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Section One: Minimum Requirements and Quality Standards of the Pediatric Residency Program

FOREWORD

Pediatric education and training has remained indelible cornerstones of the Philippine Pediatric Society, Inc. (PPS) in its thrust to provide "optimum pediatric exposure and immersion" to all pediatric residents accredited by the PPS Hospital Accreditation board (PPS_HAB).

Aligned with this important thrust, the PPS-HAB has continuously "revisited, reviewed and revised" its existing standards on the implementation and evaluation of pediatric residency training program nationwide.

It has through the years, "conceptualized, crafted out and checked" the status of both the program and the product ensuring that both comply with the both nationally and internationally accepted standards. The PPS-HAB streamlines policies proposes plans of action and encourages through recommendations the improvement of pediatric training and practice in the country.

This year, in response to the call of the times, the PPS-HAB has again introduced innovations and modifications intended to level up the breadth and depth of training programs intended to produce a new generation of constructive, competent and collaborative pediatric medicine practitioners.

Allow me to express the Society's sincerest appreciation and gratitude to the members of the PPS-HAB especially our dedicated and hardworking Secretary, Dr. Ramon L. Arcadio for the experience, expertise and empiricism they have selfless shared to make this publication another testament the Society can be proud of. Their wisdom, foresight and vision have brought to light countless clinical practice guidelines, ethical standards and best practices all empowering the Filipino pediatrician to be the best in this craft.

I strongly encourage every PPS-HAB accredited hospital to continue revisiting the contents of this new edition in their quest to apply excellence and practice the highest standards of pediatric care in their work places.

MELINDA M. ATIENZA, MD
President
Philippine Pediatric Society, Inc.

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HOSPITAL ACCREDITATION BOARD (HAB)

1. The members of the Hospital Accreditation Board (HAB) shall consist of fifteen (16) Fellows of the Society in good standing for at least five (5) years.
   - **1.1** President – as Chair
   - **1.2** Vice President - as co-chair
   - **1.3** Immediate Past President
   - **1.4** The following members shall be appointed by the President and approved by the BOT
     - 1.4.1 Four (4) members from the Specialty Board
     - 1.4.2 Four (4) Past Presidents
     - 1.4.3 Four (4) appointees with a tenure one (1) year each:
       - two (2) from Luzon
       - one (1) from the Visayas
       - one (1) from Mindanao

   1.5 The Board Secretary, a voting member, is a Fellow appointed by the President and approved by the BOT with a term of two (2) years.

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

   1.7 When deemed necessary, the president shall appoint a hospital accreditation team to assist the HAB. The members of the hospital accreditation team 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 department of pediatrics with at least level II accreditation.

2. Functions of the Board are as follows:

   2.1 General Functions: The sole authority to

   - 2.1.1 Promulgate the core curriculum requirements for residency training program in coordination with the SB and approved by the BOT
   - 2.1.2 Recognize and coordinate subspecialty fellowship training programs with the respective subspecialty societies and approved by the BOT

   2.2 Specific Functions:
   - 2.2.1 Accredit hospitals for pediatric residency training and service according to the standards set by the HAB. The HAB reserves the right to disapprove any applicant.
   - 2.2.2 Coordinate with the Council on Subspecialties and Sections through the respective boards to ensure maintenance of high standards of training and service

2.2.3 Approve the recommendation of the subspecialty societies in the accreditation of a fellowship training program based on the criteria set by their respective subspecialty boards.

The HAB Fund shall consist of the fees paid by institutions to PPS upon submission of application for accreditation/re-accreditation or reclassification.

GUIDELINES FOR THE DEPARTMENTAL SELF-ASSESSMENT OF THE PEDIATRIC RESIDENCY PROGRAM

1. The Accreditation Concept

1.1 Accreditation is the recognition of a pediatric residency program as possessing certain standards of quality or excellence.

1.2 It is a concept based on self-regulation which focuses on evaluation and the continuing improvement of educational quality.

1.3 It is a process by which departments of pediatrics and their residency programs continuously upgrade their educational quality and services through self-assessment and the judgment of peers.

1.4 It is the status granted to a pediatric residency program which meets standards of quality or excellence.

1.5 An accredited pediatric residency program is not a perfect program but is a genuinely good program. It is effectively doing what it says it should be doing according to the departmental vision-mission statement and the stated objectives of the residency program.

2. The PPS Accreditation Process

There are three stages in the PPS accreditation process, namely:

2.1 Departmental self-assessment of the pediatric residency program

This is the essential and most important aspect of the PPS accreditation process. The self-assessment is an analysis of the department's educational resources and effectiveness by its own consultants and residents. It should be viewed, therefore, as a responsibility inherent in education and in the continuing development of a department of pediatrics offering a postgraduate program of study like the residency program. The activities include:

2. 1.1 A thorough self-examination based on the evaluation instruments and involving the collection of specific data given, supportive of the beliefs and the objectives underlying the departmental program.

2.1.2 An assessment of the validity of the vision-mission in terms of current trends and needs.

2. 1.3 An evaluation of the extent to which the department of pediatrics is achieving the vision-mission, based on an analysis of all its activities.

2. 1.4 A careful consideration of various ways and means by which the vision-mission may be fully attained.

2.1 The Formal Accreditation Visit

The primary task of the accrediting team is to verify claims and statements in the self-assessment report through the following activities:

2.2.1 Dialogue with the representatives of the consultant staff
2.2.2 Dialogue with the residents
2.2.3 Separate or joint interviews with the department chair, vice-chair, training officer, chief resident and other officials of the hospital
2.2.4 Observation of any ongoing clinical conference, lecture or training activity
2.2.5 Inspection of physical facilities
2.2.6 Examination of exhibits, documents, publications, logbooks, minutes of departmental meetings, manual of standard operating procedures (SOP), development plan, research papers, etc.

2.2 Evaluation by the Hospital Accreditation Board (HAB)

The accrediting team submits a formal assessment of the accreditation visit to the HAB. 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 Administration
3.4 Consultants
3.5 Patient Services & Facilities
3.6 Research
3.7 Community Involvement

4. LEVELS OF ACCREDITATION

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

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:

1.1 The Neonatal Unit is classified as Level II by the HAB or the Philippine Society of Newborn Medicine.

1.2 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 fifty percent (50%) must pass.

1.3 The department applying for initial accreditation must have been in existence for at least one (1) year.

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:

2.1 A credible 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 seventy per cent (70%) must pass.

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

2.2.1 a significant number of general pediatric admissions
2.2.2 a variety of clinical/teaching activities in general pediatrics
2.2.3 a daily (Monday to Friday) general pediatric service clinic for the indigent patients.

2.2 A strong community involvement program as evidenced by:

2.2.1 a family/home visitation program as shown by family case study reports on file
2.2.2 participation in at least two (2) public health projects
2.2.3 daily presence (Monday to Friday) at the community venue, either half or full day

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 (3.1 to 3.5), and at least one (1) of the remaining three (3.6 to 3.8):

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.

3.2 The Neonatal Unit is classified as Level III by the HAB or the Philippine Society of Newborn Medicine.

3.3 A well equipped Intensive Care Unit.

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 ninety percent (90%) must pass

3.5 A sustained highly visible, fully operational community involvement program with good outcomes. A description of the program, its strengths, the nature and extent of resident and consultant involvement, family/home visitation reports, daily presence in the venue, and other details shall be submitted as documentation for this indicator.

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

3.6.1 reasonable budget
3.6.2 quality of research output
3.6.3 number published or given awards
3.6.4 number read in scientific conferences or conventions
3.6.5 involvement of a significant number of faculty members
3.6.6 visible, tangible and measurable impact on the community

3.7 Existence of working consortia, integrated programs or linkages with other pediatric programs, schools or pediatric agencies. Documentary evidence shall include memorandum of agreement, description of the nature, mechanism, and other details.

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

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:

4.1 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.

4.2 The Neonatal Unit (classified as Level III) and the Intensive Care Unit carry state-of-the-art equipment and facilities.

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 ninety percent (90%) must pass.

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

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

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.

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

Accreditation of Subspecialty Fellowship Programs: The HAB shall approve the recommendation of the subspecialty societies in the accreditation of a fellowship program based on the criteria set by their respective subspecialty boards.

NOTE: The Specialty Board performance and accreditation are subject to the deliberation and final decision of the HAB.

SPECIAL BENEFITS CORRESPONDING TO ACCREDITATION LEVELS

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

2. Level - 11
   - 2.1 Official recognition by PPS as accredited training program for three (3) years
   - 2.2. The department is eligible to apply for PPS research grant
   - 2.3 Residency graduates may apply to take the written part (Part I) Specialty Board Examination immediately subject to the approval of the Specialty Board and oral examination (Part II) after 2 years of pediatric practice
   - 2.3 The department may offer one scientific forum every two (2) years

3 Level - 111
   - 3.1 Official recognition by PPS as accredited training program for three (3) years
   - 3.2 The departments 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 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 2 years of pediatric practice subject to the approval of the Specialty Board.

4 Level - 1V
   - 4.1 Official recognition by PPS as accredited training program five (5) years
   - 4.2 The department is eligible to apply for several slots of PPS Research grant.

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 examination 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 year of pediatric practice subject to the approval of the Specialty Board.

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 or weaknesses 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 realization by all those involved that the department of pediatrics has many component parts—residents, consultants, other personnel, a residency training program, services, 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, in developing consensus or future departmental priorities, 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: 926-6758 to 59; 922-2435
Fax: 926-2381
Email: ppsinc@pps.org.ph

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 and residents—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 2 members (consultant and resident) for each area to be evaluated, namely:

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

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

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 the light of the vision-mission if 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 the light of the clientele 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 his/ her 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 7 Evaluation Instruments and compute the ratings for each of the 7 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 7 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 7 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
1.	1. Implemented
2.	2. Partially implemented Explanation
3.	3.Not implemented Explanation

2.7 STEP SEVEN: For each of the 7 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

2.9 STEP NINE: All the 7 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 and residents should be called. The 7 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 on the 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 7 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 at least one month 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.

Note:

1. A requirement prior to the scheduling of an accreditation visit is the submission of the Registry of Diseases Report (ICD-10).
2. In the area of Consultants, please indicate their certification status in the PPS (non certified, diplomate, fellow, emeritus fellow).
3. In the area of Training Program, please indicate the specialty board performance of the graduates during the last 3 years (names and number of graduates, how many took the examination, who passed, who failed).

MINIMUM REQUIREMENTS 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 post graduate 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 the pediatric Residents

2.5 Develop in the pediatric residents such 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 OF PEDIATRICIANS

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

3.1 Pediatric Care Provider
3.2 Health Educator
3.3 Researcher
3.4 Pediatric Health Care Manager
3.5 Social Mobilizer

4. COMPETENCY STANDARDS (TRAINING OUTCOMES)

The terminal competencies for pediatric residency graduates based on the professional roles are:

4.1 Pediatric Care Provider

4.1.1 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.

4.1.2 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.

4.2 Health Educator

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

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

4.2.3 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.

4.3 Researcher

4.3.1 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.

4.3.2 Given a problem area or a research question, the pediatrician, utilizing holistic approach and critical thinking, shall formulate and implement a research proposal and disseminate the results in the appropriate forum.

4.4 Pediatric Health Care Manager

4.4.1 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.

4.4.2 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.

4.5 Social Mobilizer

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

4.5.1 Act as advocate of people empowerment and self-reliance

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

4.5.3 Participate in community organization

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

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

Area 1: VISION-MISSION-OBJECTIVES

A. Minimum Requirements (Basic Standards)

1. The department of pediatrics must define its vision-mission-objectives that are aligned with the PPS vision/mission and their own hospital/institution and make them known to its constituency.

2. The department must define the objectives of the residency program and the competencies (intermediate and terminal) that pediatric residents should exhibit at the end of the training program

3. The statements of vision-mission-objectives of a department of pediatrics must be defined by its stakeholders.The stakeholders should include the:
   a) PPS
   b) hospital, local government units, and other external agencies (governmental/non-governmental).

c) faculty and administrative staff, trainees (undergraduates, junior interns, residents, fellows, etc) patients,

3. The vision-mission statements should include governance.

4. The vision-mission statements should include a mechanism of ensuring that graduates of the program pass the certification examinations within four (4) years.

B. Quality Standards

1. The statements of vision-mission-objectives should encompass:
   - quality training and continuing pediatric education(professional/personal development of faculty and trainee, exposure to subspecialties and readiness for lifelong self-directed learning),
   - quality research,
   - quality patient care and social responsibility,
   - quality governance (inclusion of IQA in the department's organizational chart, and ethics and professionalism).
2. Broad and specific competencies to be acquired by the pediatric residents should be specified and linked with the competencies as a result of basic medical education, and competencies needed for postgraduate training.

C. Annotations

1. 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. 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.

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

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

D. Analysis Instrument for the Area of Vision-Mission-Objectives

The department's vision-mission-objectives reveal, not what the department is, but what it professes to be. The accreditors should use these as their guideposts in evaluating the different

areas of the department. The varied features, activities, and practices of the department should be aligned with its avowed vision-mission-objectives.

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 not evident or missing.

Instructions: Write the symbol (E, N, or M) inside the parentheses to the left of the statements.

( ) 1. The statements of vision-mission-objectives of the department are clearly stated

( ) 2. The statements of vision-mission-objectives of the department are aligned and in harmony with the PPS and the institution's vision-mission-objectives.

( ) 3. The competencies to be acquired by the residents are clearly specified (intermediate and terminal competencies).

( ) 4. The objectives and terminal competencies of the pediatric residency program are adapted to the needs of the local, regional and national community.

