissions a. Admissions according to maturity and weight for age b. Admissions according to sex c. Leading causes of admissions 4) Practice of EINC (4 Core steps)	Level I plus the following: 1) Morbidity rates (no. of cases/ total live births) for specific conditions including, but not limited to: a. Prematurity b. Asphyxia c. Sepsis and severe infections d. Congenital anomalies 2) Total number of mortalities/mortality rates a. Perinatal death rate = (no. of	Same as Level II	Same as Level II

	a. Complete b. Incomplete 5) Practice of Breastfeeding a. Breastfeeding initiation within an hour after birth b. Breastfeeding rate until discharge 6) Newborn metabolic screening (ENBS) rate 7) Newborn hearing screening (OAE testing) rate 8) CCHD screening rate 9) ROR screening rate	stillbirths + neonatal deaths/ total number of deliveries) x 1000 b. Neonatal mortality rate = (no. of deaths before 28 days/ total live births) x 1000 c. Cause-specific mortality rates (Preterm, asphyxia, sepsis and severe infections, congenital anomalies) d. Case fatality rates (Preterm, term, low birth weight, asphyxia, sepsis) e. Leading causes of mortalities 3) Antenatal steroid use and newborn outcomes a. No. of preterms whose mothers received at least one dose of antenatal steroid/ preterms less than 34 weeks AOG x 100 b. No. of preterm deaths from respiratory distress syndrome (RDS)/ no. of preterms whose mothers received at least one dose of antenatal steroid 4) Surfactant use and patient		

		outcomes a. No. of preterms who received one dose of surfactant/ preterms with RDS b. No. of preterm deaths from RDS/ no. of preterms who received one dose of surfactant 5) Practice of KMC a. Number of eligible patients b. Number of enrolled patients c. Patient outcomes (discharged, mortality) 6) Retinopathy of Prematurity (ROP) screening rate		
XI. CERTIFICATIONS				
MBFHI	Full Accreditation	Full Accreditation	Full Accreditation	Full Accreditation

References:

1. PPS HAB 2013
2. Hernandez EA, Matias AD, Santos W. & Salazar, J. B. (2017). 'Ethics in Perinatal Care' in *Standards of Newborn Care (4th ed.),* Philippine Society of Newborn Medicine, Quezon City, Philippines
3. Department Order 2017- Establishment of Neonatology Centers in Selected Department of Health (DOH) Hospitals
4. Self-assessment Tool for the Z Benefits for Premature and Small Newborns

NEOHAB Assessment Checklist for Classification of Neonatal Units

Date of Assessment:

Name of Institution:

Name and signature of Assessor:

Instructions:

1. Indicate compliance with requirement by placing a check (✓) in the column after the description.
2. For parameters with additive components, ex: Level II (Level I plus the following):, please check all that apply.
3. Classification of Level of Care will be filled up last.

REQUIREMENT	✓	REMARKS
I. LEVEL OF CARE		
Level I: Well Newborn Unit		
Level II: Special Care Unit		
Level III: Neonatal Intensive Care Unit		
Level IV: Referral NICU		
Classification of Level of Care:		
II. PATIENT CATEGORY		
Level I:		
Full term		
Stable preterm ≥ 34 weeks (BW ≥ 2000 g) (Note: If unstable, transfer to higher level of care)		
Level II (Level I plus the following):		
Preterm ≥ 32 weeks		
Post-term ≥ 42 weeks		
Stable preterm ≥ 32 weeks and > 1500 g for transfer		
Small for gestational age		
Large for gestational age		
Level III (Level II plus the following):		
Sick neonates up to 44 weeks post-conceptional age		
< 32 weeks and <1500 g		
Level IV (Level III plus the following):		
Infants with complex congenital anomalies		
Infants requiring ECMO		
Classification of Patient Category:		
III. LABORATORY/ ANCILLARY SERVICES AVAILABLE		
Level I:		
Laboratory – CBC, CBG		
Radiology		
ENBS		
OAE testing		
CCHD screening		
Level II (Level I plus the following):		
Laboratory –Biochemistry		
Radiology + trained staff		
Blood Bank		
Microbiology		
Serology		
X-ray machine (portable)		
Pharmacy		

Level III (Level II plus the following):		
Ultrasound (portable)		
CT scan		
MRI		
Echocardiography (portable)		
Ophthalmologic screening		
Pharmacy with life-saving drugs, e.g. surfactant		
Human Milk Storage Facility		
Human Milk Bank - *optional*		
Level IV (Level III plus the following):		
Drug levels determination		
Classification of Laboratory/Ancillary Services Available:		
IV. STRUCTURAL REQUIREMENT		
Level I:		
Proximity to Delivery Room		
Good lighting		
1 Sink for every 6-8 patients		
Electrical outlets (at least four per functional area)		
Oxygen		
Compressed air		
Level II (Level I plus the following):		
Oxygen and compressed air		
Foot-knee/elbow or sensor operated scrub sink		
Level III-IV (Level II plus the following):		
Piped-in oxygen and compressed air		
Classification of Structural Requirement:		
V. FUNCTIONAL AREAS		
Level I:		
Handwashing Area		
Resuscitation/Admitting Area		
Breastfeeding Area/ Kangaroo Care Area		
Storage area for supplies and equipment		
Nurses' Station/Clerical Area		
Utility Room (clean & dirty)		
Staff Room/Quarters		
Level II (Level I plus the following):		
Intermediate Room (Special Care/Continuing Care/Step-down Area)		
Intensive Care Room		
Isolation Room		
Level III-IV (Level II plus the following):		
Conference Room		
Bereavement Area		
Classification of Functional Areas:		
VI. HUMAN RESOURCES		
1. Training		
Level I (80% of newborn care staff trained):		
Philippine Essential Newborn Care and Resuscitation Program (NRPh+)		
Lactation Management Training (LMT)		
Level II-IV (80% of staff in maternal and newborn care trained):		
Philippine Essential Newborn Care and Resuscitation Program (NRPh+)		
Lactation Management Training (LMT)		
Care of the Small Baby (CSB)		
2. Medical Staff		
a. Pediatrician/ Neonatologist		
Level I:		
Board Certified Pediatrician		

Level II:		
Board Certified Neonatologist		
Board Eligible Neonatologist – *should be certified within 2 years*		
Board Certified Pediatrician		
Level III-IV:		
Board Certified Neonatologist		
b. Pediatric Medical Subspecialists		
Level II:		
Cardiologist		
Level III-IV (Level II plus the following):		
Neurologist		
Hematologist		
Infectious Disease specialist		
Gastroenterologist		
Pulmonologist		
Endocrinologist – on call		
Developmental Pediatrician – on call		
Geneticist – on call		
c. Pediatric Surgery Subspecialists		
Level II:		
Pediatric Surgeon		
Ophthalmologist		
Otorhinolaryngologist (ENT)		
Level III-IV (Level II plus the following):		
Pediatric Ophthalmologist/ Retina specialist		
Cardiovascular Surgeon (TCVS)		
Neurosurgeon		
Orthopedic Surgeon		
Urologist		
d. Other Pediatric Subspecialists		
Level II:		
Radiologist		
Infection Control Committee		
Level III-IV (Level II plus the following):		
Pediatric Radiologist		
Infection Control Committee		
Pediatric Anesthesiologist		
Rehabilitation Medicine		
e. Pediatric Residents		
Level I:		
Year I Resident		
Level II-IV:		
Year II-III Residents		
3. Nursing Staff		
Level I:		
Trained in perinatal care		
Recognizes need for transfer or referral to higher level facility		
Skilled in breastfeeding techniques		
Level II (Level I knowledge and skills plus the following):		
Trained in O2 therapy, CPAP/ventilator use		
Trained in caring for sick neonates		
Trained in advanced resuscitation		
Can operate NICU equipment		
With Lactation Nurse		
Level III-IV (Level II knowledge and skills plus the following):		
Can understand principles of mechanical ventilation		
4. Ideal Nurse to Patient Ratio*		
Level I:		

1:6		
Level II:		
1:3-5		
Level III-IV:		
1:1-2		
Special Care 1:3-5		
Intermediate Care 1:5-6		
5. Support Personnel		
Level I:		
Laboratory Technician		
Radiology Technician		
Level II (Level I plus the following):		
Social worker		
Pharmacist		
Biomedical engineer - *optional*		
Level III-IV (Level II plus the following):		
Respiratory therapist		
Nutritionist-Dietician		
Biomedical engineer		
Clinical Pharmacist - *optional*		
Classification of Human Resources:		
VII. EQUIPMENT		
Level I:		
Emergency Cart (with drugs and IVF)		
Resuscitation set containing the following: Laryngoscope (straight blade 0,1, 2) Neonatal resuscitation bag with preterm/term mask sizes Endotracheal tubes (Fr 2.5, 3.0, 3.5, 4.0)		
Resuscitation Table		
Radiant warmer or secure overhead source of heat		
Pulse oximeter		
Stethoscopes		
NIBP apparatus with neonatal cuff		
Suction machines with pressure regulator		
Phototherapy units		
Clock or timer		
Digital thermometers		
Non-mercury room thermometers		
Weighing scale, preferable digital		
Level II (Level I plus the following):		
Diagnostic set (otoscope & ophthalmoscope)		
Syringe/infusion pumps		
Neonatal incubator/ radiant warmer		
Transport incubator		
CPAP machine		
Umbilical catheterization set		
Exchange transfusion set		
KMC reclining chair		
Freezer for breast milk storage		
Level III (Level II plus the following):		
Mechanical ventilator		
ABG machine		
Oxygen blender		
Cardiac monitor/VS monitor		
PICC Line set		
Thoracostomy set		
Therapeutic hypothermia capability		
Level IV (Level III plus the following):		
High frequency ventilator		

Research Facility		
Nitric oxide machine - *optional*		
ECMO capability - *optional*		
Classification of Equipment:		
VIII. RECORDS (Hospital Information System)		
Levels I-IV:		
Individual Patient Records		
IX. PROTOCOLS & PROCEDURES		
PROTOCOLS (including not limited to the following):		
Level I:		
Prevention of preterm birth and its complications		
Essential Intrapartum and Newborn Care		
Neonatal resuscitation (NRPh+)		
Criteria for admission to the NICU and admission set up and care guidelines		
Breastfeeding/ Lactation Management		
Level II (Level I plus the following):		
Respiratory distress syndrome		
Neonatal hyperbilirubinemia		
Neonatal hypoglycemia		
Neonatal hypothermia		
Neonatal sepsis		
Kangaroo Mother Care (KMC) Method		
Infection Control (Antimicrobial surveillance – monthly monitoring/ hospital antibiogram)		
Level III-IV (Level II plus the following):		
Anemia of prematurity		
Intraventricular hemorrhage		
Birth asphyxia		
Therapeutic hypothermia		
Kangaroo Mother Care (KMC) Program		
PROCEDURES (including but not limited to the following):		
Level I:		
Neonatal resuscitation		
Newborn metabolic screening (Expanded newborn screening)		
Newborn hearing screening (Otoacoustic emissions testing)		
Critical congenital heart disease (CCHD) screening		
Red orange reflex (ROR) screening		
Level II (Level I plus the following):		
Lumbar tap		
Blood transfusion		
Retinopathy of Prematurity (ROP) Screening		
Phototherapy		
Surfactant administration		
Umbilical cannulation		
Double volume exchange transfusion		
Ventilatory support		
Level III-IV (Level II plus the following):		
Endotracheal intubation		
Peripherally Inserted Central Catheter (PICC) line insertion		
Needling		
Thoracentesis		
Thoracostomy tube insertion		

Classification of Protocols and Procedures:		
X. STATISTICAL REPORT		
Level I:		
Total number of live births		
Manner of delivery (NSD, CS, etc.)		
Total number of admissions a. Admissions according to maturity and weight for age b. Admissions according to sex c. Leading causes of admissions		
Practice of EINC (4 Core steps) a. Complete b. Incomplete		
Practice of Breastfeeding c. Breastfeeding initiation within an hour after birth d. Breastfeeding rate until discharge		
Newborn metabolic screening (ENBS) rate		
Newborn hearing screening (OAE testing) rate		
Critical congenital heart disease (CCHD) Screening rate		
Red orange reflex (ROR) Screening rate		
Level II-IV (Level I plus the following):		
Morbidity rates (no. of cases/ total live births): a. Prematurity b. Asphyxia c. Sepsis and severe infections d. Congenital anomalies		
Total number of mortalities/mortality rates a. Perinatal death rate = (no. of stillbirths + neonatal deaths/ total number of deliveries) x 1000 b. Neonatal mortality rate = (no. of deaths before 28 days/ total live births) x 1000 c. Cause-specific mortality rates (Preterm, asphyxia, sepsis and severe infections, congenital anomalies) d. Case fatality rates (Preterm, term, low birth weight, asphyxia, sepsis) e. Leading causes of mortalities		
Antenatal steroid use and newborn outcomes a. No. of preterms whose mothers received at least one dose of antenatal steroid/ preterms less than 34 weeks AOG x 100 b. No. of preterm deaths from respiratory distress syndrome (RDS)/ no. of preterms whose mothers received at least one dose of antenatal steroid		
Surfactant use and patient outcomes c. No. of preterms who received one dose of surfactant/ preterms with RDS d. No. of preterm deaths from RDS/ no. of preterms who received one dose of surfactant		
Practice of KMC a. Number of eligible patients b. Number of enrolled patients c. Patient outcomes (discharged, mortality)		
Retinopathy of Prematurity (ROP) Screening rate		
Classification of Statistical Report:		
XI. CERTIFICATIONS		
Levels I-IV:		
MBFHI Full Accreditation		

*May be lenient with the requirement

APPENDIX 6

SPCCMP HICUAB ASSESSMENT CHECKLIST FOR CLASSIFICATION OF PEDIATRIC INTENSIVE CARE UNITS

(Note: This form shall be accomplished and submitted by the Institution to the PPS HAB for classification or re-classification)

Name of Institution:

Date:

The Philippine Pediatric Society Hospital Accreditation Board (PPS HAB) requires that all residents-in-training should be exposed to the management of critically-ill pediatric patients in a designated pediatric intensive care unit during their second and third year. In order to fulfill this, residents will need to rotate in a PICU designated and maintained to provide for maximum patient care experience. In line with this, the Society of Pediatric Critical Care Medicine Philippines (SPCCMP) has set forth certain criteria to be fulfilled by HAB-accredited hospitals which will serve to improve the level of care given to children in need of our services wherever and whenever they may need it.

In order to establish, operate and maintain an area designated for pediatric intensive care while preserving the minimum standards of care for critically-ill children, all PPS HAB-accredited hospitals in the Philippines henceforth must conform to specific criteria set by the SPCCMP and approved by the PPS.

