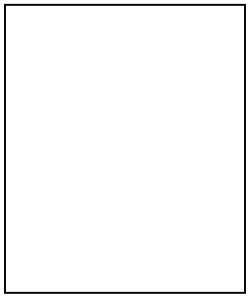
LOG BOOK

MD Paediatrics and Allied Subjects

BANGABANDHU SHEIKH MUJIB MEDICAL UNIVERSITY

CONTENTS

Personal details of the Resident



Discipline :

Name :
University Regd no :
BMDC Registration no :
Date of joining : Course duration:
Date of birth :
Fathers name :
Mother's name :
Address with Telephone
Permanent Mailing

Phone no (land/mobile) :
Email :
Nationality :

National ID no :
(If aplicable)
Passport No :
(Foreign students)

Objective of the training program:

The aim of the training program in Phase A of the residency program is to guide the students to acquire broad based knowledge on the subject before entering the final part (Phase B). in this context it is expected that the student will be able to –

i) acquire knowledge of common problems, emergencies and their management and rehabilitation
ii) acquire skill – procedural, diagnostic, interpretative and decision making
iii) develop attitude – caring, learning, ethical and interpersonal relations

The components of the objectives are as follows: the resident should

- Acquire sufficient theoretical knowledge (the 'core' knowledge as defined in the syllabus)
- Be able to take full historians be competent in performing a full physical examination
- Be competent in performing different procedure
- Formulate a working diagnosis
- Decide whether the patient requires ambulatory care or hospitalization or referral to other place/person
- Become competent in interpreting and evaluating the presenting symptoms and physical signs
- Be able to interpret and evaluate the laboratory reports of the patients problem
- Plan investigations and interpret them
- Decide and implement appropriate treatment
- Competent in handling common emergencies and common chronic problems including their rehabilitation
- Maintain records
- Develop skill of good prescribing
- Establish good doctor-patient, doctor-nurses relation
- Be able to maintain highest standard of ethical and professional standard
- Develop as a good communicator
- Be able to advise and promote health of the community and individual including disease prevention

The purpose of the Log Book is to:

- Help maintain a record of the work done during training
- Enable trainers to have direct information about the work and intervene where necessary
- Use it to assess the experience gained periodically
- The log book shall be used to aid the internal evaluation of the student
- The Logbook has been designed to enable trainees to record the necessary aspects of their training experience as approved by the University
- The record of experience provides trainees with a personal record of all procedural and other training experiences, that are requirements for satisfactory completion of the training program
- The record of experience provides trainees with the basis for completing the four-monthly Block Training Summaries of training experience which are an essential requirement for assessment
- The record of experience will allow four-monthly Block Training Summaries which will be used by the discipline Coordinator and the Course Director to monitor the trainee's experience to ensure that it is appropriate for the level of training.
- These summaries are also used to plan further training, if felt necessary, by the discipline Coordinator.
- The record of experience will also be used by the respective authority to monitor the experience provided for trainees by the Supervisor and their (supervisors) capability to provide training

General information:

- Duration of residency training for phase A is 3 years
- Resident will obtain logbook from Course Coordinator of parent discipline immediately after joining
- The log book is to be maintained throughout the period of training
- He/she will make the required entries in the log book on the same day of the event and get it signed by the supervisor
- Entries in the Log-book will be block-wise
- The completed Log Book will be a pre-requisite for appearing in Phase A summative examination
- Required entries in each rotation are elaborated in corresponding section
- Process to enter the task is elaborated at the beginning of the section
- Resident should go through the whole document immediately after obtaining the log-book
- For any confusion or clarification Resident should consult with the Supervisor

Loss or damage of logbook

It is the responsibility of the resident to keep the logbook safe and secured

Information to Supervisors:

- Log-book is a tool to monitor the training. Success of the training rests on proper monitoring. Regular and timely entry and supervision by the supervisor is essential to make the log-book successful
- The log-book has to filled sooner after specific activity followed by signing of the supervisor
- Procedure skill should be observed by the supervisor and necessary entry to be done
- All entries where a grading is expected are to be filled and signed by the Supervisor sooner after the function
- The performance of some of the activityies may need to be assessed, as marked in the log-book, as per following 'competence level' or different 'grade level':