( ) 5. The departmental statements of vision-mission-objectives are made known to its constituency regularly through various means.

( ) 6. The objectives of the residency program are well-defined and attainable.

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

( )8. The departmental statements of vision-mission-objectives encompass quality training, research, patient care and social responsibility, and governance.

Note: a numerical rating is not needed for the area on vision-mission objectives

AREA 2: TRAINING PROGRAM

A. Minimum Requirements (Basic Standards)

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

    1.1. General objectives
    1.2. Competencies at the end of each year level (intermediate competencies)
    1.3. Terminal competencies
    1.4. Competencies of a general pediatrician in each subspecialty rotation
    1.5. Curricular content
    1.6. Instructional activities
    1.7. Evaluation instruments for residents
    1.8. Policies for admission of residents
    1.9. Duties of residents per year level
    1.10. Duties of the chief resident
    1.11. Other unique features of the residency program

2. The curriculum content must include:

    2.1. Growth and development
    2.2. Nutrition and nutritional disorders
    2.3. Community, ambulatory and preventive pediatrics
    2.4. Genetics / Dysmorphology
    2.5. Fetus and newborn
    2.6. Allergy, immunology and related disorders
    2.7. Infectious diseases
    2.8. Respiratory disorders
    2.9. Gastrointestinal disorders
    2.10. Fluid, electrolytes and acid-base
    2.11. Renal disorders
    2.12. Cardiovascular disorders
    2.13. Collagen, vascular and other multisystem disorders
    2.14. Metabolic and endocrine disorders
    2.15. Disorders of the blood/neoplasms
    2.16. Genital system disorders
    2.17. Neurologic disorders
    2.18. Musculoskeletal disorders
    2.19. Skin disorders
    2.20. Disorders of the eye, ear, nose and throat
    2.21. Adolescent medicine / Gynecology
    2.22. Child abuse
    2.23. Behavioral disorders
    2.24. Critical care
    2.25. Emergency care
    2.26. Poisoning
    2.27. Sports medicine

2.28. Pharmacology
2.29. Environmental Health
2.30. Ethical issues in pediatrics
2.31. Care of children with special needs

3. 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:

3.1. First Year

Ward	6 months
OPD / ER	4 months
NICU	2 months

3.2. Second Year

Ward	4 months
OPD / ER	3 months
Subspecialties / Electives	2 months
Community	1 month
NICU	2 months

3.3. Third Year

Ward	3 months
OPD / ER	2 months
NICU	2 months
Subspecialties / PICU	4 months
Community	1 month

4. The learning activities must encompass integrated practical and theoretical instruction. This must include didactic learning sessions, supervised patient care experiences and clinical case presentations / discussions.

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

5.1. Office procedures
- 5.1.1. Anthropometric studies
- 5.1.2. Vital signs measurements
- 5.1.3. Subcutaneous injection
- 5.1.4. Intramuscular injection
- 5.1.5. Intradermal injection
- 5.1.6. Oral administration
- 5.1.7. Nebulization
- 5.1.8. Fever control
- 5.1.9. Cord care

5.1.10. Incision and drainage

5.2. Eye procedures
- 5.2.1. Topical drug administration
- 5.2.2. Foreign body removal (assist or observe)

5.3. Ear procedures
- 5.3.1. Foreign body removal (assist or observe)
- 5.3.2. Cerumen removal

5.4. Nose procedures
- 5.4.1. Foreign body removal (assist or observe)
- 5.4.2. Control of epistaxis

5.5. Endotracheal intubation

5.6. Thoracentesis (assist or observe)

5.7. Nasogastric tube placement

5.8. Genitourinary procedures
- 5.8.1. Urethral catheterization
- 5.8.2. Supra-pubic bladder puncture

5.9. Lumbar puncture

5.10. Bone marrow aspiration

5.11. Exchange transfusion

5.12. Vascular procedures
- 5.12.1. Percutaneous peripheral venous access
- 5.12.2. Peripheral venous access by cut down
- 5.12.3. Umbilical vessel cannulation
- 5.12.4. Blood extraction
  - capillary blood sampling
  - arterial blood sampling
- 5.12.5. Intra-osseous infusion

5.13. Bedside sedation for procedures

5.14. Aseptic techniques

5.15. Specimen collection and handling
- 5.15.1. Throat culture
- 5.15.2. Urethral swab
- 5.15.3. Vaginal swab
- 5.15.4. Blood culture
- 5.15.5. Urine culture
- 5.15.6. Stool culture
- 5.15.7. Gram stain
- 5.15.8. Cellulose (scotch tape) tape method

5.16. Miscellaneous procedures
- 5.16.1. Restraints
- 5.16.2. Splints
- 5.16.3. Dressings
- 5.16.4. Wound care

6. The PPS-required textbooks, journals and PPS publications must be available at the library.

   Latest edition of the following books and journals:

1. Basic Textbooks
    1) Del Mundo
    2) Nelson
    3) PALS Manual
    4) NRP Manual
    5) Bioethics
    6) Fundamentals of Pediatrics
    7) PE and Data Gathering
2. Journals
    1) PJP
    2) One foreign pediatric journal (online acceptable)
    3) National Formulary
    4) All PPS Publications
        a) Anthropometrics FNRI
        b) Standards of Child Care
        c) Standards of Newborn Care
        d) Handbook of Infectious Diseases
        e) TB
        f) IMCI / CATT WHO
        g) Core Pediatrics
        h) Preventive Pediatrics
        i) CPGs
        j) Policy Statements
        k) UPEC Manual and Teaching Modules
        l) ICD 10
        m) PPS Code of Ethics
        n) Code of Ethics of the Medical Profession

7. Each resident must be certified by the PPS of having attended the following courses:
    7.1. Basic Life Support (BLS)
    7.2. Pediatric Advanced Life Support Seminar (PALS)
    7.3. Neonatal Resuscitation Program (NRP)
    7.4. TB DOTS Training Program

8. There must be evaluation instruments that measure clinical competence, promote learning, and document adequacy of training.

9. An evaluation must be done at the end of the first and second years of residency and a summative evaluation at the end of the third year.

10. The consultant to resident ratio must be at least 1:2.

11. The minimum number of staff required for the opening of a residency program must be:

    11.1. Consultants – 3
    11.2. Residents – 3

B. Quality Standards

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

2. The training process should ensure the development of knowledge, attitudes, skills and personal attributes in the pediatrician's professional roles of (a) pediatric health care provider, (b) health educator, (c) researcher, (d) pediatric health care manager, and (e) social mobilizer.

3. The training process should emphasize the principles of competency-based approach, problem-oriented strategies, evidence-based medicine, and practice-based training including values formation, bioethics, and community orientation.

4. The residency curriculum should be relevant, flexible, innovative and focused on primary pediatric care.

5. The learning activities should guide the residents towards self-realization, develop their analytical and critical judgment, encourage independent study, develop clinical skills, and strengthen their social awareness.

6. The program should include a process of evaluation stating the methods used for assessment of the residents including criteria for passing examinations. Evaluation should also emphasize constructive feedback.

7. The program should include a departmental quality assurance committee.

C. Evaluation Instrument for the Quality of the Training Program\

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 (non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. The objectives and content are in consonance with the health needs and expectations at the national, regional and local levels.	5 4 3 2 1 NA
2. The training program reflects the competencies and learning desired in the residency program in terms of knowledge, attitudes and skills to enable the pediatrician to perform his / her professional roles as:	
2.1. Pediatric health care provider	5 4 3 2 1 NA
2.2. Health educator	5 4 3 2 1 NA
2.3. Researcher	5 4 3 2 1 NA
2.4. Pediatric health care manager	5 4 3 2 1 NA
2.5. Social mobilize	5 4 3 2 1 NA
3. The program content includes topics from the latest PPS "Guide to Core Pediatrics" including community-orientation, values formation, bioethics, socio-cultural problems, and behavioral disorders.	5 4 3 2 1 NA
4. The program content and rotations are practice-based, emphasizes principles instead of facts, adopts a problem-oriented approach, and utilizes evidence-based medicine guidelines. It should provide for the needs, expectations, interests, and concerns of the residents.	5 4 3 2 1 NA
5. The technical skills part of the program includes sufficient practice opportunities for pediatric bedside procedures utilizing references / guidelines from a published manual / handbook or teacher-made instructional materials by consultants of the program.	5 4 3 2 1 NA
6. A variety of learning activities are implemented like: 6.1. Bedside rounds with consultants, chair, training officer, and chief resident 6.2. Conferences with family members 6.3. Chart reviews 6.4. Supervised ambulatory (OPD) clinics 6.5. Supervised lectures and journal articles review by residents 6.6. Clinical conferences 6.6.1. Clinical case conferences (case presentations, grand rounds, new case hour, management and therapeutics conference, case dilemma, bioethics conference, clinico-radiologic conference) 6.6.2. Mortality and morbidity conference 6.6.3. Endorsement conference / rounds 6.6.4. Specialty conference (optional) 6.6.5. Clinico-pathologic conference 6.6.6. Interdepartmental conference	5 4 3 2 1 NA
7. The following areas of clinical competence are evaluated: 7.1. Knowledge 7.2. Clinical skills (objective evaluation of PE) 7.3. Technical skills 7.4. Interpersonal skills 7.5. Comprehensive decision-making (including knowing when to refer) 7.6. Professional attitudes and habits	5 4 3 2 1 NA
8. A variety of evaluation strategies is used to evaluate clinical competence like: 8.1. Written examination 8.2. Observation rating sheet (consultant evaluation of residents) 8.3. Oral examination 8.4. Objective Structured Clinical Examination (OSCE) 8.5. Practical examination and return demonstration 8.6. Chart review 8.7. Written reports	5 4 3 2 1 NA
9. The resident receives feedback about his / her performance.	5 4 3 2 1 NA

Computation for final rating of Training Program:
Add the ratings of individual statements and divide by the number of rated statements. There are 13 rated statements.

Rating for Training Program = **Sum of Ratings of Individual Statements** / **13**

AREA 3: ADMINISTRATION

A. Minimum Requirements (Basic Standards)

1. The governance structures and functions of the department must be defined, including their relationships within the hospital/university.

2. There must be an organizational chart depicting the training**, service,** research and governance.

3. There must be a description of the department's short- and long-term development plans.

4. The qualifications and job descriptions of departmental officers must be defined.

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5. The minimum PPS certification for the following positions must be observed:

   5.1 Department Head – Fellow
   5.2 Training Officer – Fellow
   5.3 Section Chiefs – Diplomate
   5.4 All consultants – Diplomate

6. For departments with accredited post-residency fellowship programs, the section chiefs must be PPS fellows and/or fellows of the subspecialty society/board.

7. The department must have a clear line of responsibility and authority for the training program and resources including a dedicated training budget.

8. The staffing pattern in all pediatric patient care area must be described.

9. Records of departmental meetings, data of consultants and residents, official rules, policies, and reports must be kept on file.

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10. A Bioethics Committee (department or hospital level) must be organized.

11. The mother institution must include a program of quality assurance and the whole department should submit itself to regular internal and external evaluation.

12. There must be formal, open communication lines between the officers of the department and of the mother institution, on the one hand, and between the consultants and the residents, on the other.

13. The department must have regular or periodic planning sessions with the participation of the consultants and residents.

14. The department must have working linkages with institutions involved in child health.

B. Quality Standards

1. The department should have an administrative organization which facilitates the attainment of its vision and mission.

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

3. The department should make provisions for the participation of the alumni of the residency program in the affairs of the department.

4. The mother institution should include a program of quality assurance and the whole department should submit itself to regular internal and external evaluation.

5. There should be formal, open communication lines between the officers of the department and of the mother institution, on the one hand, and between the consultants and the residents, on the other.

6. The department should have regular or periodic planning sessions with the participation of the consultants and the residents.

7. The department should participate in integrated programs, consortium arrangements and linkages with pediatric institutions in the area for supplemental learning, training, collaboration in research and socio-cultural activities.

C. Evaluation Instrument for the Quality of Administration

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 (Non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. The official departmental documents include a clear and detailed description of the organizational structure illustrated by an organizational chart. 5 4 3 2 1 NA

2. The administrative policies and procedures contain the duties and

responsibilities, process of selection, terms of office of the department's administrative officials including, among others: 5 4 3 2 1 NA

2.1 Department Chair
2.2 Vice-Chair
2.3 Training Officer
2.4 Section Chiefs
2.5 Committee Chairs

3. Planning is a regular departmental exercise and involves the participation of its consultants, residents and resident alumni. 5 4 3 2 1 NA

4. The actual operation of the administrative bodies shows: 5 4 3 2 1 NA

4.1 Effective leadership
4.2 Systematic decision-making
4.3 Long-range planning
4.4 Alertness to opportunities for linkages
4.5 Social awareness and civic consciousness

5. There is an open line of communication between departmental officials, on one hand, and between consultants and residents, on the other. 5 4 3 2 1 NA

6. The staffing pattern in all patient care areas is clearly described. 5 4 3 2 1 NA

7. The medical supplies and assets are effectively managed. 5 4 3 2 1 NA

8. Reports and records are adequate, accurate, accessible, up-to-date, and systematic. 5 4 3 2 1 NA

9. The hospital/university administration is supportive of departmental needs. 5 4 3 2 1 NA

10. There is a functioning Bioethics Committee or body. 5 4 3 2 1 NA

Computation for Final Rating of ADMINISTRATION:

Add the ratings of individual statements and divide by the number of rated statements. There are 10 rated statements.

$$\textbf{Rating for Administration} = \frac{\textbf{Sum of Ratings of Individual Statements}}{\textbf{10}}$$

AREA 4: CONSULTANTS

A. Minimum Requirements (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. As part of their professional obligations, all consultants must recognize their responsibilities to participate in the residency training program.