The SPCCMP accredits pediatric intensive care units in 3 levels:

LEVEL I PICU – the institution or hospital meets all the essential & 50% of the desired criteria. Level I-IV PPS HAB hospitals who belong in this category can only have their residents rotate in LEVEL II PICUs

LEVEL II PICU – the institution or hospital meets all the essential & 75% of the desired criteria plus have at least 3 critically-ill admitted or referred patients per month. A structured, monitored program of rotation will be expected. A PPS HAB Level I hospital may apply to be accredited in this category; levels II-IV must be in this category. PPS HAB Level I hospitals which cannot fulfill LEVEL II criteria must have their residents rotate either in a Level II or III PICU

LEVEL III PICU – the institution or hospital has a highly-specialized PICU with an accredited pediatric critical care fellowship training program

Whatever the PICU level, the hospital must have a board-certified pediatric intensivist, in either an active or visiting capacity in the pediatric department, as its director or head. The accredited pediatric intensivist is the designated captain of the ship while patients require intensive care management. The hospital must exert all efforts in order to satisfy and maintain these criteria to keep its status in succeeding accreditations.

ESSENTIAL REQUIREMENTS	✓	REMARKS
GENERAL HOSPITAL WITH FULL TIME SERVICES		
Emergency Room		
Pediatrics		
Surgery		
Radiology (X-ray)		
Laboratory		
Mortuary		
POLICIES		
Admission and Discharge		
Patient Monitoring		
Safety		
Infection Control		
Traffic Control/Visiting Hours		
Maintenance of Equipment		
Record Keeping		
Periodic Review		
Morbidity/Mortality		
Quality of Care		
Safety and Medical/Pharmacy error		
Disaster Response and Preparedness		
PHSYICAL FACILITY INTERNAL (as per hospital policies)		
Medication Station with Drug Refrigerator		
Designated Bed (At least one)		
Emergency Equipment Cart with Cardiac board		
Hand Washing Facility		
Available oxygen outlet/tank per bed		

Available compressed air outlet/tank per bed		
Available Suction outlet/machine per bed		
PERSONNEL		
Director/Head		
Has written appointment		
Certified and in good standing by SPCCMP		
Physician Staff		
Pediatric Residency in training 24 hour duty		
Updated Pediatric Basic Life Support certificate or its equivalent in the institution		
Updated Pediatric Advanced Life Support certificate or its equivalent in the institution		
Nursing staff		
Nurse Manager		
Nurse:Patient Ratio of 1:2 to 1:3		
Updated Pediatric Basic Life Support certificate or its equivalent in the institution		
Updated Pediatric Advanced Life Support certificate or its equivalent in the institution		
HOSPITAL EQUIPMENT AND SERVICES		
Emergency drugs (Epinephrine, Lidocaine, Glucose, Crystalloids, Atropine, Diazepam/Midazolam, Mannitol, Furosemide, Dopamine, Dobutamine, Norepinephrine)		
Infusion/Syringe pumps		
Defibrillator		
Blood pressure apparatus (all pediatric cuff sizes)		
Weighing scale		
Beds/Cribs with side rails		
Wall Clock (analog)		
Pulse Oximeter		

Intubation sets (all sizes)		
Resuscitation bag and mask (all sizes)		
Endotracheal tubes (all sizes)		
Vascular access equipment		
Respiratory Support Equipment		
Oxygen delivery (Cannula, Face Mask, Non-rebreather Mask)		
Nebulizer		
Ventilators (owned/rental)		
Quality Improvement		
Mortality and Morbidity Review		
Medical Records Review		
Logbook of Activities		

DESIRED REQUIREMENTS (at least 50% for LEVEL I and 75% for LEVEL II, inclusive of items with an asterisk*)	✓	REMARKS
GENERAL HOSPITAL WITH FULL TIME SERVICES		
Otorhinolaryngology		
Ophthalmology		
Orthopedics		
Toxicology/Poison Control		
Child Protection Services		
Rehabilitation Medicine		
Blood gas machine*		
Computed Tomography Scan		
Magnetic Resonance Imaging		
PHYSICAL FACILITY EXTERNAL		
Distinct Separate Unit		
Controlled Access (Visiting hours/Security)*		

PHYSICAL FACILITY INTERNAL		
Isolation Room*		
Clean Utility Linen Room		
Soiled Utility Linen Room		
Staff toilet		
10 or more electrical outlets per bed		
PERSONNEL		
Pediatric Subspecialist		
Cardiologist*		
Nephrologist		
Hematologist/Oncologist		
Pulmonologist*		
Endocrinologist		
Gastroenterologist		
Allergy/Immunology		
Neurologist		
Infectious Disease*		
Toxicologist		
Pediatric Radiologist		
Respiratory Therapist*		
Pastoral service		
HOSPITAL FACILITIES AND SERVICES		
Blood bank with storage		
Electrocardiography machine*		
Electroencephalography machine		
2D- Echocardiography machine		
Infant warmer		
Transport Monitor		

Capnograph		
PATIENT LOAD REQUIREMENT		
At least 3 admissions/referrals per month*		

Accomplished by:

_____

Name and signature / Date

Department chair/representative:

_____

Name and signature / Date

APPENDIX 7

LIST OF DOCUMENTS TO BE SUBMITTED BY HOSPITAL APPLYING FOR ACCREDITATION OR REACCREDITATION

Area 1: VISION-MISSION-OBJECTIVES

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. VMO of the institution
2. VMO of the department

EVALUATION INSTRUMENT

The accreditors should use the vision-mission-objectives as guideposts in evaluating the different areas of the department. Since these analysis statements are not weighted, their scores are not included in the overall computation. The following symbols should be used:

E	The statement or condition is clearly evident.
N	The statement or condition is not clearly evident.
M	The statement or condition is missing or not evident.

INSTRUCTIONS: Evaluate each statement using the scale provided. Write the assessment inside the parenthesis. A numerical rating is NOT needed for this area.

( ) 1. The vision-mission-objectives are aligned with the vision-mission-objectives of the PPS and the institution.

( ) 2. The vision-mission-objectives are clearly stated.

( ) 3. The vision-mission-objectives are made known to its constituency through various means.

( ) 4. The vision-mission-objectives encompass quality training, research, patient care, and social responsibility.

( ) 5. The vision-mission-objectives include governance.

( ) 6. The objectives of the residency program are aligned with the program outcomes set by the PPS.

( ) 7. The objectives of the training program are clearly specified and attainable.

( ) 8. The objectives of the training program address the development of habits and attitudes necessary to practice the profession with integrity and ethical conduct.

Area 2: TRAINING PROGRAM

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Brief description of the training program, including its unique features
2. Instructional design in general pediatrics
3. Instructional designs in the subspecialties
4. Schedule of rotations of trainees
5. Monthly and weekly schedules of activities
6. List of books and references indicating the years of publication
7. Evaluation tools for:
   a. Different conferences and activities
   b. Monthly or quarterly clinical evaluation
   c. Annual summative evaluation
   d. Program evaluation
8. List of graduates in the past accreditation period with the results of their performances in the PPS certifying examinations.
9. Yearly performance report on the WISE indicating the number of examinees per year level and the percentage of successful examinees

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Curriculum and Educational Program (Instructional Design)

( ) 1. The objectives and content are appropriate to the national and regional health needs, and expectations / demands of the Filipino population.

( ) 2. There are well written instructional designs in general pediatrics and the subspecialties according to year levels.

3. The instructional designs address the different professional roles of a pediatricians:

( ) 3.1. Healthcare provider with emphasis on primary care

( ) 3.2. Health educator

( ) 3.3. Researcher

( ) 3.4. Healthcare manager

( ) 3.5. Social mobilizer

( ) MEAN

Instructional Materials, Delivery, and Resources

( ) 1. The rotations follow the HAB recommendations outlined in Appendix 2.

( ) 2. The learning activities encompass integrated practical and theoretical instruction (competency-based approach, problem-oriented strategies, evidence-based medicine, and practice-based training including values formation, bioethics, and community orientation).

( ) 3. The learning activities include the must-have activities recommended by the HAB:
- 3.1. Bedside rounds with the chair, training officer, or consultants
- 3.2. Supervised ER and OPD clinics
- 3.3. Supervised lectures and journal reviews
- 3.4. Clinical conferences
  - 3.4.1. Case presentations (grand rounds, case discussions, diagnostic / management conferences, and bioethics conferences)
  - 3.4.2. Morbidity and mortality conferences
  - 3.4.3. Endorsement conferences / rounds
- 3.5. Conferences with family members

( ) 4. The pediatric procedures outlined in Appendix X are included in the technical skills training part of the program.

( ) 5. Child Protection is included in the curriculum.
- 5.1. Level 1 – lectures or workshops
- 5.2. Level 2 – lectures or workshops and exposure in a CPU
- 5.3. Level 3 – CPU desk
- 5.4. Level 4 – CPU unit

( ) 6. The latest editions of the HAB-required textbooks, journals, and PPS publications are available at the department's library.

( ) 7. Each trainee has satisfactorily completed the following courses:

7.1. Basic life support

( ) 7.2. Cardio-Pulmonary Resuscitation / Pediatric Advanced Life Support

( ) 7.3. Neonatal Resuscitation Program

( ) MEAN

Evaluation

1. The program includes a process of evaluation that measures clinical competence, promote learning, and document adequacy of training, including the criteria for passing assessments.

( ) 2. The following areas of clinical competence are evaluated:

2.1. Knowledge

( ) 2.2. Clinical skills / decision making

( ) 2.3. Technical skills

( ) 2.4. Interpersonal skills

( ) 2.5. Professional attitudes and habits

( ) 3. A variety of evaluation strategies is used to evaluate clinical competence including:

3.1. Clinical conferences and oral reports

( ) 3.2. Written examinations

( ) 3.3. OSOE / OSCE

( ) 4. Formative evaluations are done at regular intervals.

( ) 5. A summative evaluation is done at the end of each year level of training.

( ) 6. The trainees receive regular constructive feedback about his performance.

( ) 7. The program is evaluated and monitored regularly to ensure the attainment of program outcomes and assess the progress of trainees.

( ) 8. The results of program evaluation are utilized to enhance and revise the curriculum.

( ) MEAN

Program Outcomes

A. SB Examination

Total number of trainees during the accreditation period

Total number of trainees who took the SB written examinations (1st takers) _____

Percentage of trainees who took the SB written examinations _____

Total number of successful examinees _____

Percentage of successful examinees _____

Score _____

< 10% ---------- 0

10 – 29% --------- 1

30 – 49% -------- 2

50 – 69% -------- 3

70 – 89% -------- 4

≥ 90% ---------- 5

B. 3-Year Performance in the WISE

Number of residents who took the WISE _____

Number of residents who passed the WISE _____

Percentage of successful examinees _____

Percentage of successful examinees _____

Score _____

< 10% ---------- 0

10 – 29% --------- 1

30 – 49% -------- 2

50 – 69% -------- 3

70 – 89% -------- 4

≥ 90% ---------- 5

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Curriculum and Educational Program		20	
Instructional Materials, Delivery, and Resources		40	
Evaluation		20	
Program Outcome		20	
AREA MEAN		100	

Area 3: TRAINEES

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Departmental policies on the selection process of prospective trainees including:
    1.1. Criteria for selection
    1.2. Admission process
    1.3. Persons responsible for the admission process
    1.4. Transferees from other accredited programs
    1.5. Foreign medical graduates
2. Number of slots available per year level
3. Duties and responsibilities of trainees per year level, including the chief resident
4. Description of the assessment process of trainees indicating the formative and summative evaluation methods
5. Salaries, benefits, and other incentives for trainees
6. Policies on the promotion, retention, and dismissal of trainees
7. Guidelines on disciplinary sanctions
8. Description of the mechanism for grievance and appeal against departmental decisions
9. Description of the mentoring program

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Admission Policies

( ) 1. The selection process of prospective trainees should be clearly described including the:
1.1. Criteria for selection
1.2. Admission process
1.3. Persons responsible for the admission process
1.4. Policies on transferees from other accredited programs
1.5. Policies on foreign medical graduates

( ) 2. The admission policies of the department are consistent with governmental and institutional regulations and conform with the vision-mission-objectives of the institution and the department.

( ) 3. The criteria for selection of trainees are effective in identifying individuals capable of undergoing pediatric residency and includes:
3.1. Undergraduate performance (class rank)
3.2. Aptitude examination
3.3. Interview
3.4. Other qualities

( ) 4. The number of trainees is proportionate to the:
4.1. Adequacy of clinical materials
4.2. Availability of consultants
4.3. Other available resources

( ) 5. The trainees are oriented on the program content of the PPS-approved residency training program and the aligned institutional training manual. Promoted trainees are reoriented prior to the next year level.

( ) MEAN

Performance

( ) 1. The duties and responsibilities of trainees per year level, including the chief resident, are clearly described.

( ) 2. There is a system to monitor the progress of trainees in the form of formative and summative assessments, including reported unintended incidents.

( ) 3. Each trainee has a training portfolio that is regularly monitored and evaluated by the supervising consultants.

( ) 4. There is a mechanism to ensure the trainees' representation and participation in the following activities:
   4.1. Adequacy of clinical materials
   4.2. Availability of consultants
   4.3. Other available resources

( ) MEAN

Support Services for Trainees

( ) 1. There is a system for academic counseling, including career and guidance planning for trainees.

( ) 2. The training program provides available support addressing professional, psychological, social, material, and personal needs of the trainees.

3. The department provides appropriate and equitable remuneration and benefits, including legally mandated training interruptions (pregnancy, sickness, bereavement, and others).

( ) 4. There is a mechanism to consider safeguarding the welfare of residents in the structuring of duty hours and clinical workload.

5. The department implements a mentoring program for residents

( ) MEAN

Promotion, Retention, and Dismissal

( ) 1. There are clear policies on the promotion, retention, and dismissal of trainees. These policies are made known to them.

2. The department should provide a mechanism for grievance and appeal against decisions involving:
   2.1. Admission to the program
   2.2. Disciplinary sanctions
   2.3. Retention
   2.4. Dismissal from the program

MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Admission Policies		15	
Performance		40	
Support System for Trainees		30	
Promotion, Retention, and Dismissal		15	
AREA MEAN		100	

Area 4: CONSULTANTS

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Flowchart of recruitment and selection process of consultants
2. Qualifications and duties / responsibilities of each group of consultants (active vs visiting, or any other distinction present)
3. List of consultants based on grouping (to include academic background, PPS and subspecialty status, and professional affiliations)
4. Staff development program
5. Incentives for consultants
6. Consultants' evaluation tool

EVALUATION INSTRUMENT

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Recruitment and Selection

( ) 1. There is a formal mechanism for the recruitment and selection of consultants.

( ) 2. The selection of consultants is a cooperative process involving the administration, department heads, and other institutional members.

( ) MEAN

Academic Qualifications

( ) 1. The qualifications of each group of consultants (active vs visiting, or any other distinction present) are clearly specified.

( ) 2. The process of consultant selection considers:
2.1. Teaching ability
2.2. Character / integrity
2.3. Professional competence

2.4. Research expertise
2.5. Communication skills

( ) MEAN
Performance

( ) 1. The duties and responsibilities of each group of consultants (active vs visiting, or any other distinction present) are clearly specified.