Leveling the 'Competence'

Competence	Level
Observed	**1**
Performed under supervision	**2**
Performed independently	**3**

Leveling the 'Grade'

Grade	Level
Excellent	**4**
Good	**3**
Satisfactory	**2**
Unsatisfactory	**1**

Supervisors/Coordinators are also requested to go through the 'General Instruction' part

Rotation of Residents : Phase A

The resident will start the training rotation from the parent block initially and rotate through following blocks subsequently:

1. General Paediatrics
2. Paediatric Gastroenterology & Nutrition
3. Neonatology
4. Paediatric Haematology & Oncology
5. Paediatric Nephrology
6. Paediatric Neurology
7. Paediatric Pulmonology & Cardiology
8. Parent department

Ø **For each block a resident is to complete the following activities:**

A. POMR	:	10-16 POMR as advocated for the block
B. Academic activities	:	
Clinical Meeting	:	4
Seminar	:	1
Journal Club	:	4
Medical audit	**:**	**1**
Academic classes	:	all except during leave period
Workshop	:	all declared compulsory during the period
C. Practical Procedures	**:**	as elaborated in individual block

In each block following academic activities are to be carried out in addition during dedicated hours of the daily routine

Basic science classes will be organized by the Basic Science Faculty in consultation with relevant discipline and as per course curriculum. All these attendance are to be entered in the log-book.

Phase-I

Clinical skills

- Ø History taking
- Ø Physical examination
- Ø Enumerate the complete problem list
- Ø Formulation of the management plan as per problem list
- Ø Ordering & interpretation of investigation results
- Ø Deciding and implementing management
- Ø Practical procedures
- Ø Maintaining follow up records.

Academic Activities

1. Clinical case presentation
2. Seminar
3. Article presentation from journal
4. Medical audit
5. Involvement in research activities (optional)
6. Academic classes
7. Workshop

Practical Procedure

Related to the Blocks

Attending emergencies related to the block

End of Block Evaluation of the Resident

Name of the Student _____
Block:
Duration:
From _____ to _____

I. Professional Skills

Score

Attendance in academic activities
Performance in ward procedures
Performance in emergency procedure
Handling of equipments
Performance in laboratory procedures
Decision making/formulation of management plan
Record maintenance
Administration
Leadership qualities

Score from 1 to 5 (5: outstanding; 1: below expectation)

II. Personal Attributes

Score

- Availability (punctual, available in duty, responds promptly to calls, takes proper permission for leave)
- Sincerity & motivation (dependable, honest, admits mistake, exhibits good moral values, loyal to institution, takes initiative & responsibility, keen desire to learn)
- Diligence & performance (dedicated, hard working, does not shirk duties, leaves no pending work, competent in clinical case, skilled in procedure)
- Interpersonal skills (compassionate attitude to patients, gets along well with colleagues, paramedics & mentors

Signature of the Supervisor **Date:**

Record of discussion and assessment by supervisor during each block

It is essential that Training Supervisors review the trainee's training experiences and progress as recorded in the Logbook every four months. Training Supervisors are required to provide feedback to the trainees about their strengths and areas for improvement at a regular basis and after any within block formative assessment.

The following section is to be signed by the Training Supervisor.

I certify that I have reviewed the training recorded in this Logbook on:

Date: ..... (end of 1st month) Signed: .....

Date: ..... (end of 2nd month) Signed: .....

Date: ..... (end of 3rd month) Signed: .....

Date: ..... (end of Block) Signed: .....

A. Format to record **Problem oriented medical record (POMR) 10-16**

Sl No	Date and Reg no	Name & age of patients with diagnosis	Grade	Supervisor

B. Format to record **Procedural Skill**

Procedure	**Date**	**Level of competence**	**Grade**	**Signature**

C. Format to record academic activities

Name of event – Clinical meetings – 4

There will be entry of all the events attended by the resident in following format. In addition there will be required number to be presented by the resident himself which needs to be assessed by the supervisor as per evaluation sheet. It will be the duty of the respective resident to ensure Supervisor got the evaluation sheet before the start of the presentation.