4. The department must have a development program to enhance the professional growth of consultants.

5. There must be incentives for the consultants' participation in the teaching program. (ex. decking of private walk-in admissions, offices, etc.)

6. There must be provisions for recognition and reward for meritorious training activities of consultants. (ex. plaques, citations, gifts)

7. There must be annual performance evaluation of consultants.

8. The consultants and residents must observe a Code of Ethics of PMA and PPS.

9. For Level I and II accredited programs, the department/hospital must have on their staff:

   9.1 board certified pediatrician or board certified/ board eligible neonatologist (should pass certifying exam 2 years after he/she has finished training)

   9.2 pediatric surgeon (approved/recognized by their society; not necessarily part of active staff)

   9.3 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.

B. Quality Standards

1. In the consultant selection process, attention should be given to teaching ability, character, integrity, broad and sound scholarship, extensive preparation in their fields of interest, professional competence, research expertise, and communication skills.

2. The duties and instructional responsibilities of consultants should be specified including the balance between training and service functions.

3. There should be provisions for consultant participation in the formulation of departmental objectives and policies and in the implementation and evaluation of the residency training program.

4. The staff (consultant) development program should include opportunities to enrich professional roles, attend teacher-training seminars, and participate in scientific conferences.

5. The incentives for consultants should include financial benefits, decking for walk-in private admissions, office space, among others.

6. The department should recognize meritorious performance including functions as medical teachers, trainers, section/service supervision, research advising and mentoring.

7. The regular performance evaluation of consultants should use instruments acceptable to them and following criteria Involving teaching competence, patient care, research, and community involvement.

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

9. There should be a consultant staff association that promotes consultant welfare.

10. There should be a certified PALS instructor in level II to IV accredited hospitals.

C. Evaluation Instrument for the Quality of the Area on Consultants

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 (Non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. In addition to their being board certified (diplomate or fellow) by PPS, consultants have subspecialty board certification, special training certificates and/or graduate degrees (Masters or PhD). 5 4 3 2 1 NA

2. The process of consultant selection considers: 5 4 3 2 1 NA

2.1 teaching ability
2.2 character
2.3 integrity
2.4 values
2.5 broad and sound scholarship
2.6 extensive preparation in their fields of interest
2.7 professional competence
2.8 research expertise
2.9 communication skills

3. The teaching assignment and other responsibilities of consultants include participation in. 5 4 3 2 1 NA

3.1 bedside teaching rounds
3.2 OPD supervision
3.3 clinical conferences
3.4 lectures
3.5 research advising
3.6 mentoring
3.7 committee work

4. Consultants participate in departmental strategic planning and in the implementation and evaluation of the residency training program. 5 4 3 2 1 NA

5. The staff (consultant) development program includes opportunities for attendance in: 5 4 3 2 1 NA

5.1 formal studies
5.2 teacher-training seminars
5.3 clinical conferences, seminars, workshops, and colloquia
5.4 conventions, seminars, and meetings of professional organizations

6. Evaluation instruments for consultants are acceptable to them and follow criteria involving teaching competence, patient care, research, and community involvement. 5 4 3 2 1 NA

7. There is a system of giving consultant incentives and recognizing meritorious performance. 5 4 3 2 1 NA

8. Harmonious relationships exist among pediatric consultants, between consultants and administration, residents and staff of other departments. 5 4 3 2 1 NA

9. There is an association of consultants that promotes consultant welfare and advocates for personal and professional growth of its members. 5 4 3 2 1 NA

10. The consultants observe the Code of Ethics of the Philippine Pediatric Society and the Philippine Medical Association. 5 4 3 2 1 NA

Computation for Final Rating of CONSULTANTS:

Add the ratings of individual statements and divide by the number of rated statements. There are 10 rated statements.

$$\textbf{Rating for Consultants} = \frac{\textbf{Sum of Ratings of Individual Statements}}{\textbf{10}}$$

AREA 5: PATIENT SERVICES AND FACILITIES

A. Minimum Requirements (Basic Standards)

1. The hospital must be Philhealth accredited.

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 other pediatric areas (ex. PICU)

3. There must be a sufficient number of patients to satisfy training objectives. The minimum number of patients per area per month must be:

   3.1 inpatient admissions 50-60
   3.2 well child consultations 50-60
   3.3 OPD consultations 50-60
   3.4 ER consultations 120-150
   3.5 nursery admissions 20-30
   3.6 adolescent (in- and out-patient) 20-30

4. Ten percent of the total bed capacity must be identified for service patients.

5. The minimum equipment for pediatric patient care must be available. (Appendix 12)

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.

11. There must be physical plant facilities for:

    11.1 pediatric ward
    11.2 outpatient care (sick and well babies)
    11.3 a separate pediatric emergency area
    11.4 a treatment room at pediatric floor
    11.5 an isolation area for communicable diseases
    11.6 oral rehydration area
    11.7 reverse isolation room

12. Accredited programs (Level I and II) must fulfill the minimum standards of a Level II Neonatal Unit. Accredited programs (Level III and IV) must fulfill the minimum standards of a Level III Neonatal Unit. (See Classification of Neonatal Units, Appendix 8)

13. The physical facilities used by consultants and residents must include:

    13.1 conference room/classroom
    13.2 pediatric library
    13.3 staff and residents' offices
    13.4 sleeping quarters/call room
    13.5 multimedia resources (e.g. internet, lcd projector)

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

15. There must be a formal, written safety/disaster management plan.

16. The hospital must be certified as a "Mother-Baby Friendly" and Newborn Screening accredited hospital. The department implements rooming-in and actively advocates and complies with breastfeeding policies.

B. Quality Standards

1. The patient service areas should have a sufficient number and case-mix to allow for clinical experience in all aspects of general pediatrics including training in promotion of health and prevention of disease.

2. The physical facilities and equipment should be regularly evaluated for their appropriateness and quality regarding all aspects of residency training.

C. Evaluation Instrument for the Quality of Patient Services and Facilities

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 (Non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. There are detailed and clearly written operational plans, policies and procedures for admission, care and discharge of pediatric patients in the following areas: 5 4 3 2 1 NA

   1.1 neonatal unit
   1.2 inpatient wards
   1.3 outpatient unit
   1.4 emergency unit
   1.5 adolescent service

2. The patient service areas have a sufficient number of patients and case-mix to meet training objectives. 5 4 3 2 1 NA

3. The physical facilities and equipment are regularly evaluated for their number, appropriateness and quality regarding all aspects of residency training. (see appendix 12) 5 4 3 2 1 NA

4. Medical supplies are available and adequately meet the needs of patients. 5 4 3 2 1 NA

5. The pharmacy, laboratory, radiology and supply services are open 24 hours a day. 5 4 3 2 1 NA

6. Attending physicians for patients aged 0-18 yrs. are board-certified pediatricians (diplomate or fellow). 5 4 3 2 1 NA

7. Most adolescent patients are attended by a board certified pediatrician and referred to a multidisciplinary team when necessary. 5 4 3 2 1 NA

8. The floor space allocated to each bed is sufficient to accommodate the equipment and personnel necessary to render pediatric care. 5 4 3 2 1 NA

9. The physical plant services adequately provide for: 5 4 3 2 1 NA

   9.1 proper illumination
   9.2 proper circulation of clean air
   9.3 potable water supply
   9.4 sanitary toilets and bathrooms
   9.5 fire extinguishers and fire exits
   9.6 proper wet and dry waste disposal
   9.7 janitorial and maintenance facilities
   9.8 proper upkeep and maintenance of the building/s

10. There are clear and detailed written policies and procedures for: 5 4 3 2 1 NA

   10.1 patient safety/hospital disaster management plan
   10.2 equipment management plan

Computation for Final Rating for PATIENT SERVICES AND FACILITIES:

Add the ratings of individual statements and divide by the number of rated statements. There are 10 rated statements.

$$\textbf{Rating for Patient Services \& Facilities} = \frac{\textbf{Sum of Ratings of Individual Statements}}{\textbf{10}}$$

AREA 6: RESEARCH

A. Minimum Requirements (Basic Standards)

1. There must be a formal written departmental research program.

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

3. There must be a designated coordinator for research. (Residents may be given an adviser who will supervise them from development of proposal to completion of research.)

4. Consultants must be involved in research advising.

5. Sufficient statistical assistance must be provided by departmental staff or outside personnel.

6. Research seminars, workshops and lectures must be offered yearly by the department, to include Evidence-Based Medicine (EBM) and Good Clinical Practice (GCP).

7. The research agenda must be relevant to the national or regional health needs. (Regional health needs include those that are peculiar to a particular local setting (e.g. impact of tobacco industry on Filipino adolescents in the Ilocos region, effect of mining industry on children's health in Mindanao, etc.)

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

9. All research proposals must be evaluated. (Evaluation is to be done by the research coordinator/committee of the department.)

10. The residents' research papers must be filed in the department's library.

B. Quality Standards

1. The formal, written research program should include:

    1.1 general objectives of the program
    1.2 research competencies of residents
    1.3 policies and procedures
    1.4 budget sources
    1.5 evaluation

2. The residency program should allow sufficient time for research work.

3. The residents' research output should be in accordance with acceptable standards of quality and that these are continuously evaluated by the research committee.

4. Consultant research advisers should have adequate experience in research work and regularly attend research enrichment seminars.

5. The residents should be supervised by consultants in the conduct of their researches.

6. Research studies with social relevance in the area/community where the department is located should be encouraged.

7. The residents' research papers should be presented in various seminars organized by the department, hospital, the PPS, or other medical groups.

8. The residents' research papers should be submitted for publication in various peer- reviewed journals.

9. The residents should avail of various research funding sources including government sources, the PPS and other private funding institutions.

10. The residents' papers shall be well indexed in the library and available for borrowing. (All PPS published research papers shall be the property of the society; presentation to other scientific venues and publication in various journals require permission from the PPS)

C. Evaluation Instrument for the Quality of Research

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 (Non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. The research program emphasizes social accountability and follows the values of relevance, quality, equity and cost-effectiveness. 5 4 3 2 1 NA

2. There is evidence that the research outputs are in accordance with acceptable standards of quality: 5 4 3 2 1 NA

2.1 problem, hypotheses and objectives are well stated and appropriate for the study
2.2 the related literature is not only pertinent to the particular study but is a basis for it
2.3 subjects are suitable and scientifically selected
2.4 the research instrument is valid and reliable
2.5 data gathering is scientific
2.6 the research design is appropriate
2.7 methods for data processing and analysis are appropriate
2.8 analysis and interpretations of the findings are adequate and appropriate

3. Residents are guided on research design, statistics, research methodology, quantitative and qualitative methods of investigation. 5 4 3 2 1 NA

4. Deliberate and systematic efforts are made to orient research studies in: 5 4 3 2 1 NA

4.1 promoting values
4.2 promoting social uplift of the people and their access to health care
4.3 enriching Philippine pediatric medicine and culture
4.4 promoting the use of local materials and appropriate technology
4.5 adding to existing knowledge in the field

5. The research program: 5 4 3 2 1 NA

5.1 observes the principles of ethics
5.2 ensures integrity in research work
5.3 enforces documentation standards
5.4 requires evaluation by an internal or external technical and ethical review board

6. Consultant research advisers have adequate experience in research work and regularly attend research enrichment seminars. 5 4 3 2 1 NA

7. Consultants produce a fair amount of quality researches regularly. 5 4 3 2 1 NA

8. The residents' research papers are presented in various seminars organized by the department, hospital, the PPS or other medical groups. 5 4 3 2 1 NA

9. The residents' research papers are submitted for publication in various peer-reviewed journals. 5 4 3 2 1 NA

10. The residents avail of research funding from various private and government sources. 5 4 3 2 1 NA

Computation for Final Rating of RESEARCH:

Add the ratings of individual statements and divide by the number of rated statements. There are 10 rated statements.

$$\textbf{Rating for Research} = \frac{\textbf{Sum of Ratings of Individual Statements}}{\textbf{10}}$$

Area 7: COMMUNITY INVOLVEMENT

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

The community involvement program may use any of the following models:

a. the PPS Kalusugan ng Kabataan: Ating Kinabukasan Program or PPS-KKK (Medical Home Initiatives)
b. the PPS 1999 Primer on Community Health Development.
c. any model selected or developed by the department

A. MINIMUM REQUIREMENTS (BASIC STANDARDS)

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

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

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

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

5. Information (secondary data) concerning the community/institution must be available:

   5.1 general characteristics (geography, demography, epidemiology, socio-economic data, religious and cultural data, and others)

   5.2 resources of the community which it serves (natural, technological, educational, civic, religious, charitable, industrial, government, medical, health and other resources)

   5.3 needs of the community which it serves (health, medical, socio-economic, environmental and other social needs)

6. At least one strategy must be implemented to give the residents an opportunity to know the conditions and needs of the community (build community awareness). Examples are:

   6.1 Meetings with community leaders or institutional/school officials
   6.2 Research studies
   6.3 Community/institutional projects
   6.4 Field practicum
   6.5 Community surveys
   6.6 Family visits

7. Service must be rendered through at least one of the following or similar strategies:

   7.1 Providing regular ambulatory clinic services for well and sick children in the community.

   7.2 Participation in the work of government and non-government organizations, schools, civic and religious groups

   7.3 Undertaking its own community service projects (like environmental health, "botica sa barangay," training of barangay health workers and others)

   7.4 Participation in the provision of primary health care services (EPI, CDD, CARI, etc)

   7.5 Participation in public health education sessions (parents' class, mothers' class, etc.)

   7.6 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 program)

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

8. The service must be rendered at least three (3) days a week (full or half-day).

9. There must be an active and functioning referral network and linkages between the community/institution and the hospital.