( ) 2. The responsibilities of consultants include participation in:
2.1. Training activities
2.2. Service
2.3. Research
2.4. Formulation of policies
2.5. Evaluation of trainees

( ) 3. There is an annual performance evaluation that is acceptable to consultants.

( ) 4. The consultants observe the Codes of Ethics of the PMA and PPS.

( ) 5. There are harmonious relationships between the administration and the department, and within the department.

( ) MEAN
Benefits

( ) 1. There are incentives for the consultants' participation in the teaching program.

( ) 2. There are provisions for recognition and reward for meritorious activities of consultants.

( ) 3. The department has a staff development program to enhance their professional roles, and provisions to attend teacher training seminars and participation in scientific conferences.

( ) 4. There are activities that promotes the consultants' well-being and welfare.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Recruitment and Selection		20	
Academic Qualifications		25	
Performance		30	
Benefits		25	
AREA MEAN		100	

Area 5: ADMINISTRATION

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Hospital organization chart
2. Departmental organizational chart
3. Qualifications and job descriptions of departmental officers
4. Staffing pattern in all pediatric service areas
5. MOA with other institutions involved in child healthcare, if any.
6. Composition and functions of the hospital or departmental bioethics committee
7. Immediate (5 years) and long-range (10 years) plans
8. Acknowledgment report of ICD 10 submission.

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Administrative Organization

( ) 1. The hospital and / or university has an organizational structure which details and relationships and governance of the different departments.

( ) 2. The department has an organizational structure defining the training, service, and research functions, as well as governance (including its relationships with the hospital administration and / or university).

( ) 3. The qualifications and job descriptions of the departmental officers are defined.

( ) 4. The staffing pattern in all pediatric patient care areas is described including the number of beds and personnel per service area.

( ) 5. There are open communication lines among the hospital and / or university, department, consultants, trainees, and other healthcare providers.

( ) 6. The department has working linkages with other institutions involved in child healthcare.

( ) 7. There is a functioning Bioethics committee.

( ) MEAN

Planning and Financial Management

( ) 1. The department has regular or periodic planning sessions.

( ) 2. The planning sessions involve the consultants and residents with provisions for the participation of the alumni in the affairs of the department.

( ) 3. The department has immediate (5 years) and long-range (10 years) plans.

( ) 4. The hospital and / or university allocates resources to implement the programs of the department.

( ) 5. The records of departmental meetings, planning sessions, data of consultants and residents, official rules and policies, and reports are kept on file.

( ) MEAN

Recording and Documentation

( ) 1. The records of departmental meetings, planning sessions, data of consultants and residents, official rules and policies, and reports are kept on file.

( ) 2. The departmental records are filed systematically.

( ) 3. The department follows proper policies and procedures to ensure the confidentiality of the trainees' records.

( ) 4. The department submits an accurate ICD 10 report on time assessed by the Clearing-House Committee and signed by the department chair.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Administrative Organization		50	
Planning and Financial Management		20	
Recording and Documentation		15	
ICD 10		15	
AREA MEAN		100	

Area 6: PATIENT SERVICES AND FACILITIES

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Certificates of accreditation from: PhilHealth, MBF, NBS, and HS
2. Breakdown of number of beds per service areas: ER, OPD, NICU, rooming-in ward, in-patient wards, adolescent services (in- and out-patient), and PICU
3. SOPs at the: ER, OPD, NICU, rooming-in ward, in-patient wards, and PICU
4. Total census during the accreditation period (per year) in the: ER, OPD, NICU, rooming-in ward, in-patient wards, adolescent services (in- and out-patient), and PICU
5. Top 10 causes of morbidities during the accreditation period (per year) in the: ER, OPD, NICU, in-patient wards, adolescent services (in- and out-patient), and PICU
6. Benchmarking data: infant mortality rate, case fatality rate of the most common morbidities and mortalities.
7. Checklist of minimum equipment for pediatric patient care
8. In- and out-patient census during the accreditation period (per year) for the subspecialty programs for Levels III and IV
9. Three (3) year departmental procurement plan for medicines, drugs, and equipment
10. Safety / disaster management plan

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Physical Facilities and Equipment

( ) 1. There are written policies and procedures for the admission, care, and discharge of patients for the following service areas:
   - 1.1. Emergency room
   - 1.2. Outpatient unit
   - 1.3. Neonatal unit
   - 1.4. Rooming-in ward
   - 1.5. In-patient wards
   - 1.6. PICU

1.7. Adolescent wards

( ) 2. The neonatal unit meets the standards set by the HAB and the Philippine Society of Newborn Medicine.
   2.1. Levels I and II – Neonatal Unit Level II
   2.2. Levels III and IV – Neonatal Unit Level III

( ) 3. The pharmacy, laboratory, radiology, and central supply room render 24-hour services.

( ) 4. There are physical plant facilities for:
   4.1. Separate pediatric emergency area
   4.2. Oral rehydration area
   4.3. Reverse isolation room
   4.4. Outpatient care (sick and well patients)
   4.5. NICU
   4.6. Rooming-in wards
   4.7. Pediatric wards
   4.8. Adolescent wards
   4.9. Isolation ward for communicable diseases
   4.10. Treatment room at each pediatric floor
   4.11. PICU

( ) 5. The physical plant should provide for safety, cleanliness, comfort, and space provisions for patient care and training activities.

( ) 6. There is a written safety / disaster management plan.

( ) 7. There is a process to evaluate facilities, equipment, and supplies.

( ) 8. The physical facilities used by consultants and trainees include:
   8.1. Conference room
   8.2. Department office
   8.3. Call room for trainees
   8.4. Multimedia resources (computer, internet facilities, and LCD projector)

( ) MEAN

Patient Services

( ) 1. There is a sufficient number of patients to satisfy the training objectives.

1.1. ER consultations	120 – 150
1.2. OPD consultations	90 – 100
1.3. Well baby / child consultations	50 – 60
1.4. Deliveries	20 – 30
1.5. In-patient admissions	50 – 60
1.6. Adolescents (in- and out-patients)	20 – 30

( ) 2. At least ten percent (10%) of the total bed capacity is identified for service patients.

( ) 3. The service areas have a sufficient case-mix of patients.

( ) 4. The minimum equipment for patient care is available.

( ) 5. An updated formulary is available in all service areas.

( ) MEAN

Human Resources

( ) 1. The attending physicians for patients aged 0 – 18 years are board-certified pediatricians.

( ) 2. All patients aged 0 – 18 years at the ER are evaluated by a pediatric resident.

( ) 3. All newborns are under the care of a board-certified pediatrician. High-risk newborns are referred to a board-certified or board-eligible neonatologist.

( ) 4. The PICU should be headed by a board-certified pediatric intensivist.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Physical Facilities and Equipment		30	
Patient Services		40	
Human Resources		30	
AREA MEAN		100	

Area 7: RESEARCH

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Composition, duties, and responsibilities of the department's research committee to include statistician
2. Departmental research agenda
3. Research program of the department
4. Research seminars, workshops, and lectures conducted by the department / hospital during the accreditation period
5. Research output per year during the accreditation period to include authors, source of funding, venues / fora presented, citations / prizes won, and publication details

EVALUATION INSTRUMENT

Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Research Education and Policies

( ) 1. The department has a formal written research program.

( ) 2. The research agenda is relevant to the national or regional health needs. Research studies with social relevance in the community where the department is located is encouraged.

( ) 3. The hospital / department conducts annual:
3.1. Research lectures, seminars, or workshops
3.2. EBM
3.3. GCP

( ) 4. The residency program has a protected time for research work.

( ) 5. There are venues for oral presentations organized by the department, hospital, the PPS, or other organizations.

( ) MEAN

Resources – Human, Physical, and Financial

( ) 1. The trainees are given a consultant-adviser (co-author) who supervise them from the development of a proposal to the completion of research.

( ) 2. All research proposals are evaluated by the research coordinator or the research committee of the department.

( ) 3. All researches are approved by an ethics review committee or accredited institutional review board.

( ) 4. The trainees are given sufficient statistical assistance by the hospital or departmental staff, or outside personnel.

( ) 5. The trainees avail of various research funding sources.

( ) MEAN

Research Outputs

( ) 1. Each trainee submits a completed research paper at the end of the 3-year residency program.

Total number of residents during the accreditation period _____

Total number of completed researches _____

Percentage _____

Scoring

< 10%	0
10 – 29%	1
30 – 49%	2
50 – 69%	3
70 – 89%	4
≥ 90%	5

( ) 2. The completed researches are submitted for publication in various peer-reviewed journals.

( ) 3. The research papers are filed in the department's library.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Research Education and Policies		30	
Resources – Human, Physical, and Financial		30	
Research Outputs		40	
AREA MEAN		100	

Area 8: COMMUNITY INVOLVEMENT

SUPPORTING DOCUMENTS TO BE INCLUDED IN THE REPORT

1. Instructional design for community involvement
2. Departmental community team and health team (point person) in the community
3. MOA between the hospital / department and the community
4. Community profile indicating the duration of departmental presence in the community and the secondary data of the community.
5. Brief description of the strategies used to know the condition and needs of the community
6. Description of the public health projects of the department (include pictures and other forms of documentation)
    - 6.1. Include the schedule of clinics, services offered by the department, total number of recipients of each service during the accreditation period (per year), and top 10 causes of morbidities during the accreditation period (per year) – for regular ambulatory clinic services
    - 6.2. Include the inclusive dates of the project, background, objective, strategy, and results / evaluation for the following activities:
        - 6.2.1. Participation in the work of government and non-government organizations
        - 6.2.2. Own community service projects
        - 6.2.3. Participation in the services for the promotion of children's health
        - 6.2.4. Participation in the provision of services for disadvantaged children
        - 6.2.5. Participation in the provision of primary health care services (EPI, CDD, CARI)
    - 6.3. Include the topics discussed, materials used, participants, and results of evaluation and feedback – for participation in public health education sessions
7. Monthly schedule of trainees while on community rotation
8. Description of the referral system between the hospital and the community – including the number of beneficiaries during the accreditation period (per year)
9. Program evaluation by the community
10. Program evaluation by the department
11. Outcome measures of program intervention or impact to community.

EVALUATION INSTRUMENT
Rating scale definition:

5	Excellent compliance	Meets all the major provisions of the standard
4	Very good compliance	Meets most provisions of the standard
3	Good compliance	Meets some provisions of the standard
2	Fair compliance	Meets few provisions of the standard
1	Poor compliance	Fails to meet the provisions of the standard
NA	Not applicable	

INSTRUCTIONS: Following the rating scale definition, write the assessment that best describes to what extent the provisions of the standards are met inside the parenthesis.

Community Programs and Policies

( ) 1. The department has a formal written community program that includes objectives, content, learning strategies, and evaluation criteria.

( ) 2. A specific consultant supervises the community involvement program.

( ) 3. The department's vision-mission, projects, and services are made known to the community.

( ) 4. There is an identified health team or point person in the community.

( ) 5. There are evidences of measurable outcomes of interventions (project, activities and services).

( ) 6. At least one (1) strategy was implemented to give the trainees an opportunity to know the conditions and needs of the community. *Check the appropriate box.*

6.1. Meetings with community leaders _____

6.2. Research studies _____

6.3. Community projects _____

6.4. Field practicum _____

6.5. Community surveys _____

6.6. Interviews with key persons in the community _____

( ) 7. There is an active and functioning referral system between the community and the hospital.

( ) 8. There is a MOA between the department / hospital and the community to provide safety measures for the trainees.

( ) 9. The community involvement is periodically evaluated by the beneficiaries of the program.

( ) 10. The community program is evaluated regularly by the department based on the expected outcomes.

( ) MEAN

Community Involvement

( ) 1. Service is rendered through at least two of the following strategies (*Check the appropriate box)*:

4.1. Providing regular ambulatory clinic services for well and sick children _____

4.2. Participation in the work of government and non-government organizations, schools, civic, and religious groups _____

4.3. Conducting own community service projects (environmental health, *botika sa barangay*, training of barangay health workers, and others) _____

4.4. Participation in the provision of primary health care services (EPI, CDD, CARI) _____

4.5. Participation in public health education sessions (mothers' class) _____

4.6. Participation in the services for the promotion of children's health _____

(child safety, proper parenting and child care, reproductive health, school health, anti-smoking, alcohol and drugs, sports and other wellness programs, TB-DOTS, child protection)

4.7. Participation in the provision of services for disadvantaged children (out of school youth, juvenile delinquents, homeless, street children) _____

Scoring		Score
Number of strategies:	2	1
	3	2
	4	3
	5	4
	≥ 6	5

( ) 2. The service in the community is rendered following the frequency recommended by the HAB:
   1.1. Level I – at least twice weekly (half day)
   1.2. Level II – thrice weekly (half day)
   1.3. Levels III and IV – daily (whole or half day)

( ) 3. The trainees, under the supervision of a consultant, are involved in planning, implementing and evaluating community projects.

4. Health promotion and disease prevention is emphasized in the program rather than care of the sick.

( ) MEAN

Input the means for each section. Multiply the means by the weights to get the product. Add the products to get the mean for the area.