Sr no	**Date**	**Patients detail**	**Diagnosis/problem**	**Performance level**	**Supervisor**

Evaluation sheet for clinical meeting presentation

(when a trainee is presenting a case the respective supervisor will take this evaluation sheet and fill the form, sign it at the end and hand over to the trainee for preservation)

Name of the Student _____ Block:

	Date and score			
Logical order				
Completeness of history				
Cogency of presentation				
Whether all relevant history elicited				
Whether all physical signs elicited correctly				
Any major sign not missed or misinterpreted				
Diagnosis: whether it follows logically from history & findings				
Completes list of investigations				
Relevant order				
Interpretation of investigations				
Treatment principles & details				
Ability to react to questioning: If answers relevant and complete				
Ability to defend diagnosis				
Ability to justify differential diagnosis				
Confidence				
Communications skills				
Others				

Score from 1 to 5 (5: outstanding; 1: below expectation)

Signature of the Supervisor

C. ACADEMIC ACTIVITIES

Name of event – Seminar/symposium, workshop, conferences

There will be entry of all the events attended by the resident in following format. In addition there will be required number to be presented by the resident himself which needs to be assessed by the supervisor as per evaluation sheet. It will be the duty of the respective resident to ensure Supervisor got the evaluation sheet before the start of the presentation.

Sr no	Date	Topic/problem	Source/resource person	Performance level	Supervisor

Evaluation sheet for Seminar presentation

(when a trainee is presenting in the seminar supervisor will take this evaluation sheet and fill the form, sign it at the end and hand over to the trainee for preservation)

Name of the Student _____

	Date			
Presentation				
Completeness of preparation				
Cogency of presentation				
Use of audiovisual aids				
Understanding of topic				
Ability to answer questions				
Time scheduling				
Consulted relevant literature				

Score from 1 to 5 (5: outstanding; 1: below expectation)

Signature of the Supervisor

C. ACADEMIC ACTIVITIES
Name of event – Journal Club

There will be entry of all the events attended by the resident in following format. In addition there will be required number to be presented by the resident himself which needs to be assessed by the supervisor as per evaluation sheet. It will be the duty of the respective resident to ensure Supervisor got the evaluation sheet before the start of the presentation.

Sr no	Date	Topic/title of the paper	Source and first author	Performance level	Supervisor

Evaluation Sheet - Article presentation from journal –

(when a trainee is presenting a journal article the respective supervisor will take this evaluation sheet and fill the form, sign it at the end and hand over to the trainee for preservation)

Name of the Student _____

Choice of article	**Date**			
Cogency of presentation				
Critical review				
If cross reference and relevant publications consulted				
Audio visual aids				
Interaction				

Score from 1 to 5 (5: outstanding; 1: below expectation)

Signature of the Supervisor

C. ACADEMIC ACTIVITIES

Name of event – Medical audit

There will be entry of all the events attended by the resident in following format. In addition there will be required number to be presented by the resident himself which needs to be assessed by the supervisor as per evaluation sheet. It will be the duty of the respective resident to ensure Supervisor got the evaluation sheet before the start of the presentation.

Sr no	Date	Problem discussed	Learning from the discussion	Performance level	Supervisor

Evaluation Sheet for Medical Audit presentation

(Trainee will ensure that respective supervisor is given the evaluation sheet before start of the presentation. Supervisor will fill the form, sign it at the end and hand over to the trainee for preservation)

Name of the Student _____

	Date			
Presentation				
Completeness of preparation				
Clear thought about history, physical finding, investigations and other information in development of the presentation				
Logical order				
Critical review				
Use of audiovisual aids				
Ability to answer questions				
Time scheduling				
Consulted relevant literature				
Confidence				
Communications skills				
Others				

Score from 1 to 5 (5: outstanding; 1: below expectation)

Signature of the Supervisor

OPD consultation:

Block:

Name of the Supervisor:

Date	Consultation	Problem/diagnosis		Supervisor
	Ist FU			
	Ist FU			
	Ist FU			
	Ist FU			

Emergencies encountered:

Block:

Name of the Supervisor:

Sr no	Date	Patient details	Problem/diagnosis	Outcome	Supervisor

Lectures attended during the rotation:

Block:

Supervisor:

Sr no	Date	Topic	Presenter	Supervisor

Leave record:

Block:

Supervisor:

Sr no	Duration	Date	Reason	Supervisor

D. Block summary

Sl no	Parameters	Grade
1.	Attendance	
2.	Punctuality	
3.	Sincerity	
4.	Skill	
5.	Confidence	
6.	Counseling/Communication	
7	Managerial capability	
8	Team work	
9.	Professionalism	
10	Scholarly	
11	Special performance	

…….
Signature of the supervisor

Training Record: Summary of the Phase-A rotation

Respective Supervisors will complete their section only after formative assessment at the end of the block placement. The grade will be the one obtained in the formative assessment at the end of the block.