10. The department/hospital must provide safety measures for the trainees including a Memorandum of Agreement (MOA) between the community and the department/institution.

B. QUALITY STANDARDS

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

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

3. The pediatric residents should be involved in planning, implementing and evaluating community/institutional projects, encouraging the people to be involved in community affairs and participating in community organization.

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

5. The residents should participate in linkage work between pediatric practice and the health care system.

6. The success of the program should be measured by the evidence of excellent outcomes of the program. Community self-reliance should be the keystone of the activities.

C. EVALUATION INSTRUMENT FOR THE QUALITY OF COMMUNITY INVOLVEMENT

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 (Non-compliance)	Fails to meet the provisions of the standard
NA	Not Applicable	

Instructions: Following the rating scale definition, encircle the number that best describes to what extent the provisions of the standard are met.

1. There is a well planned community involvement program. 5 4 3 2 1 NA

2. The community involvement program is a family-centered, community-based partnership approach to providing high quality healthcare services. 5 4 3 2 1 NA

3. The department renders service to the community through a variety of strategies or public health projects. 5 4 3 2 1 NA

4. The program provides various opportunities to know the condition and needs of the community (build community awareness) like: 5 4 3 2 1 NA

4.1 Meetings with community leaders or institutional/school officials
4.2 Research studies
4.3 Community/institutional projects
4.4 Field practicum
4.5 Community surveys

5. The department and the community, mutually and generously, share available resources. 5 4 3 2 1 NA

6. The extent of achievement of the objectives is discussed by both parties. 5 4 3 2 1 NA

7. A family/home visitation program is extensively implemented. 5 4 3 2 1 NA

8. The self-evaluation report by beneficiaries of the program is excellent. 5 4 3 2 1 NA

9. A method for sustainability and continuity of the program has been developed and accepted by both parties. 5 4 3 2 1 NA

10. There are evidences of excellent outcomes of interventions (projects, activities, and services) 5 4 3 2 1 NA

10.1 Measures of PROVISION of services are documented. Examples:
a. No. and % of children with full access to MCH services
b. No. and % of schools with school-based screening program

10.2 Measures of UTILIZATION of child health services are documented. Examples:
a. No. and % of children fully immunized
b. No. and % of children under 5 and mothers regularly attending health clinic

10.3 Measures of EFFECTS of health services are documented. Examples:
a. Specific morbidity rates
b. No. of caregivers/parents who know and practice home management of common illnesses.

Computation for Final Rating of COMMUNITY INVOLVEMENT:

Add the ratings of individual statements and divide by the number of rated statements. There are 10 rated statements.

$$\textbf{Rating for Community Involvement} = \frac{\text{Sum of Ratings of Individual Statements}}{10}$$

APPENDIX 1 –

LEVELS OF ACCREDITATION

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

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:

   1.1 The Neonatal Unit is classified as Level II by the HAB or the Philippine Society of Newborn Medicine.

   1.2 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 fifty percent (50%) must pass.

   1.3 The department applying for initial accreditation must have been in existence for at least one (1) year.

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:

   2.1 A credible 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 seventy per cent (70%) must pass.

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

      2.2.1 a significant number of general pediatric admissions
      2.2.2 a variety of clinical/teaching activities in general pediatrics
      2.2.3 a daily (Monday to Friday) general pediatric service clinic for the indigent patients.

   2.2 A strong community involvement program as evidenced by:

      2.2.1 a family/home visitation program as shown by family case study reports on file
      2.2.2 participation in at least two (2) public health projects
      2.2.3 daily presence (Monday to Friday) at the community venue, either half or full day

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 (3.1 to 3.5), and at least one (1) of the remaining three (3.6 to 3.8):

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.

3.2 The Neonatal Unit is classified as Level III by the HAB or the Philippine Society of Newborn Medicine.

3.3 A well equipped Intensive Care Unit.

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 ninety percent (90%) must pass

3.5 A sustained highly visible, fully operational community involvement program with good outcomes. A description of the program, its strengths, the nature and extent of resident and consultant involvement, family/home visitation reports, daily presence in the venue, and other details shall be submitted as documentation for this indicator.

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

3.6.1 reasonable budget
3.6.2 quality of research output
3.6.3 number published or given awards
3.6.4 number read in scientific conferences or conventions
3.6.5 involvement of a significant number of faculty members
3.6.6 visible, tangible and measurable impact on the community

3.7 Existence of working consortia, integrated programs or linkages with other pediatric programs, schools or pediatric agencies. Documentary evidence shall include memorandum of agreement, description of the nature, mechanism, and other details.

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

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:

4.1 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.

4.2 The Neonatal Unit (classified as Level III) and the Intensive Care Unit carry state-of-the-art equipment and facilities.

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 ninety percent (90%) must pass.

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

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

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.

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

Accreditation of Subspecialty Fellowship Programs: The HAB shall approve the recommendation of the subspecialty societies in the accreditation of a fellowship program based on the criteria set by their respective subspecialty boards.

NOTE: The Specialty Board performance and accreditation are subject to the deliberation and final decision of the HAB.

APPENDIX 2

SPECIAL BENEFITS CORRESPONDING TO ACCREDITATION LEVELS

1. Level - 1

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

2. Level - 11

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

3. Level - 111

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 (Parts I) immediately and oral examination (Part II) after 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 I) immediately and oral examination (Part II) after 2 years of pediatric practice subject to the approval of the Specialty Board.

4.Level - 1V

4.1 Official recognition by PPS as accredited training program five (5) years
4.2 The department is eligible to apply for several slots of PPS Research grant.
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 examination 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 year of pediatric practice subject to the approval of the Specialty Board.

APPENDIX 3

Statistical Rating
(For Accreditor's use)

Weight Values for the Overall Rating

Rating Scale Definition:

5	Excellent Compliance	: Mean all major provisions of the standard
4	Every 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. Administration	[ ]	x	5	=	[ ]
3. Consultant	[ ]	x	10	=	[ ]
4. Patient Service/Facilities	[ ]	x	8	=	[ ]
5. Research	[ ]	x	6	=	[ ]
6. Community	[ ]	x	5	=	[ ]
			44		

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

Multiply each RATING X WEIGHT VALUE = PRODUCT

$$\frac{\text{Sum of products}}{\text{Sum of Weight Value } 44} = \text{AVERAGE}$$

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

APPENDIX 4

Statistical Rating
(For Self-assessment)

Weight Values for the Overall Rating

Rating Scale Definition:

5	Excellent Compliance	: Mean all major provisions of the standard
4	Every 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. Administration	[ ]	x	5	= [ ]
3. Consultant	[ ]	x	10	= [ ]
4. Patient Service/Facilities	[ ]	x	8	= [ ]
5. Research	[ ]	x	6	= [ ]
6. Community	[ ]	x	5	= [ ]
			44	

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

Multiply each RATING X WEIGHT VALUE = PRODUCT

$$\frac{\text{Sum of products}}{\text{Sum of Weight Value } 44} = \text{AVERAGE}$$

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

APPENDEX 5

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	2
	Community	1
	NICU	2
Third year (12 months)	Ward	3
	OPD/ER	2
	NICU	2
	Subspecialties and electives	4
	Community	1

APPENDIX 6

PPS Hospital Accreditation Board Visitation Guide

Evaluation Area	Whom to Interview	Innterview Coverage	Written Materials to Review	Facilities to Inspect
1. 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	Vision-mission of the hospital and department Organizational plan/chart Job descriptions Development plans – long and short term	Offices
2. 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 Relationships Grievance procedure	Consultants' manual Concultant development program (professional, personal, spiritual, social) Schedule of consultant workshops, conferences, and other professional activities Schedule of benefit, compensation & salaries	Consul;tants' lounge/office
3. Training Program	Department Chair Training Officer Consultants (as many) Chief Resident Resident Physicians (as many)	Resident admission process Residency training program Supervision of training Innovations or electives for Residents Evaluation system Enrichment opportunities/Program Outside hospital rotation for Subspecialties Use of library Community outreach program Guidance/Counseling services Co-Curricular activities Participation in iter-hospital integrated program	Admission policies Residency training program Schedule of training activities, lectures, clinical conferences Evaluation system and forms Schedule of duties/rotation Schedule of outside hospital rotation Textbooks/Journals Library acquisitions/holdings Patient records/charts	Conference room Patient care areas Library Audio-visual Equipment

Evaluation Area	Whom to Interview	Interview Coverage	Written Materials to Review	Facilities to Inspect
4. Patient Service	Consultants-in-charge of various patient areas Department Chair Chief Resident Consultants Residents Head Nurses Chief of Pharmacy Chief of Laboratory Chief of Radiology Chief of Medical	Policies and procedures in the admission, care and discharge of patients in all pediatric cares of care: - Nursery - Wards - Emergency Room - Outpatient - Pedia ICU - Medical Equipment - Drugs and medical supplies	Standard Operation Procedures or Rules and Policies in all pediatric areas of care: - Nursery - Wards - Emergency Toom - Outpatient - Pedia ICU Formulary Patient records/chart Use of growth and other PPS recommended forms	Nursery Wards E.R. OPD Pedia ICU Pharmacy Laboratory Medical Records Radiology Equipment Supplies

	Records			
5. Research	Consultant-in-charge Department Head Chief Resident Consultants Residents	Research- Objectives Strategies Policies Procedures Budget Evaluation Venue for research presentation	Written plan for research Research papers of residents and Consultants List of research in part years	
6. Facilities	Department Chair Consultant-in-Charge Chief Resident Consultants Residents Nurses Head of Maintenance	Development and maintenance program for equipment Development and maintenance program or physical plant SOPs for use of various hopsital facilities Water supply, drainage, fire, earthquake and disaster plan of hospital	Development and maintenance Program for medical equipment and physical plant Rules, policies, schedules for the use of: - Library - Conference rooms - Call room	Nursery Ward E.R. OPD Pedia ICU Library Conference Room Call Rooms Pedia Office
7. Community Involvement	Consultant-in-charge Department Head Chief Resident Residents Consultants Community Leaders Coordinators	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, chursch 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	The actual community, agency institution of population group

APPENDIX 7

GUIDELINES FOR GRANTING RE-ACCREDITATION

1. For any hospital to be accredited, the areas of Training Program 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 and Consultants is rated below three (3), the hospital is granted accreditation but is required to submit a progress report within six (6) months.

3. Interim Visit
   If two (2) areas other than the Training Program and Consultants are rated below three (3), an interim visit will be required within six (6) months.

4. Deferment

   4.1. If any item in either the Training Program or Consultants is rated below three (3), the accreditation will be deferred.
   4.2. If three (3) or more areas, other than the Training Program and Consultants, are rated below three (3), the accreditation will be deferred.

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

APPENDIX 8

CLASSIFICATION OF NEONATAL UNITS

AIM: To standardize the levels of newborn care provided by the different PPS-accredited hospitals using specific guidelines.

Classification of Levels I-III Neonatal Units
Including:

A. Extent of Service
B. Functional areas in the Nursery.
   (Optimal Structural specifications considered)
   1. Space requirements
   2. Equipment requirements
   3. Architectural design
   4. Electrical system
   5. Plumbing system
   6. Location
   (Functional Area)
   1. Resuscitation area

2. Admitting area
3. Observation/Transitional/Hold-over/Stabilization/Normal Newborn
4. Continuing Care(Step-down)
5. Intermediate(Special Area)
6. NICU
7. Isolation
8. Breastfeeding and/or kangaroo care area
9. Storage room

C. Staffing Pattern
1. Neonatologist
2. General Pediatrician
3. Resident
4. Nurses
5. Nursing Aide

CLASSIFICATION OF NEONATAL UNITS

	LEVEL I	LEVEL II	LEVEL III
A. Extent of Service			
1. Levels of Care	Basic care of normal / low-risk Newborn	Level I + selected high risk newborns requiring acute care management / monitoring of problems anticipated to resolve rapidly	Levels I & II + Comprehensive High-risk and Intensive Care
2. Patients admitted	• Full term 37-42 weeks • Preterm 34 or more completed weeks AGA (birth weight ≥ 2000 gm)	• Gestational age ≥32 weeks • Gestational ≥ 42 weeks • LBW 1000-2500 gm birth weight • SGA • LGA	• Referral center • Any sick infant up to 44 wks post-conceptional age needing medical & surgical care
3. Facilities Available	• Laboratory • Radiology	• Laboratory • Radiology + trained staff • Blood Bank	• Laboratory • Radiology + trained staff • Ultrasound • CT scan • ophthalmologic & hearing screen.
B. Functional Areas			
1. Hand-washing area	√	√	√
2. Resuscitation/ Admitting Area	√	√	√
3. Observation area (hold-over	√	√	√

area/transitional area)			
4. Intermediate room(special care/continuing care/step-down)	optional	√	√
5. Intensive Care room	x	√	√
6. Isolation room	x	√	√
7. Breastfeeding/ kangaroo care area	√	√	√
8. Storage room for supplies and equipment.	√	√	√
9. Utility room (clean & dirty)	√	√	√
10. Staff room/quarters	√	√	√
11.Conference room	optional	√	√
NOTE: Lower level units may re-admit patients from higher level units for continuing care.			