SECTIONS	MEAN	WEIGHT (%)	PRODUCT
Community Programs and Policies		40	
Community Involvement		60	
AREA MEAN		100	

APPENDIX 8

PHILIPPINE PEDIATRIC SOCIETY, INC.
HOSPITAL ACCREDITATION BOARD
SUMMARY REPORT FORM

NAME OF HOSPITAL _____

DATE OF VISITATION _____

1. FOLLOW-UP ACTION REGARDING PREVIOUS RECOMMENDATIONS

Previous Recommendations	Follow-up Action
_____	_____
_____	_____
_____	_____
_____	_____
_____ _____	_____

2. BEST FEATURES

2.1 Training Program _____
_____
_____
_____

2.2 Trainees _____
_____
_____
_____

2.3 Consultants _____
_____
_____
_____

2.4 Administration _____

_____

_____

_____

2.5 Patient Service & Facilities

_____

_____

_____

_____

2.6 Research

_____

_____

_____

_____

2.7 Community Involvement

_____

_____

_____

_____

3. RECOMMENDATIONS

3.1 Training Program _____

_____

_____

_____

3.2 Trainees _____

_____

_____

_____

3.3 Consultants _____

_____

_____

3.4 Administration _____

_____

_____

3.5 Patient Service & Facilities

_____

_____

_____

_____

3.6 Research _____

_____

_____

3.7 Community Involvement

_____

_____

_____

4. STATISTICAL RATING

Statistical Rating	Rating		Weight Value		Product
1. Training Program	[ ]	x	10	=	[ ]
2. Trainees	[ ]	x	10	=	[ ]
3. Consultants	[ ]	x	10	=	[ ]
4. Administration	[ ]	x	4	=	[ ]
5. Patient Service & Facilities	[ ]	x	6	=	[ ]
6. Research	[ ]	x	6	=	[ ]
7. Community Involvement	[ ]	x	4	=	[ ]
			50		

$$\text{Average} = \frac{\text{Sum of Products}}{\text{Sum of Wt. Value}} \qquad (\text{MPL} + 3.0)$$

LEGEND

5 Excellent	- Meets all major provisions of the standard
4 Very Good	- Meets most provision of the standard
3 Good	- Meets some provisions of the standard
2 Fair	- Meets few revisions of the standard
1 Poor	- Fails to meet the provisions of the standard

5. ACCREDITATION'S RECOMMENDATION FOR BOARD ACTION

_____

_____

_____

6. BOARD ACTION

_____

_____

_____

Accreditor Signature

Accreditor Signature

Approved by:

Attested by:

_____
President, PPS
Chair, HAB

_____
HAB Secretary

APPENDIX 9

STATISTICAL RATING
(FOR ACCREDITOR'S USE)

Weight Values for the Overall Rating

Rating Scale Definition:

5	Excellent Compliance	: Meets all major provisions of the standard
4	Very Good Compliance	: Meets most provisions of the standard
3	Good Compliance	: Meets some provisions of the standard
2	Fair Compliance	: Meets few provisions of the standard
1	Poor (Non-Compliance)	: Fails to meet the provisions of the standard

Evaluation Areas	Rating	X	Weight Value	=	Product
1. Training Program	[ ]	x	10	=	[ ]
2. Trainees	[ ]	x	10	=	[ ]
3. Consultants	[ ]	x	10	=	[ ]
4. Administration	[ ]	x	4	=	[ ]
5. Patient Service/Facilities	[ ]	x	6	=	[ ]
6. Research	[ ]	x	6	=	[ ]
7. Community	[ ]	x	4	=	[ ]
			50		

Using the appropriate EVALUATION INSTRUMENT, enter the rating for the evaluation area

Multiply each RATING X WEIGHT VALUE = PRODUCT

$$\frac{\textbf{Sum of Products}}{\textbf{Sum of Weight Value (50)}} = \textbf{AVERAGE}$$

For accreditation purposes, a rating of 3 is considered good and therefore passing.

APPENDIX 10

Statistical Rating
(For Self-assessment)

Weight Values for the Overall Rating

Rating Scale Definition:

5	Excellent Compliance	: Meets all major provisions of the standard
4	Very Good Compliance	: Meets most provisions of the standard
3	Good Compliance	: Meets some provisions of the standard
2	Fair Compliance	: Meets few provisions of the standard
1	Poor (Non-Compliance)	: Fails to meet the provisions of the standard

Evaluation Areas	Rating	X	Weight Value	=Product
1. Training Program	[ ]	x	10	= [ ]
2. Trainees	[ ]	x	10	= [ ]
3. Consultants	[ ]	x	10	= [ ]
4. Administration	[ ]	x	4	= [ ]
5. Patient Service/Facilities	[ ]	x	6	= [ ]
6. Research	[ ]	x	6	= [ ]
7. Community	[ ]	x	4	= [ ]
			50	

Using the appropriate EVALUATION INSTRUMENT, enter the rating for the evaluation area

Multiply each RATING X WEIGHT VALUE = PRODUCT

$$\frac{\textbf{Sum of Products}}{\textbf{Sum of Weight Value (50)}} = \textbf{AVERAGE}$$

For accreditation purposes, a rating of 3 is considered good and therefore passing.

SECTION TWO

OUTCOME-BASED EDUCATION

PEDIATRIC RESIDENCY CURRICULUM

HAB COMMITTEE ON CURRICULUM

Chair	Madeleine Grace M. Sosa, MD
Members	Jindra H. Tetangco, MD
	Maria Isabel M. Atienza, MD
Advisers	Ramon L. Arcadio, MD
	Melinda M. Atienza, MD

PROPOSED OUTCOMES – BASED EDUCATION CURRICULUM OF THE PEDIATRIC RESIDENCY TRAINING PROGRAM
Calendar Year 2019-2022

Madeleine Grace M. Sosa, MD, FPPS, FPNA, FCNSP, MSCE
Jindra H. Tetangco, MD, FPPS
Maria Isabel M. Atienza, MD, MHPEd, FPPS, FPAPP

CHAPTER 1: INTRODUCTION

Based on the Philippine Qualifications Framework (Giron, 2014), the Commission on Higher Education through Memorandum Order 46 Series 2012, unmistakably espouses ***outcome-based education*** as the main approach to higher education learning. It stipulates that quality assurance system is enhanced by the use of learning competency-based standards and an outcome-based system of quality assurance. Under this mandate, the goal of Philippine higher education is a critical mass of high quality graduates who meet national and international academic standards. This is in accordance with the transformative scale up of the education of health professions as recommended by the WHO in 2011 which states that: "Driven and informed by population health needs, transformative scale up means delivering educational reforms that address not only the *quantity*, but also the *quality* and *relevance* of health care providers in order to achieve improvements in population health outcomes." Social accountability of health professionals is thus emphasized. There should be a match or congruence of professional competencies to patient and population priorities through an outcome-based curricula.

In view of this mandate, the Philippine Pediatric Society in 2015 recommended a relevant, outcome-based curriculum for the Residency Training Program of its accredited hospitals. It followed the steps in developing outcome-based programs by Davis (2003). Components of this OBE curriculum thus include the following: defined outcome, concept integration, effective teaching-learning strategies, expanded opportunities for students, cooperative learning and collaborative structure. Furthermore, this curriculum follows the organizing principles of outcome-based education by Spady (1994) which includes: experiential learning, learner-centered, holistic, teacher as facilitator, work-based learning and quality assurance. According to McGaghie, et.al. (1997), this is ideal for professional education where the aim is to train individuals to competently undertake the responsibilities expected of them in professional practice.

CHAPTER 2 LEARNING OUTCOMES CHED, AGME, WFME, PRC

Each of the following **Learning Outcomes** (LOs) recommended by the Center for Higher Education (CHED) is represented in all the formulated teaching activities and are numbered accordingly:

LO1. Competently manage clinical conditions of clients in various setting

LO2. Convey information, in written and oral formats, across all types of audiences, venues and media in a manner that can be easily understood

LO3. A. Initiate planning, organizing, implementation and evaluation of programs and health facilities;

B. Provide clear direction, inspiration and motivation to the healthcare team/ community

LO4. A. Utilize current research evidence in decision making as practitioner, educator or researcher

B. Participate in research

LO5. Effectively work in teams with co-physicians and other professionals in managing clients, institutions, projects and similar situations

LO6. A. Utilize systems-based approach in actual delivery of care

B. Network with relevant partners in solving general health problems

LO7. Update oneself through a variety of avenues for personal and professional growth to ensure quality healthcare and patient safety

LO8. Adhere to national and international codes of conduct and legal standards that govern the profession

LO9. Demonstrate love for one's national heritage, respect for other cultures and commitment to service

LO10. Adhere to the principles of relevance, equity, quality and cost effectiveness in the delivery of healthcare to patients, families and communities

ACGME Competencies: The program must integrate the following ACGME competencies into the curriculum: (Core)

ACGME approved focused revision: September 29, 2013; effective: July 1, 2016

1. Patient Care and Procedural Skills

   Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents: (Outcome) [As further specified by the Review Committee] Residents must be able to competently perform all medical, diagnostic, and surgical procedures considered essential for the area of practice. Residents: (Outcome)

2. Medical Knowledge

   Residents must demonstrate knowledge of established and evolving biomedical, clinical, epidemiological and social behavioral sciences, as well as the application of this knowledge to patient care. Residents: (Outcome)

3. Practice-based Learning and Improvement

   Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and life-long learning. (Outcome) Residents are expected to develop skills and habits to be able to meet the following goals: IV.A.5.c).(1) identify strengths, deficiencies, and limits in one's knowledge and expertise; (Outcome) IV.A.5.c).(2) set learning and improvement goals; (Outcome) IV.A.5.c).(3) identify and perform appropriate learning activities; (Outcome) IV.A.5.c).(4) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; (Outcome) IV.A.5.c).(5) incorporate formative evaluation feedback into daily practice; (Outcome) IV.A.5.c).(6) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems; (Outcome) IV.A.5.c).(7) use information technology to optimize learning; and, (Outcome)

   participate in the education of patients, families, students, residents and other health professionals. (Outcome)

4. Interpersonal and Communication Skills

   Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. (Outcome)

   Residents are expected to:

   (1) communicate effectively with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

   (2) communicate effectively with physicians, other health professionals, and health related agencies;

   (3) work effectively as a member or leader of a health care team or other professional group;

(4) act in a consultative role to other physicians and health professionals; and

(5) maintain comprehensive, timely, and legible medical records, if applicable. [As further specified by the Review Committee]

5. Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an adherence to ethical principles.

Residents are expected to demonstrate:

(1) compassion, integrity, and respect for others;

(2) responsiveness to patient needs that supersedes self interest;

(3) respect for patient privacy and autonomy;

(4) accountability to patients, society and the profession; and Common Program Requirements

(5) sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation. (Outcome) [As further specified by the Review Committee]

6. Systems-based Practice

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. (Outcome) Residents are expected to:

(1) work effectively in various health care delivery settings and systems relevant to their clinical specialty;

(2) coordinate patient care within the health care system relevant to their clinical specialty;

(3) incorporate considerations of cost awareness and risk benefit analysis in patient and/or population-based care as appropriate;

(4) advocate for quality patient care and optimal patient care systems;

(5) work in inter-professional teams to enhance patient safety and improve patient care quality; and,

(6) participate in identifying system errors and implementing potential systems solutions. (Outcome)

CHAPTER 3 PPS LEARNING OUTCOMES FOR PPS PEDIATRIC RESIDENCY TRAINING PROGRAM

The Philippine Pediatric Society formulated its learning outcomes which are congruent with the 10 learning outcomes of CHED but with an addition of community – based practice. Each learning outcome has well defined competencies.

Roles of Pediatricians	**PPS Program Outcomes**	**Competencies**
Clinician Educator Researcher Leader/ Manager Social advocate	1. Clinical competence	Patient care
		Medical knowledge
		Technical procedural skills
		Attitudes and values
	2. Communication and interpersonal skills	Inter-personal relationships
		Oral, written and para-verbal skills
	3. Leadership and management skills	Organizational skills
		Problem-solving and decision-making skills
	4. Evidence-based practice (Practice-based learning)	Critical appraisal of evidence
		Self-assessment and reflection
		Production of relevant quality research
	5. Inter-professionalism	Collaboration with other health professionals
		Teamwork
	6. Health system-based practice	Awareness of health systems
		Knowledge of societal needs
		Ability to call on other resources to improve patient care
		Cost-effective health care practice
	7. Continuing professional development	Self-directed lifelong learning PPS
	8. Professionalism	Adherence to ethical and legal principles
		Compliance to existing laws, rules and regulations that govern the medical profession

		Compassionate responsibility and accountability to patient welfare
Leader/ Manager Social advocate	9. Nationalism and internationalism	Awareness of global health care challenges
		Awareness of cultural and religious diversity
	10. Social accountability	Knowledge of the concept of social accountability and its values
		Knowledge of the priority health needs in terms of pediatrics and the national objectives for health of the nation
	11. Community – oriented practice	Awareness of important characteristics and needs of the community that might impact on patient care
		Application of the understanding of these features to improve the management of the patient's population
		Awareness of social determinants of health
		Knowledge of resources available in the community and effective use of these resources
		Knowledge of the principles of preventive pediatric health care

CHAPTER 4 PROGRAM AND COURSE OUTCOMES OF THE PEDIATRIC RESIDENCY TRAINING PROGRAM

I. PROGRAM AND COURSE OUTCOMES OF THE (NAME OF HOSPITAL) PEDIATRIC RESIDENCY TRAINING PROGRAM

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
1. Competently manage clinical conditions of patients in various settings	***> In terms of patient care and medical knowledge:*** Given a clinical situation in the wards, OPD, clinics or community, the Pediatric resident-in-training should: 1. Get an informed consent & assure confidentiality 2. Establish effective rapport 3. Obtain accurate history 4. Perform thorough PE 5. Formulate a list of differential diagnoses 6. Select the most appropriate diagnostic plan 7. Establish an accurate diagnosis 8. Formulate the most appropriate, patient-centered plan of management or intervention (pharmacologic & non-pharmacologic) 9. Anticipate possible complications (disease-related and	The Art of Pediatric History Taking & Physical Examination Most common pediatric diseases/ disorders organized into: a. Organ system, or b. Symptomatology c. Covering epidemiology, etiology, clinical manifestations, management, complications, prognosis & prevention Clinical practice guidelines of the PPS; WHO & DOH program guidelines Principles of adult learning; Clinical reasoning skills through: • Prototype cases/ clinical manifestations • Mental	Clinical encounter with actual patients in the various rotations Clinical teaching activities with consultants: • Preceptorials • Bedside rounds Case management presentation Structured Independent study period (ISP) Interactive, case-based lectures Subspecialty lectures	Performance rating scale or rubrics for: • Clinical ward performance • Preceptorials • Bedside rounds • Case management Portfolio/ Journal Written exam

	treatment-related) 10. Educate patient and family regarding the illness/ disorder & its prognosis 11. Formulate health and wellness plan for patient and families 12. Maintain an accurate and complete medical record 13. Refer cases appropriately, i.e. subspecialties, interdepartmental, social worker, NGOs ***> In terms of technical procedural skills:*** 14. Demonstrate mastery of the common pediatric procedures 15. Formulate appropriate and cost-effective procedure(s) for a patient for quality patient care ***> In terms of attitude & values:*** 16. Show genuine concern for the patient 17. Demonstrate the values of patience, perseverance, diligence, respect and empathy in every patient encounter	abstraction/ problem presentation Patient's complete medical record Rapport building & communication skills Pediatric procedures classified as emergency, common or special Attitudes and values espoused by the institution and the medical profession		

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
2. Develop good communication & interpersonal skills to convey information in written and oral formats, across all types of audiences, venues and media in a manner that can be easily understood	Given a clinical situation in the wards, OPD, clinics or community, the Pediatric resident-in-training should: 1. Explain clearly relevant information to the patients and their families 2. Listen actively to process information 3. Secure patients' cooperation & consent 4. Utilize available forms of communication 5. Make use of information technology efficiently 6. Practice effective and clear communication amongst learners, patients, teachers, and peers 7. Communicate effectively with other health professionals & stakeholders	Specific pediatric health education topics to be used during health education sessions, family briefing & debriefing, community assembly, conferences or seminars Health education principles & concepts Effective communication skills (verbal and non-verbal) Listening skills Rapport building skills Expected attitudes for medical professionals Building partnerships with patients & their families Ethical practice of medicine	Actual patient encounters in specific settings Interactive lecture Plenary/ video presentation of trainee Structured ISP Lay fora Community assembly Clinical teaching activities: • Preceptorials • Bedside rounds	Performance rating scale for: • Preceptorials • Bedside rounds • Clinical performance • Community activities