Block	**Discipline**	**from**	To	**Grade**	**Supervisor Name + Signature**
1st					
2nd					
3rd					
4th					
5th					
6th					
7th					
8th					

Signature
Course Co-ordinator
Department of …….....

Signature
Course Director
Paediatric and Allied Subjects

NB: Course Coordinator will check successful completion of each of the block and send the log-book for further checking by the course Director for ultimate permission to seat for the end of Phase-A summative examination. If Course Coordinator found any incomplete or poorly performed block, it will be reported to the Course Director for future block placement to complete those.

Certificate of Accuracy

I certify that the information contained in the logbook is a true and accurate record of my training experiences.

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Signature and name of the resident Date

Certification of satisfactory completion of the training logbook

I, to the best of my knowledge, certify that Dr ----------

----------, in the discipline of ----------

----------, has satisfactorily completed this logbook as required by the University.

---------- ----------

Name and signature of the Coordinator Date

Discipline:

Individual block training target:

List of skill and emergency competences to be achieved in specific rotation:

Neonatology Block

Skills

Assessment of gestational age	: 10 (at least five independently)
Umbilical catheterization	: 5 (perform at least one independently)
Mobile transfusion	: 5 (perform at least one independently)
Endotracheal Intubations	: 5 (perform at least one independently)
Neonatal B.P	: 5 (perform at least one independently)
Ventilator	: 5 (perform at least one independently)
Visual assessment	:
Auditory assessment	:
Neonatal resuscitation	: 5 (perform at least two independently)
IV cannula	: 10 (perform at least eight independently)
CBG	: 10 (perform at least eight independently)
Putting in NG tube	: 10 (perform at least five independently)
Blood sample collection	: 15 (perform at least ten independently)
Umbilical swab	: 5 (independently)
Phototherapy	: 5 (independently)
Syringe pump	: 5 (perform at least one independently)
Infusion pump	: 5 (perform at least one independently)
Drawing of Arterial blood	: 10 (perform at least one independently)
Arterial blood gas analysis	: 10 (perform at least one independently)
Pulse oxymetry	: 10 (independently)
Setting Incubator	: 10 (independently)

Emergencies:

Neonatal resuscitation
Apnoea/apnoeic spell
Seizure- septic, hypoglycaemic, hypocalcaemic, hypomagnesaemia, hypoxic, others
Sepsis and shock
Hemorrhagic disease of the newborn
Dyselectrolytemia
Fluid and electrolyte balance
Hypothermia
No urine
Bowel not moved

Paediatric Hematology and Oncology Block

Skill

Hb electrophoresis	: 5 (Observed)
Immunophenotyping	: 5 (Observed)
Automated hematological Analysis	: 5 (Observed)
Coagulation screening	: 5 (Observed)
Separation of platelets	: 5 (Observed)
IV cannuula	: 10 (independently)
Putting in NG tube	: 10 (independently)
Blood sample collection	: 10 (independently)
Blood slide preparation	: 10 (independently)
Bone marrow aspiration and slide preparation with staining	: 5 (perform at least one independently)
Lumbar puncture/IT chemo	: 5 (perform at least one independently)
Coomb's test	: 5 (perform at least one independently)

Emergencies:

Septicaemia
Neutropenia
Aplastic crisis
Hemolytic crisis
Shock – septic, hemorrhagic, hypovolemic
Convulsion
Drug hypersensitivity