C. Staffing Requirement	Must be competent to perform the following: 1. Neonatal resuscitation at the DR or neonatal unit 2. stabilization of the compromised neonate before transfer to higher level hospitals 3. routine care for normal newborn 4. giving instructions to mothers on breastfeeding techniques		
1. Medical Staff a. Consultants b. Residents	**LEVEL I** Board Certified Pediatrician Year I	**LEVEL II** Any (1) of the following: Board-certified pediatrician Board-certified or Board Eligible neonatologist Surgeon Radiologist Cardiologist (optional) Year II-III	**LEVEL III** Board certified neonatologist + subspecialty consultants in: ENT, genetics, pediatric surgery, TCVS, orthopedics, dermatology, cardiology, pulmonology, infectious diseases, endocrinology, gastroenterology, nephrology, neurology, ophthalmology radiology Year II-III
2. Nursing Staff	Skilled birth attendant who: 1. Is trained in perinatal care 2. Recognizes the need for transfer or referral to a level II or III hospital 3. Is skilled in breastfeeding techniques	Has 1-3, PLUS 4. 4. Nurse supervisor, head nurses – trained in caring for sick neonates, i.e., Has special training in cardio-pulmonary monitoring & resuscitation up to level of ambubagging, maintenance of metabolic & thermal function	Has 1-4, PLUS 5. Understands mechanical ventilation

		Can operate infusion pumps, pulse oximeter and CPAP	
3. Ratio (nurse:Patient)	1:6	1:3-5	NICU 1:1-2 Special care 1:3-5 Intermediate continuing care 1:5-6 (step-down)
4. Support Personnel	Laboratory Tech. Radiology Tech.	Laboratory Tech. Radiology Tech. Social Worker Bio-engineers (optional)	Laboratory tech. Radiology tech. Social Worker Bio-engineers(optional) Pulmonary therapist(optional) Nutritionist, clerk, secretary, Infectious disease committee
D. Equipment	**LEVEL I**	**LEVEL II**	**LEVEL III**
	1. Emergency Cart 2. Resuscitation set Laryngcope (straight blade 0-1), ambubag with mask Preterm/term endotracheal tube Fr 2.5, 3.0, 3.5, 4.0 Resuscitation table Emergency drug box/IVF 3. Source of Heat 4. Umbilical catheterization set 5. Stethoscopes 6. Suction machines 7. Oxygen sources/ compressed air 8. Clock or timer 9. Weighing scale 10. Breast Pumps 11. Diagnostic set of otoscope & ophthalmoscope 12. Phototherapy units 13. Refrigerator for medications	Has 1-13, PLUS 14. Infusion pumps with syringe 15. CPAP set-up 16. Incubator 17. Radiant warmer 18. (1) Pulse Oximeter 19. Transport Incubator (optional) 20. Exchange transfusion 21. Thoracostomy set 22. Freezer for breastmilk storage	Has 1-22 + Mechanical Ventilators

E. Structural Requirements and Specifications

1. Good illumination
2. Temperature controlled with air-conditioner
3. Wall colors – white or pastel
4. Telephones per room (optional)
5. Preferably piped-in O2 and compressed air, tanks may also be used
6. Separate outlet per equipment
   Common grounding for all electrical outlet (less than 10 microamperes)
7. Charting area for nurses and physicians
8. Floor plan and evacuation routes
9. Foot-knee or sensor operated scrub sink

10. Emergency tables for resuscitation with equipment
11. Droplights with protective screen, if without radiant warmers
12. Map of Evacuation plan
13. Fire extinguishers

Area Descriptions (Optimal features indicated)

1. **Hand-washing area** - located at the entrance; with sink, soap, towels and gowns

2. **Resuscitation area**- adjacent to DR/OR or in the OR/DR complex
   Area: 100 sq ft or 3x3 meters
   4 electrical outlets

3. **Admitting area**- may be adjacent to resuscitation area or maybe within the observation area

   Area: 30 sq ft (allow 1 space for 300 annual births)
   2 electrical outlets (hold-over, transitional)

4. **Observation room/ Hold-over, transitional** - allow 20-30 percent more of the obstetric beds

   - Area: 20 sq ft/infant with distance of 3 ft/bassinet
   - 1 electrical outlet/bassinet
   - 1 hamper (dirty)
   - breastfeeding room with ventilation & comfortable chairs
   - 1 oxygen tank or outlet, suction per room or per bassinet

   To determine bed capacity = determine average length of stay/infant & annual birth rate with average length of stay of 2 days
   e.g. Annual deliveries = 2000
   365 days/2days/infant = 182.5
   2000/182.5 = 10.9 beds→ allow 20-30% more for multiple births or improved infants from NICU

5. **Intermediate & Special Care room** – for sick neonates without assisted ventilation
   - Area: 50 sq ft/patient, 4 ft between incubator/bassinet, 85 ft space
   - May be used by babies who have improved from intensive care room
   - Needs 1 sink with footer-knee pedal for every 6 infants
   - Storage cabinets for immediately used supplies; e.g. linens
   - 8-10 electrical outlets/room
   - 2 oxygen + compressed air per room or 2 electrical outlet per bed

   To determine bed capacity: allow 3 beds/1000 births + correction factor
   correction factor depends on LBW:$\frac{\text{LBW rate x 3}}{80}$

6. **NICU – Intensive Care**- for mechanically-ventilated or monitored patients
One bed/1000 live births

- Area: allow 80-100 sq ft per incubator or 6 ft apart
- Each bed would need 10 sockets
- 1 incubator
- 1 cardiac monitor
- 1 ventilator
- 2 infusion pumps
- 1 pulse oximeter
- 1 ultrasound
- 1 x-ray machine
- 1 humidifier of the ventilator
- storage cabinets for immediate supplies, cutdown set, etc
- 1 sink/4 incubators

7. **Isolation room**- for highly septic infants and those babies needing intensive care with one likely to infect other infants

8. **Rooming-in wards**

- Mother's bed + bassinet should have 3 ft between patients and minimum work space of 5 ft.
- Mother and baby may share the same bed but side railings should be provided for protection.
- Staffing: shared by OB and Pediatric departments
- Discharge time: Babies are discharges after 24 hrs.
- Babies are roomed-in immediately after normal spontaneous delivery and within 4-6 hrs after ceasarean section provided mother's condition is stable.
- Minimum number of hrs of observation before discharge of baby to relative provided that:
  a) the baby is able to suck well
  b) the baby is able to maintain temperature > 36°C
  c) the mother has shown ability to take care of infant
  d) written instructions have been given to the mother

APPENDIX 9

CLASSIFICATION OF NURSERIES – CHECKLIST

	LEVEL I	LEVEL II	LEVEL III
I. EXTENT OF SERVICE			
Normal/Low risk Newborn			
Preterm ≥ 34 weeks AGA			
Preterm ≥ 32 weeks AGA			
Fullterm 37-42 weeks			
Post-term >42 weeks			
LBW 1000-2500 gm			
SGA			
LGA			
Medical			
Surgical			
II PERSONNEL			
Board certified pediatrician			
Board-eligible neonatologist			
Board-certified neonatologist			
Pediatric surgeon			
Radiologist			
Cardiologist		optional	
Subspecialists			
III FUNCTIONAL AREAS IN THE NEONATAL UNIT			
Handwashing area			
Resuscitation / Admitting area			
Hold-over(observation)			
Special/continuing care/step-Down unit	optional		
NICU			
Isolation			
Breastfeeding			
Storage/Utility room			
Conference room	optional		
IV SRUCTURAL REQUIREMENT			
Proximity to DR			
Good illumination			
Telephone			
Piped-in oxygen and compressed air			
Outlets(8)			
Sink			
V EQUIPMENT			
Emergency box			
Resuscitation set Laryngoscope blade 0.1 Ambubag, mask(preterm/term) Diagnostic set (otoscope, ophthalmoscope)			
Heat source			

Clock			
Suction machine			
Stethoscope			
Weighing scale			
Breast pump			
Cannulation set			
Oxygen source			
Syringe pump			
Phototherapy units			
CPAP set			
Incubators (neonatal)			
Radiant Warmer			
Pulse oximeter			
Exchange transfusion set			
Transport Incubators		optional	
Cardiac Monitor			
BP Monitor			
Oxygen and compressed air blender			
Portable x-ray machine			
Emerson pump			
High frequency ventilator		Optional	
ABG Machine		Optional	
NO machine		Optional	
Neonatal defibrillator		Optional	
Ventilators			

LABORATORIES AVAILABLE FOR 24 HOURS

CBC,blood type			
HGT			
Electrolytes			
X-Ray machine			
ABG			
CT Scan			
Hearing screen machine			
Ophthalmologic exam equipment			
Ultrasound machine			
Blood Bank			

APPENDIX - 10

SUGGESTED LEARNING ACTIVITIES FOR THE RESIDENCY PROGRAM

1. Bedside rounds with consultants, chair, training officer, and chief resident
2. Conferences with family members
3. Chart reviews
4. Supervised ambulatory (OPD) clinics
5. Supervised lectures and journal articles review by residents
6. Clinical conferences
   - 6.1 Clinical case conferences (case presentations, grand rounds, new case hour, management and therapeutics conferences, case dilemma, bioethics conference, clinic-radiologic conference
   - 6.2 Mortality and morbidity conference
   - 6.3 Endorsement conference/rounds
   - 6.4 Specialty conference (optional)
   - 6.5 Interdepartmental conference

APPENDIX 11

PPS REQUIRED TEXTBOOKS AND JOURNALS

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

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

A.Basic textbooks

1. Textbook of Pediatrics and Child Health by Del Mundo et al or the latest new Philippine textbook of pediatrics
2. Nelson's Textbook of Pediatrics
3. PALS Manual
4. NRP Manual
5. Bioethics
6. Fundamentals of Pediatrics
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 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. 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

APPENDIX 12

The PPS Minimum Equipment Requirements

TR	ER	OPC		N	
		WC	SC		
☐	☐	☐	☐	☐	Weighing scale, beam type
				☐	Clean N
				☐	Isolation N
☐	☐	☐	☐	☐	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

Legend:

TR- Treatment Room
ER- Emergency Room
OPC- Outpatient Clinic
WC- Well Child
SC- Sick Child
N- Nursery

APPENDIX 13

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

1. List down all RECOMMENDATIONS of the Hospital Accreditation Board during their last visit and describe the action taken by your department.

2. Describe the BEST FEATURES of your department in the following areas

Administration
Vision-Mission-Goals of the Hospital
Vision-Mission-Goals of the Department of Pediatrics
Organizational Chart (Department of Pediatrics)
Development Plan – long and short-term
Job Description of consultants for their teaching and administrative functions
Department Budget (optional)

Consultants
List of consultants indicating the following: Fellow, diplomate, active member
Describe the following

i. Selection process
ii. Consultant development program (professional, personal, spiritual, social)
iii. Compendation, benefits, incentives
iv. Evaluation, promotion

Training Program
Description of the Residency Training Program, stating the following:

i. General Objectives
ii. Competencies (as general pediatricians) expected of residents at the end of the 3 year program. The competencies should be specific, measurable, attainable, relevant, time-bound and behaviorally-stated
iii. Competencies in subspecialties which are appropriate for general pediatricians (only for subspecialty training available in your hospital)
iv. Competencies expected of residents at the end of each outside subspecialty rotation
v. Schedule of instructional activities
vi. Schedule of resident rotation per year indicating length of time
vii. Weekly schedule of activities for consultants and residents
viii. Effects in developing values orientation and ethics into the residency program
ix. Implementation scheme for elective rotations for residents
x. Guidance and counseling services for residents
xi. Evaluation tools for residents
xii. Resident admission policies/process

xiii. Copy of the Integrated Program if a member of an integrated hospital group
xiv. List of residents indicating year level, performance evaluation or ratings since the last HAB accreditation period

Patient Service

Standard Operating Procedures (SOP) in the admission, patient care, and discharge of patients in all pediatric areas of care:

i. Nursery
ii. In-patient/wards
iii. Emergency Room
iv. Outpatient (ambulatory care)
v. Pediatric ICU

Breastfeeding Program

Rooming-in rules

Research

A description of the research program to include:

i. Objectives
ii. Strategies
iii. Policies
iv. Procedures
v. Budget
vi. Evaluation
vii. Venue for research presentation

A list of residents researches

Facilities

An inventory of the department's basic medical equipment

Development and maintenance program for equipment

Development and maintenance program or physical plant

Water supply, drainage, fire, earthquake and disaster plan for hospital

Community Involvement

Describe the community involvement which may include the following:

i. Characteristics of the community (or the school, agency, institution or group of population)
ii. Resources available in the community
iii. Socio-economic, environment and health needs of the community
iv. 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)
v. The Department's contribution to the community's development
vi. The community's contribution to the growth of the hospital/Department of Pediatrics
vii. Details of the Community Outreach Program

APPENDIX 14

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 _____
_____
_____
_____

2.2Administration _____
_____
_____
_____

2.3 Consultants _____
_____
_____
_____

2.4 Patient Service & Facilities

_____
_____
_____
_____

2.5 Facilities _____
_____
_____

2.6 Research _____
_____
_____
_____

2.7 Community Involvement

_____
_____
_____

3. RECOMMENDATIONS

3.1 Training Program _____
_____
_____
_____

3.2 Administration _____
_____
_____
_____

3.3 Consultants _____
_____
_____

3.4 Patient Service & Facilities

_____

_____

_____

_____

3.5 Research _____

_____

_____

3.6 Community Involvement _____

_____

_____

4. STATISTICAL RATING

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

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

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

TABLE OF CONTENTS

Section Two: Competency-Based Pediatric Residency Curriculum

HAB Curriculum Committee 2013

Co-Chair: **Dr. Rudy Ng**
Dr. Merle Tan
Dr. Blesilda Concepcion

Adviser: **Dr. Ramon Arcadio**

Facilitator: **Prof. Erlyn Sana**

Adhoc Committee Curriculum Planning 2012

Past Presidents:

Esperanza F. Rivera, MD
Amelia R. Fernandez, MD
Joel S. Elises, MD
Jocelyn J. Yambao-Franco, MD

BOT 2010-2011:

Genesis C. Rivera, MD
Melinda M. Atienza, MD
Milagros S. Bautista, MD
Sally S. Gatchalian, MD
Vivina C. Chiu, MD

Acknowledgement:

Josepina R. Almonte, MD
Marcelo L. Dahinog Jr, MD
Aurelia G. Leus, MD
Michael T. Manalaysay, MD
Joselito C. Matheus, MD
Rodolfo C. Ng, MD
Maria Estella R. Nolasco, MD
Felicisima G. Paz, MD
Ma. Victoria C. Villareal, MD
Elvira M. Abreu, MD
Elizabeth R. Telado, MD
Lusita P. Aguilar, MD
Madeleine Grace M. Sosa, MD

I. VISION AND MISSION OF THE PPS

VISION

- A medical specialty society recognized regionally and internationally as the leader in relevant aspects of child care.
- An acclaimed group promoting the standards of excellence in continuing pediatric education, sub – specialty training, research and community outreach programs in the Southeast Asian region.
- A prime mover in the development of Filipino technology vital to the delivery of child health care.
- A more cohesive organization fostering harmony, integrity, ethics and professionalism.
- A society with its own permanent premises and provisions for official and administrative functions

MISSION

As an organization of physicians who care for infants, children, and adolescents, the Philippine Pediatric Society, Inc. pledges to:

- provide leadership in training, teaching and research, and expertise in medical and community aspects of child health
- ensure an environment for child survival, development, safety and protection
- be responsive to continuing problems and changing priorities of the times
- protect the interest and well-being of its members
- treat all persons with dignity, honesty and respect according to accepted ethical standards stipulated in the Code of Ethics of the Philippine Medical Association
- be a wise and diligent steward of funds entrusted to it

II. THE PEDIATRIC RESIDENCY CURRICULUM

A. GOALS OF THE PEDIATRIC RESIDENCY TRAINING PROGRAM

The Residency Training Program shall provide the opportunity for the acquisition of knowledge, skills and attitudes to be proficient in the preventive, promotive, curative and rehabilitative aspects in the practice of pediatrics. The graduate of the pediatric residency training program should be able to assume any or all of the following roles and responsibilities: **Pediatric Care Provider, Health Educator Researcher/ Research Advocate, Pediatric Care Manager and Social Mobilizer.**

B. GENERAL OBJECTIVES

The Pediatric residency program shall:

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

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

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)

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

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

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

C.PROFESSIONAL ROLES OF THE PEDIATRICIANS

1. Primarily as a **PEDIATRIC CARE PROVIDER** providing quality, compassionate and effective care to pediatric patients that is developmentally age appropriate

2. As **HEALTH EDUCATOR** involved in the teaching and training of medical students, their families, and other health care providers

3. As **RESEARCHER / RESEARCH ADVOCATE** involved in the study of current and relevant issues pertaining to child health, critical appraisal of literature and application of research output into practice

4. As **PEDIATRIC HEALTH CARE MANAGER i**nvolved in managing and organizing activities of health units.

5. As **SOCIAL MOBILIZER** involved in developing and implementing health programs with impact to the community

D. ENTRY COMPETENCIES : -APMC 2009 CORE COMPETENCIES EXPECTED OF MEDICAL GRADUATES IN PEDIATRICS (Appendix A)

E. LEVEL OF TRAINING

YEAR 1: First Year YEAR 2: Second Year YEAR 3: Third Year

F. TERMINAL COMPETENCIES

Upon completion of the residency training in pediatrics, the graduate shall have developed the following competencies:

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
HEALTH CARE PROVIDER	Provide quality and compassionate care to pediatric patients Patient care	• Gather adequately accurate and relevant information from history and physical examination • Develop patient management plans • Use information technology to support decisions in caring for pediatric patients	• Make informed diagnostic and therapeutic decisions • Perform patient management plans • Perform competently all medical and invasive procedures necessary to deliver care • Provide effective health care services and anticipatory care	Demonstrate compassionate, ethical, and spiritual care that is culturally and gender sensitive. Professionalism Dedication Integrity

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
	Medical Knowledge	• Discuss basic, clinical, and specialty pediatrics • Discuss the principles of health maintenance and the influence of the environment on health	• Apply knowledge to patient care	Continuously update one's self to evolving biomedical, clinical, epidemiological, and social behavioral sciences as life- long learners
	Interpersonal and communication skills	Discuss the basic concepts of effective communication	• Use effective communication skills to elicit and provide information using non-verbal, explanatory, questioning, and writing skills • Communicate effectively with physicians, other health care professionals and health related agencies	• Work effectively as a member or leader of a health care team. • Sustain a professional and ethical relationship with patients across a broad range of socioeconomic and cultural backgrounds.

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
HEALTH EDUCATOR	Teach patients and their families, students, trainees and other health care providers	Discuss basic adult learning principles.	• Demonstrate competence in the teaching of patients and their families, students, trainees, and other health care providers using effective teaching skills and method. • Demonstrate skills in information technology	• Patience • Resiliency • Generosity • Selflessness
PEDIATRIC CARE MANAGER	Manage a health team • Administrative and leadership skills	• Discuss the concepts of planning, human resource and financial management	• Demonstrate ability in the management of a service or unit • Practice cost – effective health care and resource allocation that does not compromise quality of care	• Fairness • Compassion • Honesty • Humility

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
	• Systems – based practice	• Explain how types of medical practice and delivery systems differ from each other in terms of assuring quality, allocating resources, payment structures and insurance issues • Discuss how their patient care and her professional services affect other health care professionals, the health care organization and the larger society	• Collaborate with health care providers to assess, coordinate and improve patient care • Acknowledge medical errors and develop systems to prevent them • Advocate for quality patient care and assist patients in dealing with system complexities	• Honesty • Humility

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
RESEARCHER /RESEARCH ADVOCATE	Study current and relevant issues pertaining to child health, critically appraise literature and apply research output into practice	• Discuss research methodology statistical methods and information technology • Explain the process of critical appraisal of literature	• Use information technology to manage information and access on line medical information • Apply knowledge of study designs and statistical methods for appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness • Apply knowledge of research methodology to conduct research • Prepare a written manuscript of research conducted	• Take primary responsibility for lifelong learning to improve knowledge. skills, and practice performance • Honesty • Integrity • Perseverance

PROFESSIONAL ROLES	PROFESSIONAL RESPONSIBILITIES/ COMPETENCIES	TASKS		
		COGNITIVE	PSYCHOMOTOR	AFFECTIVE
SOCIAL MOBILIZER	To develop and implement health programs with impact in the community	• Explain how the entire public health care system works • Discuss the epidemiologic, demographic and economic data of the community to understand the health and social risks on child outcomes and of the opportunities for successful collaboration with other child advocates.	• Work closely with the public health care system in managing community programs • Coordinate closely with the public health care system in advocating • Develop negotiation, advocacy and networking skills	• A caring, compassionate and culturally sensitive pediatrician that addresses the needs of all children in the context of the community. • Passionate • Resilience • Patience • Determination • Sincerity • Selflessness

G. LEVELS OF TRAINING: First year, Second year, Third year

H. INTENDED LEARNING OUTCOMES

I. At the end of FIRST YEAR, the RESIDENT should be able to:

1.1. AS A PEDIATRIC CARE PROVIDER

1.1.1. Evaluate a normal infant, child and adolescent
1.1.2. Manage common pediatric conditions by
a. Obtaining a complete and appropriate clinical history.
b. Performing thorough physical examination

c. Ordering pertinent laboratory and diagnostic exams
d. Interpreting the results of the laboratory examinations,
e. Correlating the history, physical examination, and laboratory examinations to arrive at
a logical diagnosis.
f. Formulating a treatment plan.
g. Referring appropriately.
h. Providing continuing care

1.1.3. Perform basic pediatric procedures. (Refer to page…. Of HAB Handbook)

1.2. AS A HEALTH EDUCATOR

1.2.2. Teach interns, medical students and /or other health care professional
1.2.1. Conduct health education lectures to patients and other health care providers their families.

1.3. AS A RESEARCHER / RESEARCH ADVOCATE

1.3.1. Present a case report in a well organized and concise manner.
1.3.2. Formulate a research question for a research study
1.3.3. Conduct literature search for the research project

1.4. AS A PEDIATRIC HEALTH CARE MANAGER

1.4.2. Coordinate activities of interns and medical students.
1.4.1. Prepare accurate census and audit reports of the department.

1.5. AS SOCIAL MOBILIZER

1.5.1. Participate in the community – based programs.

II. At the end of SECOND YEAR, the RESIDENT should be able to:

2. 1. AS A PEDIATRIC CARE PROVIDER

2.1.1. Manage complex pediatric conditions
2. 1.2. Manage pediatric emergency conditions .
2. 1.3. Perform complex pediatric procedures. (Refer to page… Guidelines of training HAB Handbook)

2.2 AS A HEALTH EDUCATOR

2. 2.1. Teach patients and their families, students, trainees and other stakeholders
2.2.2. Conduct rounds with interns and medical students.
2.2.3. Teach first year resident during the training and service activities of the department.

2.3 . AS A RESEARCHER / RESEARCH ADVOCATE

2.3.1. Write a defensible research proposal

2.4 AS A PEDIATRIC HEALTH CARE MANAGER

2.4.1. Supervise first year resident/s during the service activities of the department.
2. 4.2 .Manage a health care team

2.5 . AS A SOCIAL MOBILIZER

2. 5.1. Make a community diagnosis based on the epidemiologic data of the community.
2.5.2. Participate in the implementation of community-based programs.

III. At the end of THIRD YEAR, the RESIDENT should be able to:

3.1. AS A PEDIATRIC CARE PROVIDER

3. 1.1. Recognize and initially manage uncommon, chronic, complicated pediatric problems.
3. 1.2. Recognize complications and disorders that will necessitate referrals.
3. 1.3. Perform most complex procedures

3.2 AS A HEALTH EDUCATOR

3.2.1. Teach second year residents in the training and service activities of the department.
3.2.2 . Supervise the teaching of interns, medical students and /or other health care professional
3. 2.3. Conduct teaching rounds with interns and medical students.

3.3. AS A RESEARCHER / RESEARCH ADVOCATE

3.3.1. Conduct the research study.
3. 3.2. Report the completed research study, conducted either in a written and/or oral form.

3.4. .AS A PEDIATRIC HEALTH CARE MANAGER

3.4.1. Supervise all first and second year residents during the training and service activities of the department.
3.4.2. Oversee the conduct of services in the various sections of the department

3.5. AS A SOCIAL MOBILIZER

3.5.1. Identify socially relevant issues related to child health together with the community

3.5.2. Implement a well-designed community – based program

G. INTERMEDIATE YEAR LEVEL COMPETENCIES -

I. FIRST YEAR RESIDENCY LEVEL

A. AS HEALTH CARE PROVIDER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Evaluate normal a. Newborn b. Infant c. Child and d. Adolescent	- Normal and abnormal patterns of growth and development - complete history taking for appropriate age a. Normal NEWBORN: - NB care - Normal growth and development - Interpretation of WHO growth chart standards - NB screening (metabolic screening, hearing screening, vision screening)	-Computation skills	-Sensitivity and concern -Thoroughness - Diligence	Trainer: -- - demonstrate. - Workshop or small group discussion (SGD) Trainee: - participate in workshop or SGD return demo	- Written exam - OSCE - MiniCEX

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
	- Lactation / breastfeeding (benefits , contents , of breast milk; proper breastfeeding technique; "Unang Yakap "module;) - Preventive Pediatrics (safety and injury prevention, oral hygiene, nutrition, immunization, growth and development) - PPS Policy statement - Legal issues in Pediatrics INFANCY: - Normal growth and development - Interpretation of WHO growth chart standards - Normal nutritional requirements (pure breastfeeding vs milk formula; weaning food) - Screening (hearing, visual) - Preventive Pediatrics - PPS Policy statement			-	-

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
	- Legal issues in Pediatrics CHILD: - Normal growth and development - Interpretation of WHO growth chart standards - Normal nutritional requirements (proper nutrition) - Screening (hearing, visual, BP) - Preventive Pediatrics - PPS Policy statement - Legal issues in Pediatrics ADOLESCENT: complete history taking including HEADSS - Normal growth and development - Interpretation of WHO growth chart standards - Normal nutritional requirements (proper nutrition) - Screening (scoliosis, IDA) - Issues in adolescent period.			-	-

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Manage common pediatric conditions (Appendix B1). a. Obtain a complete and appropriate clinical history. b. Perform a thorough physical examination c. Order pertinent laboratory and diagnostic exams d. Interpret the results of the laboratory examinations e. Correlate the history, physical examination, and laboratory examinations to arrive at a logical diagnosis.	- Preventive Pediatrics - PPS Policy statement - Legal issues in Pediatrics Pediatric history taking - Clinical manifestations of the common disorder / conditions - Pediatric PE -Basis and interpretation of diagnostic investigations - Range of normality - Laboratory procedure -Epidemiology of disease - Pathophysiology of diseases / conditions - Natural course of diseases - Pharmacology of drugs to include adverse effects - Clinical manifestations of complications	Interviewing skills - Listening skills - Communication skills	- Gentleness - Good rapport with patient and relatives - Sensitivity and concern - Diligence and thoroughness - Professionalism	Trainers: - Lecturrete - SGD - Case base discussion - One on one Preceptorial Trainee: - Hands on Practice - Peer Teaching - Reflection	Written examination OSCE MiniCEX - Workplace Assessment