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
3.A. **Management skills:** Initiate planning, organizing, implementation, and evaluation of programs and health facilities 3.B. **Leadership skills:** Provide clear direction, inspiration, and motivation to the healthcare team/community	***> In terms of organizational skills:*** Given a health program to manage/ health team to lead/ support group to organize, the resident-in-training should: 1. Assume leadership roles 2. Provide clear direction, inspiration and motivation to the team & community 3. Implement the program as planned 4. Monitor process of the program 5. Evaluate outcomes 6. Recommend improvements in health of a patient 7. Apply the principles & steps of organizing communities for health ***> In terms of problem-solving and decision-making skills:*** 8. Evaluate factors to come up with the best solution for	Health programs Health facilities Leadership skills Management skills Working in a team Programs that address problems in development &behavior in families and communities Advocacy work Organizing identified support groups for the community Project planning, implementation and evaluation Social mobilization rationale/ definition/ steps/ framework	Preceptorials SGDs Structured ISP Community work through advocacy projects	Performance rating scale for: • Preceptorials • Advocacy project Reflection paper Portfolio/ Journal

	the case/ problem at hand 9. Develop competence and confidence in decision-making			

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
4. Demonstrate an evidence-based practice (or practice-based learning) through: a. Use of current research evidence in decision making as practitioner, educator or researcher b. Participation in research activities	***> In terms of critical appraisal of evidence:*** Utilizing various data and information from all available resources, the resident-in-training should: 1. Utilize evidence-based medicine in the diagnosis, management, health promotion and prevention of pediatric diseases/ disorders 2. Provide health services to patients, their families and the community as a whole using current, acceptable practice guidelines ***> In terms of self-assessment & reflection:*** 3. Regularly reflect on the events happening in the clinical practice for improvement/ enhancement of critical thinking skills > ***In terms of production of relevant quality research:***	Literature search journals/ articles Research methods Evidence-based medicine Components of a research paper	Literature search/ review; Structured ISP Research process	Performance rating scale for: • Clinical performance Research output Reflection paper Portfolio/ journal

	4. Create a research related to the field of pediatrics following appropriate research methodology			

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
5. Practice inter-professionalism by effectively working in teams with co-physicians and other professionals in managing clients, institutions, projects, and similar situations	***> In terms of collaboration with other health professionals, the Pediatric resident-in-training should:*** 1. Work effectively with the department of pediatrics staff 2. Work effectively, harmoniously and professionally with peers, faculty and all stakeholders in the hospital & community in planning, implementation, monitoring & evaluation of advocacy projects and provision of health care for children & adolescents 3. Demonstrate the attributes of collaboration with co-learners intra- and inter-departmentally 4. Collaborate appropriately with other allied health professionals inside and outside the hospital ***> In terms of teamwork:*** 5. Work professionally & efficiently as a leader or member of a team during advocacy projects 6. Reflect on personal experiences and background and how these affect team based learning	Group dynamics Team work & collaboration in health education The health systems approach Inter-relationship of the medical profession with the other allied health professions Referral process intra- and interdepartmental Networking system within and outside the hospital	Preceptorials Structured ISP SGDs Advocacy work	Performance rating scale for: • SGD • Preceptorials • Advocacy projects • Peer evaluation Portfolio/ journal

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
6. Utilize a health systems-based approach in actual delivery of care and in solving pediatric health problems	The Pediatric resident-in-training should: 1. Analyze the health systems existing in the hospital, community and the country 2. Identify the relevant health care agencies for children & adolescents that exist in the community 3. Utilize systems-based approach in planning, implementing, monitoring and evaluating programs/ advocacy projects for children & adolescents 4. Advocate for partnership with other resources such as GOs and NGOs to improve patient care 5. Practice cost effective, quality health care to all patients served	Systems-based approach to quality health care Health care agencies in the community Health care organizations (GOs & NGOs) in the country The principle of partnership & advocacy work	Actual patient encounters Preceptorials Community projects Structured ISP	Performance rating scale for: • Clinical performance • Community work Portfolio/ journal

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
7. Value the importance of a continuing professional development through a variety of avenues to ensure quality healthcare and patient safety	The Pediatric resident-in-training, in order to develop self-directed lifelong learning, should: 1. Attend lectures/ seminars/ conventions/ advocacy work related to the field of training 2. Utilize feedback from consultants, hospital staff, pediatrics department staff and members of the community for personal & professional growth 3. Practice personal reflection to direct learning with the aim of improving knowledge, skills & attitude to ensure quality health care & patient safety 4. Exhibit the attribute of a motivated, self-directed learner 5. Demonstrate desire to gain more knowledge and skills to provide quality care to patients 6. Demonstrate the attributes of integrity, compassion, gender sensitivity, resourcefulness in the dealings with co-learners, academic and non-academic staff	Lectures/ seminars on different topics regarding pediatric health care Conventions and short structured courses on pediatric-related health issues Lectures on: • Principles of Ethical Practice • Quality patient care • E-learning	Lectures/ Seminars Scientific conventions Preceptorials E-learning	Written exam Performance rating scale for: • Preceptorials • Clinical competence Portfolio/ Journal Reflection paper

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
8. Internalize Professionalism by adhering to national and international codes of conduct and legal standards that govern the medical profession	The resident-in-training should demonstrate the following Professional standards: > ***In terms of adherence to ethical and legal principles***: 1. Apply ethical and legal standards on all patients seen without discrimination 2. Practice the Oath of Professionals and Hippocratic oath > ***In terms of compliance to existing laws, rules & regulations that govern the medical profession:*** 3. Comply with ethical, legal and professional standards that the PMA, PPS and component societies espouse for the delivery of health care 4. Uphold the values of the institution in healthcare administration, conduct of researches and provision of healthcare ***> In terms of compassionate responsibility & accountability to patient welfare:*** 5. Demonstrate responsible citizenship and exhibit cultural competence in managing children and their families 6. Demonstrate professionalism with co-learners, academic, non-academic staff and patients	Principles of Legal Medicine and Medical Jurisprudence Standards for trainees of the PPS The Hippocratic oath; Principles of ethical practice Code of Ethics of PMA, PPS and component societies	Actual patient encounters Preceptorials SGDs Structured ISP	Performance rating scale for: • SGD • Preceptorials • Clinical competence

PROGRAM OUTCOMES	COURSE OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	EVALUATION
9. Demonstrate nationalism & internationalism through love for one's national heritage, respect for other cultures and commitment to service	In any encounter with patients, co-workers & co-learners, in whatever setting, the Pediatric resident-in-training should: 1. Practice appropriate attitude & values of a competent and professional health advocate with focus on service and love of country 2. Demonstrate the attributes of responsible citizenship, and cultural competence 3. Exhibit cultural & religious sensitivity 4. Manifest the attribute of dedication to service	The Philippine Culture Principles of ethical practice Service oriented curriculum Principles of advocacy work	Actual patient encounters Preceptorials Lay fora Community work	Performance rating scale for: • Preceptorials • Clinical performance Journals/ reflections Portfolios
10. Demonstrate social accountability by adhering to the principles of relevance, equity, quality, and cost effectiveness in the delivery of healthcare to patients, families and communities	In any encounter with patients, co-workers & co-learners, in whatever setting, the Pediatric resident-in-training should: 1. Adhere to the principles of relevance, equity, quality and cost-effectiveness in healthcare administration, planning and conduct of health projects for children & adolescents 2. Utilize community (public & private) resources in the conduct of health education sessions 3. Recognize the priority health needs of the pediatric patients, family and community through the use of evidence-based data and appropriate technology in the delivery of	Evidence based medicine E-learning Clinical practice guidelines Quality assurance methods for delivery of health care Health Programs of DOH, WHO, PPS, Subspecialty societies and other health agencies	Actual patient encounters Preceptorials Lay fora Health Programs	Performance rating scale for: • Preceptorials • Clinical performance Journals/ reflections Portfolios

	comprehensive health care 4. Deliver health care to all patients regardless of socio-economic status, political affiliations, religious beliefs, ethnicity and gender	Bioethical practice of medicine		
11. Practice community-oriented health care to pediatric patients & their families for realistic, feasible, cost effective and relevant service	The resident-in-training, being community oriented, should: 1. Analyze the important characteristics of and the needs of the community that might impact on patient care 2. Apply the understanding of these features to improve the management of the patient's population 3. Evaluate the social determinants of health in the community 4. Recognize the available resources in the community and effectively use these resources when necessary 5. Apply the principles of preventive and promotive pediatric health care to the community 6. Recognize the need for a consultative & participative partnership with the other stakeholders in the community 7. Coordinate communities for sustainability and self-reliance	Community-oriented residency training curriculum Professional & ethical health advocate Disease causation & prevention Biological, social, psychological & environmental determinants to health & disease Family & community medicine concepts & principles Emerging issues Health education Demography Community health indices	Actual patient encounters Preceptorials Lay fora Community work	Performance rating scale for: • Preceptorials • Clinical performance • Community work Journals/ reflections Portfolios

		Community diagnosis Principles of adult learning		

CHAPTER 5 CURRICULAR MAP

Curriculum mapping is a reflective process that helps teachers understand what has been taught in a class, how it has been taught, and how learning outcomes were assessed. The curriculum mapping process results in a document known as a curriculum map. Most curriculum maps are graphical illustrations that consist of a table or matrix. (**Karen Schweitzer** , March 2019)

As education has become more standards-based, curriculum mapping, enable teachers to compare their curriculum to the national standard. A completed curriculum map allows teachers to analyze or communicate instruction that has already been implemented by themselves or someone else. Curriculum maps can also be used as a planning tool to inform future instruction.

CURRICULAR MAP OF THE PPS PEDIATRIC RESIDENCY TRAINING PROGRAM
(I – Introduce P- Practice D- Demonstrate)

PROGRAM OUTCOMES	COURSE OUTCOMES	YEAR LEVEL I	YEAR LEVEL II	YEAR LEVEL III
1. Competently manage clinical conditions of patients in various settings	***> In terms of patient care and medical knowledge:*** Given a clinical situation in the wards, OPD, clinics or community, the Pediatric resident-in-training should: 1. Get an informed consent & assure confidentiality 2. Establish effective rapport 3. Obtain accurate history 4. Perform thorough PE 5. Formulate a list of differential diagnoses 6. Select the most appropriate diagnostic plan 7. Establish an accurate diagnosis	Demonstrate	Demonstrate	Demonstrate

	8. Formulate the most appropriate, patient-centered plan of management or intervention (pharmacologic & non-pharmacologic) 9. Anticipate possible complications (disease-related and treatment-related) 10. Educate patient and family regarding the illness/ disorder & its prognosis 11. Formulate health and wellness plan for patient and families 12. Maintain an accurate and complete medical record 13. Refer cases appropriately, i.e. subspecialties, interdepartmental, social worker, NGOs ***> In terms of technical procedural skills:*** 14. Demonstrate mastery of the common pediatric procedures 15. Formulate appropriate and cost-effective procedure(s) for a patient for quality patient care ***> In terms of attitude & values:*** 16. Show genuine concern for the patient 17. Demonstrate the values of patience, perseverance, diligence, respect and empathy in every patient encounter			

PROGRAM OUTCOMES	**COURSE OUTCOMES**	**YEAR LEVEL I**	**YEAR LEVEL II**	**YEAR LEVEL III**
2. Develop good communication & interpersonal skills to convey information in written and oral formats, across	Given a clinical situation in the wards, OPD, clinics or community, the Pediatric resident-in-training should: 1. Explain clearly relevant information to the patients and their families 2. Listen actively to process	Demonstrate	Demonstrate	Demonstrate

all types of audiences, venues and media in a manner that can be easily understood	information 3. Secure patients' cooperation & consent 4. Utilize available forms of communication 5. Make use of information technology efficiently 6. Practice effective and clear communication amongst learners, patients, teachers, and peers 7. Communicate effectively with other health professionals & stakeholders			
3.A. **Management skills:** Initiate planning, organizing, implementation, and evaluation of programs and health facilities 3.B. **Leadership skills:** Provide clear direction, inspiration, and motivation to the healthcare team/community	***> In terms of organizational skills:*** Given a health program to manage/ health team to lead/ support group to organize, the resident-in-training should: 1. Assume leadership roles 2. Provide clear direction, inspiration and motivation to the team & community 3. Implement the program as planned 4. Monitor process of the program 5. Evaluate outcomes 6. Recommend improvements in health of a patient 7. Apply the principles & steps of organizing communities for health ***> In terms of problem-solving and decision-making skills:*** 8. Evaluate factors to come up with the best solution for the case/ problem at hand 9. Develop competence and confidence in decision-making	Practice	Demonstrate	Demonstrate

PROGRAM OUTCOMES	COURSE OUTCOMES	YEAR LEVEL I	YEAR LEVEL II	YEAR LEVEL III
4.Demonstrate an evidence-based practice (or practice-based learning) through: a. Use of current research evidence in decision making as practitioner, educator or researcher *b.* Participation in research activities	***> In terms of critical appraisal of evidence:*** Utilizing various data and information from all available resources, the resident-in-training should: 1. Utilize evidence-based medicine in the diagnosis, management, health promotion and prevention of pediatric diseases/ disorders 2. Provide health services to patients, their families and the community as a whole using current, acceptable practice guidelines ***> In terms of self-assessment & reflection:*** 3. Regularly reflect on the events happening in the clinical practice for improvement/ enhancement of critical thinking skills > ***In terms of production of relevant quality research:*** 4. Create a research related to the field of pediatrics following appropriate research methodology	Practice	Demonstrate	Demonstrate
5. Practice inter-professionalism by effectively working in teams with co-physicians and other professionals in managing clients, institutions, projects, and similar situations	***> In terms of collaboration with other health professionals, the Pediatric resident-in-training should:*** 1. Work effectively with the department of pediatrics staff 2. Work effectively, harmoniously and professionally with peers, faculty and all stakeholders in the hospital & community in planning, implementation, monitoring & evaluation of advocacy projects and provision of health care for children & adolescents 3. Demonstrate the attributes of collaboration with co-learners intra- and inter-departmentally 4. Collaborate appropriately with other	Practice	Demonstrate	Demonstrate

	allied health professionals inside and outside the hospital ***> In terms of teamwork:*** 5. Work professionally & efficiently as a leader or member of a team during advocacy projects 6. Reflect on personal experiences			