Paediatric Nephrology Block

Skill

Renal biopsy	: 3 (0bserved)
Peritoneal dialysis	: 5 (perform at least one independently)
Hemodialysis	: 5 (0bserved)
IV cannula	: 10 (independently)
Putting in NG tube	: 10 (independently)
Blood sample collection	: 10 (independently)
Bed side urine testing	: 10 (independently)
Long line	: 3 (observed)
Supra pubic puncture	**: 5** (perform at least one independently)
Albumin infusion	**: 3**
FFP infusion	**: 3**
Urethral catheterization	**: 5** (perform at least one independently)
I/V cyclophosphamide infusion	**: 3**
I/V Methylprednisolone infusion	**: 3**
Ascitic fluid aspiration	**: 5** (perform at least one independently)
Long line access	**: 3** (independently)

Emergencies:

Acute renal failure/ acute tubular necrosis
Hemolytic uremic syndrome
Chronic renal failure
Urinary retention
Hypertensive encephalopathy
Hypotension/shock
Fluid overload
Ureteric colic

General Paediatrics Block

Skill

I/v cannulation : 10 (independently)
N/G tube placement : 5 (independently)
Blood transfusion including mobile transfusion : 5 (at least one independently)
Collection of sample for body fluid culture : 10 (independently)
Pleural fluid aspiration :
Ascitic fluid aspiration :
Throat swab collection : 2 (independently)
Pulse oxymetry : 5 (independently)
ECG :
Bedside test for urinary sugar, albumin, ketone : 5 (independently)
Nebulization : 5 (independently)
Lumber puncture : 4 (at least one independently)
Intra articular Injection : 4 (independently)
Synovial fluid aspiration :
Subcutanoeus drug administration : 5 (at least one independently)
BCG test :
Tuberculein test : 5 (at least one independently)
Vaccination : 10 (independently)
Anthropometry (eg., weight, height, OFC, MUAC, etc) and charting : 10 (independently)
Ophthalmoscopy : 5 (independently)
Auroscopy : 5 (independently)
Oxygen therapy : 5 (independently)

Emergencies:

Management of convulsion
Management of severe respiratory distress – use nebulizer, MDI, spacer
Management of heart failure
Management of high fever
Management of headache
Management of acute abdominal pain
Management of acute and frequent vomiting
Management of shock – septic, toxic, hypovolemic, cardiogenic
Management of unconscious child – infection, trauma, metabolic, arrhythmic

Management of severe dehydration
Management of foreign body aspiration
Management of common poisoning
Management of GI bleeding
Management of tension pneumothorax
Management of upper airway obstruction – acute/chronic
Management of torsion testes
Management of urinary retention

Paediatric Neurology Block

Skill

1. Neurological assessment	: 5 (independently)
2. Development. Assessment	: 5 (independently)
3. Psychological assessment	: 5 (independently)
4 . Neuroimaging / EEG interpretation	: 5
5. Ophthalmoscopy	: 5 (independently)
6. LP	: 4 (one independently)
7. ABG	: 2 (one independently)
8. Per rectal Inj	: 5 (one independently)
9. Intralasal midazolam	: 3 (one independently)

Paediatreic Pulmonology Block

Skill

Water seal drainage	:
Bronchoscopy (observed)	:
Pleural biopsy (observed)	:
Pl. fluid aspiration	: 3
Nebulization	: 10 (independently)
Spirometry	: 5
PEFR	: 10 (independently)
Blood gas analysis	: 5
Pulse oxymetry	: 5 (independently)
V/Q scan	: (observed)

Paediatric Cardiology Block

Skill

ECG interpretation	: 10
Echocardiography (observed)	:
Echocardiography color Doppler (observed)	:
Cardiac Catheterization (observed)	:
Angiogram (observed)	:
E.T.T. (observed)	:

Paediatric Gastroenterology & Nutrition Block

Skills

1. Assessment of dehydration
2. Fluid therapy
3. Management of dyselectrolytaemia
4. Management of GI bleeding
5. Management of abdominal pain (Acute and recurrent)
6. Management of acute liver failure
7. Management of severe malnutrition

Procedure and interpretation of imaging:

Blood sampling	: 10	(independently)
I/V cannula	: 10	(independently)
Paracentesis	: 5	
Introduction of nasogastric tube	: 10	(independently)
Liver biopsy	: 10	
Upper GI endoscopy	: 5	
Colonoscopy	: 2	
Endoscopic Variceal ligation	: 5	
Ultrasonography	: 10	
Barium study of GIT	: 5	