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
f. Formulate a treatment plan. g. Refer appropriately. h. Provide continuing care	- Natural course of diseases			-	-
Perform basic pediatric procedures (Appendix C)	- Anatomy - Indications for the procedure - Steps and precautions in the performance of the procedure - Complications of the procedure - Management of complications of the procedure	- Technical skills in blood extraction, venoclysis, NGT insertion, lumbar puncture, umbilical catheterization.	- Gentleness - Sensitivity and concern - Diligence and thoroughness - Good rapport with patient and relatives	Trainer: - Demo Skills workshop Trainee - Return Demo - Reflection	DOPS Checklist

B. AS HEALTH EDUCATOR

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Teach interns and medical students and other health care professionals in the performance of their duties	Normal patterns in pediatrics - Common pediatric diseases - Proper techniques in the performance of common pediatric procedures - Teaching methods - Evaluation techniques - Terminal competencies of undergraduate medical students and interns	Communication skills - Teaching skills - Evaluation skills	Patience - Humility - Professionalism - Diligence and thoroughness - Sensitivity and concern	- Lecturete - SGD - Mentoring	- Observation - Practicum
Conduct health education lectures to patients and other health care providers.	Teaching methods	-Interpersonal skills -Communication skills - Teaching skills - Skills in making audio – visual aids	-Patience - Humility - Professionalism - Diligence and thoroughness - Resourcefulness	- Lecturete - SGD - Mentoring	- Observation - Practicum

C. RESEARCHER/ RESEARCH ADVOCATE

COMPETENCY	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Write an interesting case report/	Knowledge of pediatric disease conditions - Information technology - Prescribed format of presentation	- Computer skills - Written communication skills (how to write a case report)	-Thoroughness - Diligence - Resourcefulness	- Workshop - Oral Case presentation/	Written case-Reports
Present the case report in a well organized and concise manner.	- Principles of oral presentation	- Oral communication skills - Presentation skills - How to make audio – visual materials	- Diligence - Thoroughness - Confidence		
Formulate a research question for a research project	- Health situation and needs - Current information on the subject - Research methodology - Information technology - Research agenda of the institution	Critical thinking - Computer skills	- Diligence - Thoroughness		
Conduct literature search for the research project	-Information technology - How to conduct literature search	-Computer skills	-Thoroughness - Diligence - Patience - Resourcefulness		

D. AS HEALTH CARE MANAGER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Coordinate activities of interns and medical students.	- Academic policies of the college and the department - Curriculum of medical students and interns in pediatrics - Schedule of college activities - Schedule of the department - Schedule of consultants' lectures and other activities - Schedule of medical students and interns' rotation including schedule of exams - Time Management and Organizational skills	-Time management - Organizational skills - Interpersonal skills	- Patience - Resourcefulness - Diligence - Dependability	- SGD - Coordinate activities - lectures	- Written output e.g. census
Prepare accurate census and audit reports of the department. (based on ICD 10)	-Census of the department (daily, weekly, and monthly) - Total workload of the department	-Time management - Organizational skills - Computer skills	- Diligence - Thoroughness - Patience - Dependability	- Audit	- Census report

E. AS SOCIAL MOBILIZER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Assist in the community diagnosis based on the epidemiologic data of the community	- Principles of community diagnosis - Epidemiology of diseases in the community Community Pediatrics	- Organizational skills Interpersonal skills	- Resourcefulness - Patience	-Attend community conference - Visit to the Community	- Attendance - Checklist
Participate in the community – based programs.	- Programs of the community and the persons involved in the project	-Interpersonal skills - Time management	-Patience -Resourcefulness		

II. SECOND YEAR RESIDENCY LEVEL

A. AS HEALTH CARE PROVIDER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Manage more complex pediatric problems a. Obtain a complete and appropriate clinical history. b. Perform a thorough physical examination c. Order pertinent laboratory and diagnostic exams d. Interpret the results of the laboratory examinations e. Correlate the history, physical examination, and laboratory examinations to arrive at a logical diagnosis. f. Formulate a treatment plan. g. Refer appropriately. h. Provide continuing care	**Complex problems (appendix B2)** - pathophysiology, etiology, differential diagnosis, and therapeutic mgt plan - preventive, promotive, curative and rehabilitative management	- Interviewing skills - Listening skills - Communication skills	- Sensitivity and concern - Thoroughness - Diligence	Trainer: - demonstrate. - Workshop or small group discussion (SGD) Trainee: - participate in workshop - SGD - return demo	- **Written exam** - **OSCE** - **MiniCEX**

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Manage pediatric emergency problems	Pediatric emergency conditions pathophysiology, etiology, differential diagnosis, diagnostic examinations, and therapeutic management plan - preventive, promotive, curative and rehabilitative management	- BLS - NALS/ NRP	Gentleness - Good rapport with patient and relatives - Sensitivity and concern - Diligence and thoroughness - Professionalism	Trainer: - demonstrate. - Workshop or small group discussion (SGD) Trainee: - participate in workshop - SGD - return demo	- WRITTEN Exam - OSCE - MiniCEX
Perform complex pediatric procedures (Appendix C).	- Anatomy - Indications for the procedure - Steps and precautions in the performance of the procedure - Complications of the procedure - Management of complications of the procedure	- Procedures like thoracentesis, lumbar puncture, Intubation, umbilical catheterization, exchange transfusion, intraosseous, suprapubic urine collections, paracentsesis	-Gentleness - Sensitivity and concern - Diligence and thoroughness - Good rapport with patient and relatives	-Demo Return Demo	- Checklist - Rating Scale

B. AS HEALTH EDUCATOR

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Teach patients and their families, students, trainees and other health care provider	Common & complex pediatric disorders	-Communication skills - Lecturing skills - Skills in making audio-visual aids	- Patience - Humility - Resourcefulness	- Lecturete - SGD	- Observation - Practicum

Conduct rounds with interns and medical students	-Common & complex pediatric diseases - Normal patterns in pediatrics - Proper techniques in the performance of pediatric procedures - Teaching methods - Evaluation techniques - Terminal competencies of undergraduate medical students and interns	Teaching skills - Evaluation skills - Time management - Skills in giving feedback	- Patience - Sensitivity - Resourcefulness - Humility - Honesty	-Bedside teaching	Observation - Rating Scale
Teach first year residents during the training and service activities of the department	-Unusual manifestations of common pediatric diseases - Usual manifestations of less commonly or complex encountered pediatric diseases	-Communication skills - Teaching skills - Interpersonal skills - Facilitating skills - Skills in giving feedback	- Patience - Humility - Honesty	- SGD	- Rating Scale

C. RESEARCHER/ RESEARCH ADVOCATE

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Write a research proposal	-Research methodology - Institution research guidelines - Statistical methods - Sampling techniques - Information technology - Resources available especially funding	-Computer skills - Written communication skills (how to write a research paper)	- Thoroughness - Diligence - Resourcefulness	- Research Workshop - Virtual learning - Consultation	Written Research proposal
Critically appraise available literature regarding a specific topic.	-Process of critical appraisal - Statistical methods	-Skills in the critical appraisal of literature	- Thoroughness - Patience - Diligence	- EBM workshop - EBM in the workplace - - SGD	- CAT report (critically appraised topic) - Oral presentation

D. AS HEALTH CARE MANAGER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Manage a health team	-Organization and management	- Time management - Organizational skills - Leadership skills - Interpersonal skills	- Patience - Resourcefulness	- Role playing - Simulation	- Checklist - Rating Scale

E. SOCIAL MOBILIZER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Make a community diagnosis based on the epidemiologic data of the community.	- Principles of community diagnosis - Epidemiology of diseases in the community	- Organizational skills - Interpersonal skills	Resourcefulness - Patience		
Participate in the implementation of community based programs.	- Community programs - Strategies in the implementation of programs - Program evaluation	-Organizational skills - Leadership skills - Time management - Program evaluation skills Interpersonal skills	- Patience - Humility - Diligence - Resourcefulness		

III. THIRD YEAR RESIDENCY LEVEL

A. AS HEALTH CARE PROVIDER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Comprehensively recognize and initially manage uncommon, chronic and complicated pediatric problems (Appendix B)	- Pediatric emergencies **and uncommon, complicated pediatric disorders (Appendix B3)**- pathophysiology, etiology, differential diagnosis, diagnostic and therapeutic management plan- preventive, promotive, curative and rehabilitative - Long term outcome.		Gentleness - Good rapport with patient and relatives - Sensitivity and concern - Diligence and thoroughness - Professionalism	**Trainer:** **- demonstrate.** **- Workshop** **- Small group discussion (SGD)** **- Preceptorial** **Trainee:** - **participate in workshop or SGD** **return demo**	- Written Exam - OSCE - MiniCEX

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
To recognize complications and disorders that will necessitate referrals	- Critically ill infants and children - Nosocomial and other resistant infections - Patients with surgical problems - Interdisciplinary care - Anatomy - Indications for the procedure - Steps and precautions in the performance of the procedure - Complications of the procedure - Management of complications of the procedure				-
Perform more complex pediatric procedures.		-Skills in the following procedures like CVP insertion	-Gentleness - Sensitivity and concern - Diligence and thoroughness - Good rapport with patient and Relatives		-

B. AS HEALTH EDUCATOR

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Teach patients and their families, students, trainees and other health care provider	Common , complex and other complicated pediatric disorders	- Communication skills - Lecturing skills - Skills in making audio-visual aids	- Patience - Humility - Resourcefulness	- Lecturete - SGD	- Observation - Practicum
Conduct rounds with interns and medical students	-Common, complex and complicated pediatric diseases - Proper techniques in the performance of more complex pediatric procedures - Teaching methods - Evaluation techniques - Terminal competencies of undergraduate medical students and interns	-Teaching skills - Evaluation skills - Time management - Skills in giving feedback	- Patience - Sensitivity - Resourcefulness - Humility - Honesty		
Teach first and second year residents during the training and service activities of the department	- Unusual manifestations of common pediatric diseases - Usual manifestations of less commonly encountered or more complex pediatric diseases - Prognosis and long term outcome	- Communication skills - Teaching skills - Interpersonal skills - Facilitating skills - Skills in giving feedback	- Patience - Humility - Honesty		

C. RESEARCHER / RESEARCH ADVOCATE

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Conduct the research project with collection and recruitment of subjects	- Institution research guidelines - Ethics in Research - Data collection system - Coding system - Sampling techniques - Information technology	- Computer skills - Scientific Paper writing	- Thoroughness - Diligence - Resourcefulness	- Workshop - Consultation - I.T. laboratories	- Research - Paper, written/published - Research Presentation
Write the finished research report and /or present a finished research project in an appropriate forum	- Format for the research report - Guidelines in writing the research paper -Knowledge of GCP - EBM - Statistical analysis	- Written communication skills - Time management	- Patience - Resourcefulness - Diligence - Thoroughness		
Apply evidence based medicine in the workplace	- Principles of EBM - Critical Appraisal - Systematic Literature review	- Conduct literature search - Time management		- Seminar workshop - SGD	- Critically appraised topic(CATs) - Rating scale

D. AS HEALTH CARE MANAGER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Supervision of second year residents in the department related to the training and service activities .	Unusual manifestations of less commonly encountered pediatric diseases or conditions	-Time management - Organizational skills - Leadership skills - Interpersonal skills	- Patience - Resourcefulness - Dependability - Sensitivity and concern	- Lecturete - SGD	- Observation - Practicum
Oversee the conduct of services in the inpatient, outpatient, and emergency sections.	-Scope of in-patient, out-patient, and emergency diseases and conditions - Institutional policies - Roles and responsibilities of each member of the health care team	-Communication skills - Problem – solving skills - Managerial and organization skills	-Sensitivity and concern - Diligence and thoroughness -Dependability and resourcefulness		

E. AS SOCIAL MOBILIZER

OBJECTIVES	TASKS			RECOMMENDED ACTIVITIES	RECOMMENDED EVALUATION
	KNOWLEDGE	SKILLS	ATTITUDES		
Identify pediatric health issues together with the community	-Community pediatrics - National health policies - Community diagnosis with identified needs of the community regarding child health	-Organizational skills - Leadership skills - Time management - Interpersonal skills - Communication skills	-Dependability and resourcefulness - Good rapport with the community - Patience - Humility - Diligence - Resourcefulness	- Community Conference - Family Visit	- Written output report - Written community Project
Based on the identified pediatric health issues design a community – based program with the community to address the above issues	- Program proposal - Resources available - Funding agencies	- Interpersonal skills - Organization and planning skills - Problem – solving skills	- Community – orientation - Perseverance - Resourcefulness - Sensitivity and concern - Good rapport with the community		

APPENDIX A

CORE COMPETENCIES EXPECTED OF MEDICAL GRADUATES IN PEDIATRICS

***Role of a Medical Graduate: CLINICIAN / HEALTH CARE PROVIDER**

Organ System: RESPIRATORY (INFECTIOUS)

Core Competencies	Major Competencies	Topic Outline
The medical graduate, utilizing holistic approach and critical thinking, shall be able to: recognize and manage **emergency** situations.	Given the following clinical scenario, acute respiratory failure secondary to severe pneumonia: 1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	Acute respiratory failure
The medical graduate, utilizing holistic approach and critical thinking, shall be able to: recognize and manage **non-emergency** situations.	Given the following clinical scenario, found in Topic Outline: 1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	Most commonly encountered pediatric conditions/disorders: 1. Upper respiratory tract diseases: URTI, peritonsillar abscesses, nasal polyps 2. Lower respiratory tract diseases: bronchitis, pneumonias 3. Pleuraldiseases: Effusion 4. Pulmonary Tuberculosis