PROGRAM OUTCOMES	**COURSE OUTCOMES**	**YEAR LEVEL 1**	**YEAR LEVEL 2**	**YEAR LEVEL 3**
6. Utilize a health systems-based approach in actual delivery of care and in solving pediatric health problems	The Pediatric resident-in-training should: 1. Analyze the health systems existing in the hospital, community and the country 2. Identify the relevant health care agencies for children & adolescents that exist in the community 3. Utilize systems-based approach in planning, implementing, monitoring and evaluating programs/ advocacy projects for children & adolescents 4. Advocate for partnership with other resources such as GOs and NGOs to improve patient care 5. Practice cost effective, quality health care to all patients served	Practice	Demonstrate	Demonstrate
7. Value the importance of a continuing professional development through a variety of avenues to ensure quality healthcare and patient safety	The Pediatric resident-in-training, in order to develop self-directed lifelong learning, should: 1. Attend lectures/ seminars/ conventions/ advocacy work related to the field of training 2. Utilize feedback from consultants, hospital staff, pediatrics department staff and members of the community for personal & professional growth 3. Practice personal reflection to direct learning with the aim of improving knowledge, skills & attitude to ensure	Practice	Demonstrate	Demonstrate

	quality health care & patient safety 4. Exhibit the attribute of a motivated, self-directed learner 5. Demonstrate desire to gain more knowledge and skills to provide quality care to patients			

PROGRAM OUTCOMES	COURSE OUTCOMES	YEAR LEVEL I	YEAR LEVEL II	YEAR LEVEL III
8. Internalize Professionalism by adhering to national and international codes of conduct and legal standards that govern the medical profession	The resident-in-training should demonstrate the following Professional standards: > ***In terms of adherence to ethical and legal principles***: 1. Apply ethical and legal standards on all patients seen without discrimination 2. Practice the Oath of Professionals and Hippocratic oath > ***In terms of compliance with existing laws, rules & regulations that govern the medical profession:*** 3. Comply with ethical, legal and professional standards that the PMA, PPS and component societies espouse for the delivery of health care 4. Uphold the values of the institution in healthcare administration, conduct of researches and provision of healthcare ***> In terms of compassionate responsibility & accountability to patient welfare:*** 5. Demonstrate responsible citizenship and exhibit cultural competence in managing children and their families 6. Demonstrate professionalism with co-learners, academic, non-academic staff and patients	Practice	Demonstrate	Demonstrate
9. Demonstrate nationalism & internationalism through love for one's national	In any encounter with patients, co-workers & co-learners, in whatever setting, the Pediatric resident-in-training should: 1. Practice appropriate attitude &	Demonstrate	Demonstrate	Demonstrate

heritage, respect for other cultures and commitment to service	values of a competent and professional health advocate with focus on service and love of country 2. Demonstrate the attributes of responsible citizenship, and cultural competence 3. Exhibit cultural & religious sensitivity 4. Manifest the attribute of dedication to service			

PROGRAM OUTCOMES	COURSE OUTCOMES	YEAR LEVEL I	YEAR LEVEL II	YEAR LEVEL III
10. Demonstrate social accountability by adhering to the principles of relevance, equity, quality, and cost effectiveness in the delivery of healthcare to patients, families and communities	In any encounter with patients, co-workers & co-learners, in whatever setting, the Pediatric resident-in-training should: 1. Adhere to the principles of relevance, equity, quality and cost-effectiveness in healthcare administration, planning and conduct of health projects for children & adolescents 2. Utilize community (public & private) resources in the conduct of health education sessions 3. Recognize the priority health needs of the pediatric patients, family and community through the use of evidence-based data and appropriate technology in the delivery of comprehensive health care 4. Deliver health care to all patients regardless of socio-economic status, political affiliations, religious beliefs, ethnicity and gender	Demonstrate	Demonstrate	Demonstrate
11. Practice community oriented health care to pediatric	The resident-in-training, being community oriented, should: 1. Analyze the important characteristics of and the needs of the community	Practice	Demonstrate	Demonstrate

patients & their families for realistic, feasible, cost effective and relevant service	that might impact on patient care 2. Apply the understanding of these features to improve the management of the practice patient's population 3. Evaluate the social determinants of health in the community 4. Recognize the available resources in the community and effectively use these resources when necessary 5. Apply the principles of preventive and promotive pediatric health care to the community 6. Recognize the need for a consultative & participative partnership with the other stakeholders in the community 7. Coordinate communities for sustainability and self-reliance			

EXERCISE # 1: MAKE A CURRICULAR MAP FOR YOUR OWN INSTITUTION (NAME OF HOSPITAL): Make a curriculum mapping of your current curriculum to assess where you are now.

I: INTRODUCE D: DEMONSTRATE P: PRACTICE

PROGRAM OUTCOME	COURSE OUTCOME	YEAR 1	YEAR 2	YEAR 3

CHAPTER 6: INSTRUCTIONAL DESIGN

The importance of an Instructional Design (ID) for any teaching-learning encounter is reiterated. Educators should know its definition, importance, components as well as how to construct an ID. This chapter highlights concepts pertinent to these factors.

Definition

- An ID is a systematic process of planning instruction. It takes into consideration the variables affecting the teaching-learning process to ensure successful achievement of learning outcomes set for the particular instruction.

Importance

- With the formulation of an ID, the instruction can be focused on essential objectives aligned with appropriate assessment methods. It serves as a teaching guide to faculty members facilitating coordination among team members and other personnel involved in the teaching-learning process. This contributes to efficiency in teaching.

Components

I. Learning Objectives

A. *Its Significance*

- All current medical education is objective-based. Achievement of learning is gauged by acquisition of the objectives of the course. All program evaluators will be answering the question: Is the program achieving its objectives?

B. *Three Elements*

1. *Performance*

- Describes the specific activity that the learner should be able to do upon completing the learning experience expressed using an action verb that is observable
- Examples:
  1. Identify the signs & symptoms of nephrotic syndrome
  2. Perform the EINC on a newborn
  3. Respond to a patient's concern over his chronic illness

2. *Standard*

- Describes the minimum acceptable level or degree of performance; describes how well the learner must demonstrate the performance as evidence that he has learned what was expected of him
- Examples:
  - Identify the triad of signs & symptoms of nephrotic syndrome
  - Perform the EINC on a newborn with ease

- Respond to a patient's concern over his chronic illness such that the patient appears less anxious

3. ***Condition***
   - Describes the specific circumstances under which the performance must be demonstrated; may refer to the setting, equipment, materials or information that will be provided to the learner; reflects the test situation
   - Examples:
     1. Given a list of the signs & symptoms, identify the triad of nephrotic syndrome
     2. In the delivery room setting, perform the EINC on the newborn
     3. Given a patient referred for counseling, respond to the concerns on the chronic illness such that the patient appears less anxious

C. *Classification*

- **Three Domains:**
  1. Cognitive - focuses on intellectual abilities
  2. Psychomotor – focuses on practical skills requiring the use and coordination of skeletal muscles
  3. Affective – focuses on attitudes, values & feelings

  (Specific statements of what learners are expected to know, perform, or feel at the end of instruction)

- **Levels or hierarchy for each of the 3 domains**

  Each of the domains have different levels or category of cognitive/ psychomotor/ attitudinal processes starting from the lower order to the higher order skills. This is presented in Bloom's taxonomy best presented in a pyramid. Tables of specification then follows for better understanding of each of the categories.

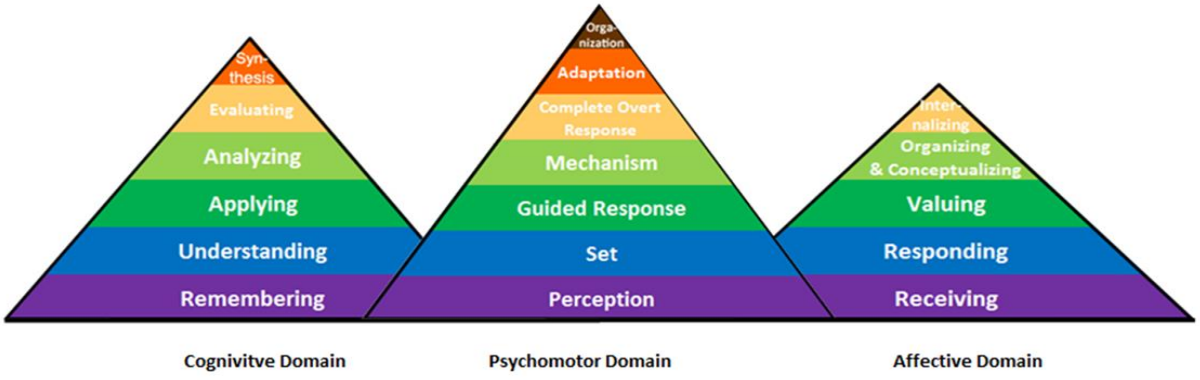

Table 1. The different categories of the cognitive process

Level	Cognitive Process	Definition	Key words (action verbs which describe the knowledge to be taught and measured)	Sample objectives for each level *Upon completion of the Research Module, the resident should be able to:*
1	***Remember***	Retrieve relevant knowledge from long term memory	Define, duplicate, identify, list, name, recall, recognize, relate, record, repeat, reproduce, state	***Define*** "sample" and "population"
2	***Understand***	Construct meaning from instructional messages, including oral, written & graphic	Choose, cite examples of, classify, describe, differentiate between, discriminate, discuss, explain, give in own words, locate	***Differentiate between*** random and non-random sampling
3	***Apply***	Carry out or use a procedure in a given scenario; use of principles to solve problems; use of learned information in new situations	Apply, choose, demonstrate, dramatize, employ, generalize, illustrate, interpret, initiate, operate, operationalize, practice, relate, schedule	Given a research problem and target population, ***select*** the most appropriate sampling method
4	***Analyze***	Break the material into constituent parts and determine how parts relate to one another and to an overall structure or purpose; distinguishing & comprehending interrelationships	Analyze, diagnose, appraise, calculate, categorize, compare, contrast, deduce, detect, determine, develop, diagram, distinguish, draw, estimate, examine, infer	***Attribute*** weaknesses in conclusions made to an error in sampling
5	***Evaluate***	Make judgments based on criteria & standards	Appraise, assess, argue, critique, defend, judge, measure, rate, revise	***Critique*** a given sampling method used in a given protocol
6	***Create***	Put the elements together to form a coherent or functional whole;	Arrange, assemble, collect, compose, construct, create, design, develop, devise,	***Produce*** a research protocol

		Reorganize elements into new pattern	formulate, manage, modify, organize, plan, prepare, produce, propose	

Table 2. The different categories of the psychomotor domain

Level	Cognitive Process	Definition	Key words (action verbs which describe the skill to be trained and measured)	Sample objectives for each level *Given an actual patient with congenital heart disease, the resident should be able to:*
1	***Perception***	*Awareness;* ability to use sensory cues to guide motor activity	Recognize, distinguish, notice, touch, hear, feel	Recognize the various equipment needed for history & physical examination
2	***Set***	*Mindset;* readiness and willingness to act (includes mental, physical, and emotional components)	Arrange, prepare, get set	Prepare for an actual interview and examination
3	***Guided response***	*Imitation and trial & error;* students rely on the teacher's demonstration of the behavior or step-by-step instructions written in manuals	Imitate, copy, follow, try	Follow what the facilitator demonstrated to the group
4	***Mechanism***	*Automaticity;* learned responses have become habitual and the movements can be performed with some confidence & proficiency	Make, perform, shape, complete	Perform with confidence the steps in the PE of the cardiovascular system
5	***Complex overt response***	*Expert proficiency;* ability to do complex movement patterns with minimal effort; proficiency is indicated by a quick, accurate, and highly coordinated performance	Coordinate, fix, demonstrate	Demonstrate accurate and highly coordinated PE of the cardiovascular system

6	***Adaptation***	*Adaptable proficiency;* can modify movement patterns to fit special requirements	Adjust, integrate, solve	Adjust to the special requirements of a patient who has a chronic illness
7	***Origination***	*Creative proficiency;* creating new movement patterns to fit a particular situation or specific problem	Design, formulate, modify, re-design, trouble-shoot	Design a plan for given clinical scenarios which are beyond the usual

Table 3. The different categories of the attitudinal domain

Level	**Cognitive Process**	**Definition**	**Key words (action verbs which describe the attitude to be trained and measured)**	**Sample objectives for each level** *At the end of the rotation, the resident should be able to:*
1	***Receive***	Attend, listen, take an interest in, and passively participate	Acknowledge, ask, attend, develop, identify, listen, locate, name, observe, realize, recognize	Follow rules and regulations pertinent to the clinical rotation
2	***Respond***	React, question & probe ideas & actively participate	Clarify, complete, comply, conform, contribute, cooperate, exhibit, help, interpret, participate, perform	Dutifully perform all procedures prescibed for each patient assigned
3	***Value***	Decide the worth & relevance of ideas & actively participate	Demonstrate, differentiate, enable, invite, join, justify, persuade, prefer, select, study, work	Demonstrate concern for the progress of patients
4	***Organize***	Bringing together different values and reconciling internal conflicts; integrating a new value	Generalize, integrate, judge, modify, prepare, prioritize, regulate, relate, systematize, synthesize, transform, weigh	Prioritize provision of quality care especially when pateints are in critical conditions
5	***Characterize***	Act consistently with the new value	Serve, solve, view, verify	View the medical profession as a field of dedication and service for patients, community and country

D. Criteria for Evaluation of the objectives

Always make your objectives SMART: Specific, Measurable, Attainable, Relevant and Time-bound

II. SUBJECT CONTENT

- The content of the instruction should be based on specific objectives
- Questions to ask when selecting content on a specific topic:
    1. What specifically must be taught/ learned?
    2. What facts, concepts & principles relate to this?
    3. What steps are involved in necessary procedures?
    4. What techniques are required in performing essential skills?
- Should be organized in any of the following methods so that learners will not find it difficult to comprehend
    1. Simple to complex
    2. Concrete to abstract
    3. Life cycle
    4. Time series
    5. Systems approach
    6. Normal to abnormal

III. TEACHING-LEARNING ACTIVITIES

- May be classified into three:
    1. Presentation – lecture, demonstration, showing audio-visual materials
    2. Individualized learning – reading text, solving problems, writing reports, working in labs/clinics, doing exercises
    3. Interaction – SGDs, preceptorials, group tutorials, bedside teaching, role playing, mentoring

IV. RESOURCES

- To make the teaching-learning activities interesting & effective
- Several factors to consider when selecting media: availability, cost, time to prepare, simplicity, clarity, maintenance & storage, learner's and teacher's preference; make sure that the instructional media chosen are appropriate to the learning objective
- Examples of instructional media: printed materials (textbooks, study guides, pamphlets, handouts, monographs); audio-visual aids; models & simulation task trainers; real objects; standardized patients; actual patients
- Support services (budget, facilities, equipment)

V. EVALUATION

- Involves finding out how much learning has taken place; the result of which reflect the amount of learning that has occurred

- A continuous process (done during & at the end of instruction) based on clearly stated objectives
- Make sure that the assessment method used is congruent to the learning domain to be evaluated

In Pediatric Residency Training, instructional designs may be formulated for the following:

1. For lectures delivered for the trainees on general pediatrics or subspecialty topics
2. For the different rotations as they may be considered the "courses" during the entire training

A Course Syllabus in Pediatric Residency Training is a document containing all the instructional designs of the different rotations including the course information, description, resources, assessment plan and course policies. Each rotation has its different competencies and learning outcomes thus an instructional plan is needed for each:

1. Pediatric wards
2. Pediatric Intensive Care Unit (PICU)
3. Neonatal Intensive care unit (NICU)
4. Emergency room
5. Outpatient department
6. Community rotation
7. Subspecialty rotations

Another important consideration is the year level of training which entails different levels of competencies as well. Research is considered a required competency across all year levels and should likewise be included.