Organ System: RESPIRATORY (NON-INFECTIOUS)

Core Competencies	Major Competencies	Topic Outline
The medical graduate, utilizing holistic approach and critical thinking, shall be able to: recognize and manage **emergency** situations.	Given the following clinical scenario, status asthmaticus: 1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	Status asthmaticus
The medical graduate, utilizing holistic approach and critical thinking, shall be able to: recognize and manage **non-emergency** situations.	Given the following clinical scenario, found in Topic Outline: 1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	Cough and colds Gurgly chest "Halak" Hoarseness

Organ System: NON-RESPIRATORY

Core Competencies	Major Competencies	Topic Outline
The medical graduate, utilizing holistic approach and critical thinking, shall be able to: recognize and manage **emergency** situations.	Given the following clinical scenario, found in Topic Outline: 1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	Most commonly encountered pediatric emergencies apart from respiratory: 1. Apnea 2. Asystole 3. Poisoning 4. Foreign body aspiration 5. Burns 6. Drowning 7. Cardiopulmonary arrest 8. Arrythmias 9. Meconium aspiration 10. Convulsions 11. GI bleeding 12. Abdominal pain/abdominal distention 13. Diarrhea 14. Anaphylaxis 15. Diabetic Ketoacidosis 16. DIC
The medical graduate, utilizing holistic approach and critical	Given the following clinical scenario, found in Topic Outline:	Most commonly encountered pediatric conditions/disorders apart from

thinking, shall be able to: recognize and manage **non-emergency** situations.	1. Arrive at the most logical diagnosis. 2. Interpret diagnostic exam findings. 3. Select the most appropriate management strategy. 4. Determine appropriate health promotion and disease preventive measures.	respiratory: 1. Allergic conditions 2. Musculoskeletal problems 3. Dermatologic conditions 4. Developmental disorders 5. Endocrinologic conditions 6. Cardiovascular diseases 7. Digestive system 8. Genetic disorders 9. Hematologic discorders 10. Immunologic disorders 11. Infectious diseases 12. Diseases of the newborn 13. Urinary disorders 14. Neurologic disorders 15. Nutritional disorders 16. Oncologic conditions

*Role of a Medical Graduate: EDUCATOR / COMMUNICATOR

Core Competencies	Major Competencies	Topic Outline
The medical graduate shall be able to do a comprehensive history taking.	1. Given a pediatric patient and his family in a clinical encounter: a. Determine baseline knowledge and attitude of parents, caregivers, or child (when appropriate) about the problem/condition. b. Address issues/concerns peculiar to pediatric cases. c. Assess parents/child action d. Continuously monitor knowledge and practice after health education 2. Given a population group in a community: a. Plan health education in the community particularly regarding maternal and child care. b. Support and provide primary health care to a community in a manner that is practical, acceptable and implementable. c. Evaluate educational activity. 3. Given a group of students: a. Plan an instructional design for a module. b. Implement the instructional design for a module. c. Evaluate instructional design for a module.	How to obtain baseline knowledge from parents and caregivers

***Role of a Medical Graduate: RESEARCHER**

Core Competencies	Major Competencies	Topic Outline
The medical graduate shall be able to participate in research activities.	1. Given a difficult patient to diagnose or treat: a. Formulate relevant clinical questions. b. Critically appraise relevant literature to diagnose and treat patients. c. Make clinical decision based on critical appraisal. 2. Given a problem area or a research question: a. Formulate a research proposal. b. Implement the research proposal. c. Disseminate research results in an appropriate form.	Formulation of appropriate clinical question

***Role of a Medical Graduate: MANAGER**

Core Competencies	Major Competencies	Topic Outline
The medical graduate shall be able to plan and monitor operations of a medical facility.	1. Given a health care facility in the community, plan or monitor operations of the facility. 2. Given an area to start a project in the community: a. Identify relevant data indicative of the child health situation in the community and the factors responsible for it when asked to examine a hypothetical situation or after a tour of the community. b. Identify possible sources of assistance using locally available resources. c. Prepare work plan to address child health problems d. Participate in health promotion activities. e. Prepare an evaluation plan for a specific activity to assess its effects/impact on a target.	Data categories in the health area: demography, health status, ecological data, health resources

***Role of a Medical Graduate: SOCIAL MOBILIZER / ADVOCATE**

Core Competencies	Major Competencies	Topic Outline
The medical graduate shall be able to mobilize the community into worthy endeavours.	Given a community or population, a. Act as advocate of people empowerment and self-reliance. b. Get the people involved in the affairs of their own community.	Common maternal and child health issues: EPI, IMCI, MCH

	c. Participate in community organization. d. Promote people participation in problem solving. e. Contribute to the building of partnerships and collaborations among different institutions, agencies and groups.	

APPENDIX B
Competency-based Pediatric Residency Training Curriculum

Appendix B1: Common Acute Childhood Illnesses:

1. Sore throat: Pharyngitis, Peritonsillar abscess and Infectious mononucleosis
2. Cough:
    a. Acute cough (< 2 weeks): AURI, Asthma w/o Exacerbation and Pneumonia, minimal/low risk
    b. Acute cough in distress: Bronchiolitis, Pnumonia, moderate risk, Foreign body,, Laryngotracheitis (Croup), Epiglittitis, Tracheitis or Asthma with exacerbation
    c. Subacute (2-4 weeks): Bronchitis, TB and Atypical respiratory infections (Chlamydia/Mycoplama pneumonia), and rhinosinusitis
3. Headache: Migraine, Tension headache, acute sinusitis
4. Eye pain and discharge: Conjunctivitis, Orbital cellulitis,
5. Diarrhea: Viral & bacterial gastroenteritis, Protozoan and parasitic infections, Toddler's diarrhea and Pseudomembranous colitis
6. Constipation: Functional
7. Fever: URI, Otitis media, bacterial sinusitis, bronchiolitis, pneumonia, viral syndromes, and UTI, DF/DHF, Typhoid fever, leptospirosis
8. Ear pain: Otitis media/externa and Foreign body
9. Weight gain: Obesity and Cushing disease
10. Dysuria: UTI, Trauma, STD/child abuse and Vulvovaginitis
11. Fever and Rash: Viral exanthems, Meningococcemia, Henoch-shoelein purpura, Toxic shock syndrome, Kawasaki disease and Acute rheumatic fever
12. Anemia: Iron defieciency anemia, G6PD defieicncy, Thalassemia, Lead poisoning and Physiologic anemia of infancy
13. Neonatal fever: Sepsis, UTI, Meningitis or encephalitis
14. Seizures: Febrile seizure, CNS infection, Metabolic & electrolyte disturbances, Trauma, Toxic ingestions
15. Skin and soft tissue infections: Cellulitis, abscss, Necrotizing fasciitis, Erysipleas, Impetigo, and Scrofula
16. Limping child: Trauma, Child abuse, Osteomyelitis, Synovitis and Septic arthritis
17. Neonatal jaundice: Physiologic jaundice, Sepsis, ABO hemolytic disease, G6PD deficiency and Breastfeeding jaundice
18. Abdominal pain: Appendicitis, Intussusception, Malrotation with midgut volvulus, Gastroenteritis, Mesenteric adenitis, Constipation, Incarcerated hernia and UTI

19. Allergic disorders: Eczema, Urticaria/angioedema/anaphylaxis
20. Common viral illnesses: measles, mumps, rubella, roseola infantum, erythema infectiosum, 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).
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.
22. Fungal infection: Candidiasis
23. Parasitic infections: Giardia lamblia, Toxoplasma gondii, Trichomonas, Visceral larva migrans, Ascaris lumbricoides, Enterobius vermicularis, E. histolytica, Plasmodium sp.
24. Colds: Common colds, Allergic rhinitis
25. Renal disorders: UTI, AGN, nephrotic suyndrome
26. Genital disorders: undescended testes, retractile testes, hernia, hydrocele, imperforate hymen, ovarian torsion and vulvovaginitis

Appendix B2 : Complex Pediatric Conditions

1. Acute cough in distress: Pneumonia, high risk, ARDS and Status asthmaticus
2. Headache: Brain tumor; Pesudotumor cerebri
3. Diarrhea: Malabsorption and Inflammatory bowel disease
4. Constipation: Hirshprung disease, hypothyroidism, Spinal cord abnormalities and Lead poisoning
5. Fever: Occult bacteremia, CNS infections, PFAPA syndrome and FUO.
6. Weight gain: Prader-Willi syndrome and Hypothalamic obesity
7. Dysuria: Urolithiasis
8. Anemia: Anemia of chronic disease
9. Seizure: Epilepsy , Status epilepticus, and Brain tumor
10. Prolonged jaundice: Biliary atresia, Choledochal cyst
11. Respiratory distress in newborn: RDS, TTN, Meconium aspiration syndrome, Pneumonia, Air leak syndrome, Congenital diaphragmatic hernia, TE Fistula
12. Delayed meconium passage: Meconium ileus/meconium plug syndrome, Hirschprung disease
13. Heart murmur: Congenital heart diseases (Cyanotic/acyanotic) and Acquired heart disease (Rheumatic Fever/RHD)
14. Abdominal distention: NEC
15. Raised intracranial pressure: Hydrocephalus, Brain tumor, CNS infection, and Intracranial hemorrhage
16. Arrthymia: Sinus tachycardia/bradycardia, SVT, Heart block and VT
17. Shock: Hypovolemic, distributive, obstructive and neurogenic shock
18. Diabetic ketoacidosis
19. Trauma: Traumatic brain injury
20. Heart failure: Congestive heart failure, Myocarditis/pericarditis, Cardiomyopathy
21. Chest pain: Muscle strain, Costochondritis, Contussion, Pleural effusion, GERD, Esophagitis, Rhythm disturbances, ischemia and Anxiety/stress
22. Child abuse
23. Pediatric poisonings
24. Animal bite

25. Short stature: Growth hormone deficiency, Failure to thrive, hypothyroidism, malnutrition
26. Common bacterial causes of nosocomial infections: Klebsiella, Enterobacter, Pseudomonas, CONS
27. Renal disorders: Urolithiasis, Renal TB, Renal tubular acidosis, Acute and chronic renal failure
28. Hypertension: Renal, vascular, endocrine and neuroblastoma
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.
30. Metabolic disorders: IEM
31. Endocrine disorders: Adrenal disorders, Disorders of gonads & puberty, Diroders of parathyroid
32. Musculo-skeletal disorders: Developmental dysplasis of hip, skeletal dysplasis, osteogenesis imperfect, fractures, Torticollis, Legg-Calve-Perthes disease, Osgood-Schlatter disease
33. Skin disorders: Hemangiomas, Scabies, SSSS, Pediculosis, Molluscum contagiosum, Steven-Johnson syndrome

Appendix B3: Common Chronic Childhood Conditions:

1. Chronic cough (>4 weeks): Pertussis, GERD, Airway anomaly (TEF, tracheal ring, tracheomalacia, laryngeal cleft)
2. Newborn dysmorphology
3. Chronic child: Congenital neuromuscular disorders, HIE, Static encephalopathy, BPD/Chronic lung disease
4. Malformations: Trisomies, Turner syndrome, Fragile X
5. Children with special needs: Autism, ADHD, Cerebral palsy, Intellectual disability, Learning disability
6. Palliative care for cancer patients
7. Medical Home Initiative

Appendix C
Pediatric Procedures

1.1. Office procedures
- 1.1.1. Anthropometric studies
- 1.1.2. Vital signs measurements
- 1.1.3. Subcutaneous injection
- 1.1.4. Intramuscular injection
- 1.1.5. Intradermal injection
- 1.1.6. Oral administration
- 1.1.7. Nebulization
- 1.1.8. Fever control
- 1.1.9. Cord care
- 1.1.10. Incision and drainage

1.2. Eye procedures
- 1.2.1. Topical drug administration
- 1.2.2. Foreign body removal (assist or observe)

1.3. Ear procedures
- 1.3.1. Foreign body removal (assist or observe)
- 1.3.2. Cerumen removal

1.4. Nose procedures
- 1.4.1. Foreign body removal (assist or observe)
- 1.4.2. Control of epistaxis

1.5. Endotracheal intubation

1.6. Thoracentesis (assist or observe)

1.7. Nasogastric tube placement

1.8. Genitourinary procedures
- 1.8.1. Urethral catheterization
- 1.8.1.Supra-pubic bladder puncture

1.9. Lumbar puncture

1.10. Bone marrow aspiration

1.11. Exchange transfusion

1.12. Vascular procedures
- 1.12.1. Percutaneous peripheral venous access
- 1.12.2. Peripheral venous access by cut down
- 1.12.3. Umbilical vessel cannulation
- 1.12.4. Blood extraction
  - capillary blood sampling
  - arterial blood sampling
- 5.12.5. Intra-osseous infusion

1.13. Bedside sedation for procedures

1.14. Aseptic techniques
1.15. Specimen collection and handling
    1.15.1. Throat culture
    1.15.2. Urethral swab
    1.15.3. Vaginal swab
    1.15.4. Blood culture
    1.15.5. Urine culture
    1.15.6. Stool culture
    1.15.7. Gram stain
    1.15.8. Cellulose (scotch tape) tape method
1.16. Miscellaneous procedures
    1.16.1. Restraints
    1.16.2. Splints
    1.16.3. Dressings
    1.16.4. Wound care