The format to be followed for a Course Syllabus on the different rotations is shown:

NAME OF HOSPITAL
DEPARTMENT OF PEDIATRICS
COURSE SYLLABUS FOR _____ (Specify Rotation)

I. Course information

Course Code: PedWards (if rotation is in the Pedaitrics Ward)
Course Title: Ward rotation for the Pediatric Residency Training Program
(sample only)
Credits/ Hours:
Venue/ setting:
Course Supervisor & Faculty:

II. Course Description (rationale, focus, entry & terminal competencies)

III. Instructional Design

LEARNING OUTCOMES	CONTENT	TEACHING – LEARNING ACTIVITY	ROTATION/ TIME FRAME (of acquisition of outcomes)	ASSESSMENT

IV. Resources

V. Assessment Plan

VI. Course policies (Rules & Regulations)

See Appendix A1 *- Sample Course Syllabus of the Pediatric Wards rotation*
See Appendix A2 *- Sample Course Syllabus of Research*

EXERCISE #2: CONSTRUCT A COURSE SYLLABUS OF THE OUTPATIENT DEPARTMENT ROTATION

CHAPTER 7: TEACHING - LEARNING STRATEGIES

Pediatric residency training in this generation has evolved together with significant changes in the medical profession. The exponential growth in scientific information and the latest technologies have changed the landscape for teaching and learning in medicine. The widespread use of the Internet, cellphones and the social networking phenomenon has also altered the learning environment. At the same time, attending physicians have acquired different roles and responsibilities such that bedside teaching with residents has been reduced significantly.

The key to maximizing learning for the pediatric residents rests on creating a better clinical learning environment. Evidence suggests that the more effective teaching occurs when the teaching consultant's role is to coach and facilitate. This relationship contrasts with the traditional role of the teaching consultant as the primary source of information and the evaluator. The responsibility for learning shifts from the consultant to the resident in training.

Key concepts that need to be observed to make any teaching and learning strategy work for the new crop of pediatric residents:

1. Identifying the resident as an essential part of the healthcare team has been recognized as a strong factor in motivating residents to learn. Placing value on the role of the resident as a partner in the care of patients results to more positive impact on learning.
2. Encouraging the pediatric resident to reflect on their observations and experiences helps them develop their goal-setting and problem solving abilities.
3. The effective teaching relationship must be grounded on mutual trust. The process of granting increasing degrees of autonomy in making decisions to the resident establishes a safe learning environment.
4. The teaching consultants need to be open to innovate ways of teaching the pediatric residents. They must be encouraged to be curious and search for more knowledge but need to be assisted in interpreting the information and applying them in the proper context.
5. Teaching the residents must be brief and concise. There has to be a balance between time for service to patients and learning. Brief teaching sessions with clear-set objectives can make the learning process more interesting to the resident and preceptor alike.
6. Providing timely feedback is crucial for the resident's learning. Both positive and negative feedback from trainor to trainee are necessary but must be preceded by a respectful trainor-trainee relationship. Communicating timelines and expected outcomes for tasks will also be helpful to minimize confusion.
7. The patient must remain at the center of all learning opportunities. Highlighting the centrality of the patient is essential and the preceptor must find ways to provide context and connect the learning experience to the patient.

Popular approaches for teaching pediatric residents may be adapted:

A. The One-Minute Preceptor

This strategy is a structured framework for clinical teaching that can be accomplished within a few minutes. This model uses a five-step approach:

Step 1. Getting a commitment:
The preceptor elicits from the resident(s) opinions on the differential diagnosis and management rather than giving their own conclusions and plans. The question must be asked in a non-intimidating manner so that the resident trainee(s) will feel "safe" enough to risk a commitment, even if it is wrong.

Step 2. Probing for supporting evidence:
The preceptor should encourage the resident(s) to 'think out loud' and give the rationale for the commitment they have just made to diagnosis, treatment, or other aspects of the patient's problem. The preceptor should either validate the answers they have committed to or reject them gently if flawed.

Step 3. Teaching general rules:
Learning from one patient can be applied to other situations. The learner is primed for new information they can apply to a given patient as well as future patients.

Step 4. Reinforcing what was done well:
Effective reinforcement should be specific and behavior-based. Positive feedback also builds the trainee's self-esteem.

Step 5. Correcting mistakes:
Encouraging self-assessment is a good way to provide feedback. Allowing the resident trainee(s) to identify their own errors enhances their self-reflective abilities. If ever mistakes need to be pointed out, they must be specific, timely, and behavior based.

SNAPPS:

This strategy with a six-step mnemonic is another learner-centered model that is often applied in the outpatient setting. In this model, the resident presents the patient's case summary to a preceptor followed by five steps that require clinical reasoning and discussion.

1. **S**ummarize briefly the history and physical findings
   The resident obtains the history, performs the physical examination of a patient, and presents a concise summary to the preceptor.

2. **N**arrow the differential to two or three relevant possibilities
The resident verbalizes what he or she thinks is going on in the case, focusing on the most likely possibilities. For follow-up or sick visits, the differential may focus on why the patient's disease is active, what therapeutic interventions might be considered, or relevant preventive health strategies. This step requires a commitment on the part of the resident similar to the OMP model of clinical teaching.

3. **A**nalyze the differential by comparing and contrasting the possibilities
The resident discusses the differential by comparing and contrasting the relevant diagnostic possibilities and discriminating findings. This discussion can stimulate an interactive discussion with the preceptor.

4. **P**robe the preceptor by asking questions about uncertainties, difficulties, or alternative approaches
During this step, the resident is expected to reveal areas of confusion and knowledge deficits. This step is the most unique aspect of the learner-driven model because the resident initiates an educational discussion by probing the preceptor with questions rather than waiting for the preceptor to initiate the probing. The preceptor can learn a great deal about the resident's thought process and knowledge base by such interactions.

5. **P**lan management for the patient's medical issues
The resident explains the patient management with the preceptor and must attempt either a brief management plan or suggest specific interventions. This step asks for a commitment from the resident.

6. **S**elect a case-related issue for self-directed learning
This final step encourages the resident to read about focused, patient-based questions. The learner may identify a learning issue at the end of the patient presentation or after seeing the patient with the preceptor. The learner should check with the preceptor to focus the reading and frame relevant questions. The resident should devote time to reading soon after the office encounter as possible.

C. Bedside Teaching

Teaching at the bedside provides a great opportunity for the attending pediatrician to diagnose the patient, "diagnose" the resident and teach at the same time. Thus this method of teaching should not be removed among the teaching and learning strategies for pediatric residents. Studies have shown that if done properly, the bedside teaching can foster a stronger patient-physician bond. Selection of patients may also be observed according to factors that may affect the health team workflow, the trainees' learning needs and clinical requirements as seen in Table 1.

Table 1. Prioritization of patients chosen for and deferred from bedside rounds

Definitely perform bedside rounds	Sick patients requiring immediate care
	New admissions to team
	Post-call days
Likely to perform bedside rounds	Clinical-decision making required
	High educational value for trainees
	Geographic considerations
Variable (depending on time and patient census)	Patients pending discharge
	House staff preference
Likely to defer bedside rounds	Clinically stable patients with low educational value
	Sensitive issues anticipated in discussion
	Patient on contact or respiratory isolation
Definitely defer bedside rounds	Patient not available (e.g. off floor for testing)
	Patient status impairs adequate communication (e.g. if obtunded)
	Unwilling patient

*Reference: Gonzalo, JD, Heist, BS, Duffy, BL, Dyrbye, L, Fagan, MJ, et.al., (2012). The art of bedside rounds: A multi-center qualitative study of strategies used by experienced bedside teachers. *J Gen Intern Med.* 28(3):412–20.

Although bedside teaching may seem like a complex strategy for teaching, observing the following steps will help make it a valuable learning experience for the residents:

1. Meet as a team before rounding the patient.
2. Review the chart first and have a resident give an oral presentation of the patient's case.
3. As the patient is approached, the preceptor must role-model the proper bedside behavior to the team. All members of the team must be introduced to the patient and permission to perform bedside round must be obtained from the patient. It is imperative to explain to the patient how the bedside teaching will be done and ensure that the patient is comfortable all throughout the teaching round.
4. The bedside evaluation may entail asking more questions for additional details of the patient's history or to examine the patient.
5. Before leaving the patient, make sure that the patient's own questions or concerns have been addressed and the patient remains comfortable.

CHAPTER 8. ASSESSMENT & EVALUATION OF RESIDENTS

Assessment can be formative (guiding future learning, providing reassurance, promoting reflection, and shaping values) or summative (making an overall judgment about competence, fitness to practice, or qualification for advancement to higher levels of responsibility).

Formative assessments provide benchmarks to orient the learner who is approaching a relatively unstructured body of knowledge. They can reinforce students' intrinsic motivation to learn and inspire them to set higher standards for themselves. On the other hand, summative assessments are intended to provide professional self-regulation and accountability and are especially important in selecting a method of evaluating competence for high-stakes assessments like for licensing and certification examinations.

GENERAL RULES IN PREPARING A WRITTEN / ORAL / PRACTICAL EXAMINATION

1. Describe the nature of the students and purpose of the test.
    a. Assess entering knowledge
    b. Assess progress
    c. Diagnose areas of strength and weaknesses
    d. Prediction
    e. Motivate students
    f. Provide terminal evaluation
2. For each category or objective, decide how, where and when such competency will be assessed.
    a. Based on the learning objectives
    b. Based on content
3. Construct a test blue print
4. Select the most appropriate test
    a. Objective (Appendix B)
    b. Essay
    c. Oral (OSCE, OSOE) (Appendix D)
    d. Practical (MiniCex) (Appendix C)
5. Construct the test
6. Determine the passing rate or MPL
7. Administer the test
8. Collect, analyze and interpret data.
9. Give feedback

Areas, Methods and Tools used for Assessment & Evaluation

Areas	Methods	Tools
Knowledge (Cognitive)	Written Exam	Objective Essays Simulation
Skills (Psychomotor)	Practical Exam	Checklist Rating Scales OSCE
Attitudes (Affective)	Oral Exam Indirect	Interview Rating scale Reflections Portfolio

Constructing a Test Blueprint

1. List the objectives or content areas on the first left hand column of the table.

2. Determine the weights (number of test questions or % for each content area)

3. Decide on a second dimension to constitute the other column in the table. (Recall, comprehension, application)

4. Determine the number of test questions or % for each item in the second dimension.

5. Complete the table

Example: Intestinal Obstruction in Children

Objectives

1. Diagnose the more common disorders causing intestinal obstruction in children

2. Formulate a management plan for these disorders

Year level of training: 3rd year
Total Number of Items: 50

Construct	Percentage (number of items)	Categories of cognitive domain					
		Remember	Understand	Apply	Analyze	Evaluate	Create
Diagnosis	70% (35 items)	0	0	10	15	10	0
Management	30% (15 items)	0	0	0	10	5	0
	Total items per category	0	0	10	25	15	0

EXERCISE #4: CONSTRUCT A TEST BLUEPRINT OF THE TOPIC YOU WILL LECTURE

Topic: _____
Year of Resident: _____
Total number of items: _____
Steps to follow:

1. List the constructs (whether as objectives or content areas) on the first left hand column of the table

   1_____

   2._____

   3. Etc. _____

2. Determine the weights (number of test questions or % for each content area)

3. Distribute the items according to the appropriate categories of the cognitive domain (remember, understand, apply, analyze, evaluate, create)

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APPENDIX A1

SAMPLE INSTRUCTIONAL DESIGN

NAME OF HOSPITAL
DEPARTMENT OF PEDIATRICS
PEDIATRIC RESIDENCY TRAINING PROGRAM CURRICULUM IN OUTCOME-BASED DESIGN

COURSE SYLLABUS FOR CLINICAL WARD ROTATION

I. Course information

Course Code: PedWards
Course Title: Clinical ward rotation in Pediatric Residency Training Program
Credits/Months of rotation: As recommended by the Hospital Accreditation Board of the Philippine Pediatric Society
Venue/Setting: Pediatric wards
Write full name of hospital including address
Course Supervisor and Faculty: Consultant-of –the month

II. Course description (rationale, focus, entry, and terminal competencies)

The clinical ward rotation is the best area where all the learning outcomes recommended by WHO, CHED, PRC and the Philippine Pediatric Society can be achieved. Clinical competence, communication skills, managing health care teams, evidence-based practice, inter-professionalism, systems-approach to health care, ethical practice, nationalism & dedication to service as well as social accountability should all be taught, learned and enhanced during the ward rotation. Various clinical teaching activities would help facilitate accomplishment of all these learning outcomes. Assessment of the performance of the residents is equally important to evaluate achievement of these outcomes.

A. Year level 1

As early as Year Level 1 residency training, the residents rotating in the pediatric wards are expected to master the diagnosis and management of the ***common pediatric illnesses/ conditions*** in the national or international level. They will be trained to be knowledgeable on all the aspects of pediatric illnesses including the epidemiology, incidence, pathophysiology, clinical manifestations, diagnosis, differential diagnosis, treatment, complications, prognosis and preventive measures. This is in terms of the learning outcome on clinical competence. Actual patient encounters would develop their good communications skills, rapport building, ethical practice of medicine and their

dedication to service. Team work with co-residents, students and other members of the team caring for the patients would enhance their professionalism, inter-professionalism as well as teaching skills. Networking with other hospitals, clinics, health centers, support groups for a comprehensive, long term management for a patient is likewise developed during the ward rotation. Acquisition of ***basic procedural skills*** as well as ***proper attitude*** is given equal importance.

B. Year level 2

During the Year Level 2 clinical ward rotation, the residents are expected to master not only the common but as well as the ***more complex pediatric conditions***. They should perform not only the basic procedural skills but the ***complex pediatric procedures*** such as thoracentesis, intubation, exchange transfusion, lumbar puncture, among others. Greater responsibility in terms of teaching junior residents as well as medical students are also given to 2nd year residents. Greater administrative duties are also entrusted to them to train them to be good managers and social mobilizers.

C. Year Level 3

The 3rd year pediatric residents-in-training are expected to comprehensively diagnose and initially manage ***uncommon, chronic and complicated pediatric conditions,*** aside from the mastery of the common and complicated cases. Management of the more common subspecialty cases are included in their learning outcomes. In addition, the ***more complex pediatric procedures*** such as CVP insertion and cutdown are additional skills they need to perform. Teaching skills are highlighted during this year which includes bedside rounds, preceptorials and must know lectures to the rotating medical students, junior residents and other health care providers included in the team. Planning and implementation of community outreach projects for social accountability to the community is one of the learning outcomes that is emphasized during the last year of training.

III. Instructional Design

Learning Objectives (Learning outcome covered)	Content	Teaching-Learning Activities	Rotation/ Time frame	Assessment
Year Level 1: At the end of the 1st year of pediatric residency training, the resident rotating in the pediatrics wards is expected to perform the following learning outcomes during actual patient encounters:				
1. Diagnose the more common pediatric illnesses/ disorders *(LO1, LO2, LO4)*	Pediatric history taking; Pediatric PE; Common pediatric disorders/ illnesses (See Core Pediatrics for the list) to include: ▪ Epidemiology ▪ Pathophysiology ▪ Clinical manifestations ▪ Differentials ▪ Diagnostics ▪ Diagnosis ▪ Prognosis (***Appendix A1:*** *List of Common Pediatric Conditions)*	▪ Actual patient encounters ▪ Monthly staff lectures ▪ Monthly audit/ Mortality review ▪ Monthly subspecialty hour ▪ Daily rounds ▪ Mentoring ▪ Preceptorials ▪ Bedside rounds	Minimum of 6 months cumulative rotation at the wards for the entire 1st year of training *(remaining 4 months for ER/OPD rotation and 2 months for NICU rotation)*	Written exam & quizzes; Oral examination; Performance rating scale for: • Clinical performance • Bedside rounds • Preceptorials • Conferences (audits, case presentations, etc) • Mini-CEX
2. Manage these common pediatric illnesses/ conditions appropriately	Treatment plan ▪ Therapeutic/ Pharmacologic ▪ Surgical ▪ Supportive/ Rehabilitative			

(LO1, LO2, LO4, LO5)	Referrals needed Complications Preventive measures			
3. Perform basic pediatric procedures *(LO1, LO2)*	List of basic pediatric procedures: a. Anthropometric studies b. Vital signs measurement c. Blood extraction d. Urethral catherization e. Venoclysis f. Intraosseous infusion g. NGT insertion h. Lumbar puncture i. Umbilical catheterization j. Specimen collection and handling k. Dressing and wound care l. BLS m. PALS n. NRP Indications, procedural steps, precautions, complications of these procedures	• Demonstration-Return Demonstration • Actual patient encounters • Preceptorials • BLS, PALS, NRP trainings		• Observation checklist for the procedures; • OSCE
4. Demonstrate professionalism & inter-professionalism in the	Professionalism; Teamwork; Collaborative, inter-professionalism in the	• SGD • Community projects		Performance rating scale for: • Clinical performance

management of patients in and outside the hospital including the community *(LO5, LO8)*	workplace	• Lay fora • Preceptorials Advocacy work		• Preceptorials • Community project
5. Network with other health care institutions as needed for a comprehensive management plan for patients *(LO6, LO10)*	Systems-based approach to health care; Process of referrals to other hospitals; The Philippine Health care system	▪ Actual patient encounters; ▪ Community exposure		• Observation checklist; • Clinical performance evaluation tool with rubrics;
6. Practice self-directed lifelong learning *(LO4, LO7)*	Continuing professional development through: ▪ attendance in conferences, conventions ▪ presentations during the required departmental conferences ▪ self-study habits	▪ ISPs ▪ Conferences		• Performance rating scale for specific conferences
7. Demonstrate dedication to service in dealing with patients *(LO9, LO10)*	Principles of relevance, equity, quality, and cost effectiveness in the delivery of healthcare to patients, families and communities	▪ Actual patient encounters; ▪ Community exposure		• Clinical performance evaluation tool with rubrics
8. Participate in the teaching activities for	Health education principles & concepts;	• Bedside rounds • Preceptorials		• Clinical performance evaluation

medical interns (LO1, LO2, LO4, LO7)	Clinical teaching skills	• Mentoring • Role playing		tool with rubrics
Learning Objectives (Learning outcome covered)	**Content**	**Teaching-Learning Activities**	**Rotation/ Time frame**	**Assessment**
Year Level 2 **At the end of the 2nd year of training, with a 4 month cumulative period, the resident rotating in the pediatric wards is expected to perform with excellence all of the learning outcomes for 1st year residents PLUS:**				
1. Diagnose complex pediatric conditions *(LO1, LO2, LO4)*	Unusual manifestations of common pediatrics diseases; Usual manifestation of complex or less commonly encountered pediatric diseases as to their: ▪ Epidemiology ▪ Pathophysiology ▪ Clinical manifestations ▪ Differentials ▪ Diagnosis ▪ Diagnostics/ clinicodiagnostic correlation ▪ Prognosis (***Appendix A2:*** *List of unusual & complex pediatric conditions)*	▪ Actual patient encounters ▪ Monthly staff lectures ▪ Monthly audit/ Mortality review ▪ Monthly subspecialty hour ▪ Daily rounds ▪ Mentoring ▪ Preceptorials ▪ Bedside rounds	4 months cumulative rotation at the wards for the entire 2nd year of training *(remaining 3 months for ER/OPD, 2 months for subspecialties/ electives/ outside rotations, 1 month for community and 2 months at the NICU)*	Written exam & quizzes; Oral examination; Performance rating scale for: • Clinical performance • Bedside rounds • Preceptorials • Conferences (audits, case presentations, etc.) • Mini-CEX
2. Manage these complex conditions appropriately *(LO1, LO2, LO4, LO5)*	Treatment plan ▪ Therapeutic/ pharmacologic ▪ Surgical ▪ Supportive/ Non-pharmacologic ▪ Preventive ▪ Rehabilitative Referrals needed Complications Preventive measures			
3. Perform complex pediatric procedures *(LO1, LO2)*	List of complex pediatric procedures: 1. Thoracentesis 2. Lumbar puncture 3. Intubation	• Demonstration-Return demonstration • Actual patient encounters		Observation checklist for the procedures; OSCE

	4. Umbilical catherization 5. Exchange Transfusion 6. Intraosseous infusion 7. Suprapubic urine collection 8. Paracentesis 9. Emergency needling	• Preceptorials • Mentoring		
4. Lead pediatric resuscitation measures *(LO1, LO2, LO3, LO5)*	Application of BLS/ PALS/ NRP trainings	• Actual patient encounters		Observation Checklist for the procedures
5. Manage a health care team (LO1, LO2, LO3, LO5, LO6, LO9, LO10)	More extensive delivery of leadership & management skills; Organizing communities for health –related activities	• SGD • Community projects • Lay fora • Preceptorials		Perforamance rating scale for: • Clinical performance • Preceptorials • Community project
Year Level 3 **At the end of the 3rd year of training, with a 4 month cumulative period, the resident rotating in the pediatric wards is expected to perform with excellence & mastery all of the learning outcomes for 1st year and 2nd year residents PLUS:**				
1. Diagnose uncommon, chronic & complicated pediatric conditions *(LO1, LO2, LO4)*	Uncommon, chronic & complicated pediatric conditions as to its: a. Epidemiology b. Pathophysiology c. Clinical manifestations d. Differentials e. Diagnosis f. Diagnostics/ clinicodiagnostic correlation g. Prognosis (***Appendix A3:*** *List of uncommon, chronic & complicated pediatric conditions)*	• Actual patient encounters • Monthly staff lectures • Monthly audit/ Mortality review • Monthly subspecialty hour • Daily rounds • Mentoring • Preceptorials • Bedside rounds	Minimum of 3 months cumulative rotation at the wards for the entire 3rd year of training *(remaining 2 months for ER/OPD, 2 months NICU, 4 months for subspecialty/ electives/ outside rotation, and 1 month community)*	Written exam & quizzes; Oral examination; Performance rating scale for: • Clinical performance • Bedside rounds • Preceptorials • Conferences (audits, subspecialty lectures/ presentations, etc) Mini-CEX
2. Manage these complex conditions appropriately *(LO1, LO2, LO4, LO5)*	Treatment plan ▪ Therapeutic/ Pharmacologic ▪ Surgical ▪ Supportive/ Rehabilitative Referrals needed Complications Preventive measures			

3. Perform more complex pediatric procedures *(LO1, LO2)*	a. CVP insertion b. Cut down	• Demonstration/ Return demonstration • Actual patient encounters		Observation checklist for the procedures
4. Conduct teaching sessions (didactic or clinical teaching rounds) with the junior residents and medical students *(LO1, LO2, LO4, LO7)*	Clinical teaching skills; Microteaching skills	▪ Bedside rounds ▪ Preceptorials ▪ Demonstration-Return demonstration		Checklist for teaching performance

IV. Resources

A. References: Textbooks, Handbooks, updated Journals, e-books, PPS Clinical Practice Guidelines; websites
B. Equipment:
C. Human resources:
D. Administrative support:

V. Evaluation plan

Sample:

Clinical performance in the wards comprise the majority of the grade of each resident comprising _____% of the over-all grade as can be seen in the following grading scheme:

Clinical performance	=
Written exam	=
Practical/ oral exam/ OSCE	=
Research	=
	_____
Total	= 100%

VI. Course policies (Rules & Regulations)

Include policies specifically on ward rotation, i.e. non-compliance with required outputs, requirement for graduation or issuance of residency training certificates if clinical competence is not satisfactory, absences, problems in attitude, etc.

APPENDIX A2

SAMPLE INSTRUCTIONAL DESIGN

NAME OF HOSPITAL
DEPARTMENT OF PEDIATRICS
PEDIATRIC RESIDENCY TRAINING PROGRAM CURRICULUM IN OUTCOME-BASED DESIGN

COURSE SYLLABUS FOR RESEARCH

I. Course information

Course Code: PedResearch
Course Title: Research in Pediatric Residency Training Program
Credits/Hours: Process covers entire years of residency training in pediatrics
Venue/Setting:
Course Supervisor and Faculty:

II. Course description (rationale, focus, entry, and terminal competencies)

A. Year level 1

The Year Level I residency training in research involves the resident in the study of current and relevant issues pertaining to child health. A resident is required to choose a case for presentation which should meet any of the following criteria: (1) a rare condition, (2) a common condition presenting uncommonly, or (3) conditions with updates in diagnosis and/or treatment. The first parts of research writing are also introduced at this stage. Entry competency includes research output/s conducted alone or with a group in medical school so that a background on case history and research writing is assured. Terminal competencies at the end of the 1st year include: good technical skills in writing a case history according to prescribed format, ability to correctly formulate a research question and efficiently conduct relevant literature search and critically appraise relevant literature.

B. Year level 2

The Year Level II residency training in research focuses on the skills in writing a research proposal. Understanding the parts of a research will translate to a correctly written research manuscript. Entry competency includes an approved research question and well written review of related literature. Terminal competencies include understanding of ethical issues in conducting research, mastery of research methodology, statistical methods and sampling methods.

C. *Year Level 3*

The Year Level III residency training in research focuses on the actual conduct of the research proposal. Time management with regards research activities is important. Entry competency includes a research proposal duly approved by the IRB. Terminal competencies include a final manuscript written in the prescribed format and presentation of the finished research project in an appropriate forum.

III. Instructional Design

LEARNING OUTCOMES	CONTENT	TEACHING-LEARNING ACTIVITIES	ROTATION / TIME FRAME	ASSESSMENT
Year Level 1 **At the end of the 1st year of training, the resident is expected to perform the following specific steps for *Learning Outcome 3 - Engage in research activities:***				
1. Present an interesting case report in the prescribed format	Common and rare pediatric conditions (with identified gaps in knowledge; practical issues in management; with updates on the disease condition); Prescribed format of a case report for written and oral presentation; Communication & presentation skills	▪ Workshop on case report writing & presentation; ▪ Research process: Literature search/ review; ▪ Structured Independent Study Period (ISP); ▪ Mentoring	1st 6months (case report writing) 2nd half of 1st year (case report presentation)	Performance rating scale for: ▪ Case report presentation (to include technical competence & communication skills) Grade for written case report **Required output:** Final case report written in prescribed format successfully presented to the

				department staff
2. Conduct appropriate literature search for the chosen research question	Formulating a research question; Literature search - Gathering information - How to conduct literature search; Journals/ articles - Evaluating information - Journal appraisal Journals/ articles; Evidence-based medicine; Good clinical practice (GCP) guidelines; Research methods ▪ Choosing a topic (health situation & needs; current information on the chosen subject) ▪ Formulating a research hypothesis	▪ Workshop for: - Research writing; - GCP guidelines - Evidence-based medicine ▪ ISP ▪ Mentoring	9th to 12th month of 1st year residency	Checklist for: ▪ Formulated research question & research hypothesis ▪ Literature search ▪ Journal appraisal **Required outputs:** 1. List of research questions for possible research project 2. Draft of literature review for chosen research question
Year Level 2 **At the end of the 2nd year of training, the resident is expected to perform the following specific steps for**				

***Learning Outcome 3 - Engage in research activities*, as a continuum from YL1:**				
1. Write a research proposal	Literature search; Journals/ articles; Evidence-based medicine; Research methods; Prescribed format for research proposal; Institutional review board policies & guidelines	▪ ISP ▪ Research workshop ▪ Mentoring	2nd half of 2nd year residency	Written output grade (for research proposal) **Required output:** 1. Research proposal written in prescribed format and approved by IRB
Year Level 3 **At the end of the 3rd year of training, the resident is expected to perform the following specific steps for *Learning Outcome 3 - Engage in research activities*, as a continuum from YL2:**				
1. Conduct the research project	Literature search; Journals/ articles; Evidence-based medicine - Ethics in research; Research methods - Institution research guidelines - Data collection system - Coding & sampling Prescribed research format; Prescribed format for audio-visual presentation of the research	▪ ISP ▪ Mentoring ▪ Actual conduct of research	1st month to 10th month of 3rd year residency	Written output grade (for final paper) **Required output:** Final research paper written in prescribed format successfully presented to the department staff
2. Finalize the written research output		Research writing	10th to 12 month of 3rd year residency	
3. Present the final research output		Research presentation	10th to 12 month of 3rd year residency	

IV. Course Resources

A. References: textbooks, handbooks, updated journals, e-books, PPS Clinical Practice Guidelines; websites

B. Equipment: medical or departmental library with updated references and webpages especially for literature search, computers/ laptops

C. Human resources: Consultant mentors, epidemiologists, research experts for proper guidance during the entire conduct of the research

D. Administrative support: logistics for the conduct of the research, research funds

V. Evaluation plan

Sample:

Research in the pediatric residency training comprise ____ % of the over-all grade of the resident as can be seen in the following grading scheme:

Clinical performance	=
Written exam	=
Practical/ oral exam/ OSCE	=
Research	=
	_____
Total	= 100%

VI. Course policies (Rules & Regulations)

Include policies specifically on research, i.e. non-compliance with required outputs, requirement for graduation or issuance of residency training certificates if lacking research or non-compliance with submission dates, etc.

The Philippine Pediatric Society, Inc.

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