Logbook

(Undergraduate Competency Based Curriculum)

Obstetrics and Gynaecology

Logbook

Department of Obstetrics and Gynaecology

Name of student: ……..

Admission Batch: ……..

Name of the College. ……

…….

College Roll No.……..

University Registration number…….

Glossary & General Instructions

Logbook:

Logbook is defined as a verified record of the progression of the learner documenting the acquisition of the requisite knowledge, skills, attitude and or competencies. Logbook is the most important tool that will help us to achieve successful implementation of the key aspects of New Undergraduate Competency based curriculum. It forms an integral part of internal assessment/formative assessment and the eligibility to appear in the summative assessment conducted by the concerned University. Successful documentation and submission of logbook is a pre requisite for being allowed to appear in the final summative examination.

Points to be noted by the student:

1. The logbook is a record of the academic/ co curricular activities of the designated student, who is responsible for maintaining his/her logbook.

2. The student is responsible for getting the entries in the logbook and verified by designated faculty on regular basis.

3. Entries in the logbook will reflect the activities undertaken in the department and have to be scrutinized by the concerned Head of the department.

4. The logbook should be verified from the college before submitting the application to the student for University examination.

Activity: Predefined task performed by the learners that contribute to the achievement of objectives and competencies.

Remedial: A planned activity aimed at correcting deficits that prevent a learner from achieving an intended outcome.

Feedback: A formal active interaction performed at the completion of an observed activity intended to facilitate positive change, growth and improvement of the learner through guided reflection of the activities performed.

Understanding the logbook activity table:

S No.	Competency # addressed	Name of Activity	Date completed: dd-mm-yyyy	Attempt at activity: First (F) Repeat (R) Remedial (Re)	Rating: Below (B) expectations Meets (M) expectations Exceeds (E) expectations OR Numerical Score	Decision of faculty: Completed (C) Repeat (R) Remedial (Re)	Initial of faculty and date	Feedback Received: Initial of Learner and date
1.								
2.								
3.								
4.								
5.								
6.								
7.								

1. **The number of the competency addressed**, includes the subject initial and number (from Volume III of the UG Curriculum) e.g. OG 2.1

2. **Name of activity:** Seminar / Small Group Discussion/ Skills Lab / Drill / Role Play

3. **Date the activity gets completed**

4. **Attempt at activity by learner**, indicate if:
   a. First attempt (or) only attempt
   b. Repeat (R) of a previously done activity
   c. Remedial activity (Re) based on the determination by the faculty

5. **Rating**, use one of the following three grades:
   a. Below expectations (B)
   b. Meets expectations (M)
   c. Exceeds expectations (E)

6. **Decision of faculty**
   a. C: activity is completed, therefore closed and can be certified, if needed
   b. R: activity needs to be repeated without any further intervention
   c. Re: activity needs remedial action (usually done after repetition did not lead to satisfactory completion)

8. **Initial (Signature) of faculty** indicating the completion or other determination

9. **Initial (Signature) of the learner** if feedback has been received.

CERTIFICATE OF COMPLETION

This is to certify that the candidate Mr/ Ms……, Regn. No……, Admitted in the year ..... in ……

……

has satisfactorily completed/not completed all the assignments /requirements mentioned in this logbook in the subject(s) of Obstetrics and Gynaecology during the period from……to ……She/ He is/is not eligible to appear for 3rd Prof Part II examination(Summative) conducted by the WBUHS.

Signature of Unit head: Signature of Head of the Institute
With seal and date

Countersigned by

Head of the department:

ATTENDANCE RECORD- CLINICAL POSTING

Phase	Duration	From	To	Remarks	Faculty Signature
Phase-II					
Phase-III, Part 1					
Elective					
Phase-III Part-2					
Repeat posting (if any)					

Phase wise distribution of activities

PHASE	ACTIVITY	NUMBER
Phase II	Antenatal case history record	**2**
	Gynaecological case history	**1**
	Hand washing and personal protective precautions as DOAP in simulated environment	**1**
Phase III, part 1	Antenatal case history record	**2**
	Gynaecological case history	**2**
	Labour record	**1**
	Obtain a pap's smear in simulated environment	**1**
Phase III, part 2	Antenatal case history record	**4**
	Gynaecological case history	**2**
	Labour record	**2**
	Obtain a pap's smear in simulated environment	**2**
	Counseling for breast feeding as DOAP in simulated environment	**1**
	Counseling for contraception as DOAP in simulated environment	**1**
	Caesarean Section and informed consent	1
	IUCD insertion and removal	**1**
	Newborn resuscitation	**1**
	Mechanism of conduct of normal delivery and assisted breech vaginal delivery in a simulated environment	**1**

PHASE II

Activity 1a. Antenatal case history record

Activity 1b. Antenatal case history record

Activity 2. Gynaecological case history record

Activity 3: Hand washing and personal protective precautions as DOAP in Simulated environment

Done –

Not done -

SCORE CARD (PHASE II)

Name of activity	Date of activity completed (DD/MM/YY)	Attempt at Activity (F, R, Re)	Rating (B,M,E)	Decision of Faculty (C, R, Re)	Initial of faculty	Feedback Initial of learner and date
1a. Antenatal case history record						
1b.Antenatal case history record						
2.Gynaecological case history record						
3. Hand washing and personal protective precautions as DOAP in Simulated environment						

Phase- 3

Part - 1

Activity 4a. Antenatal case history record

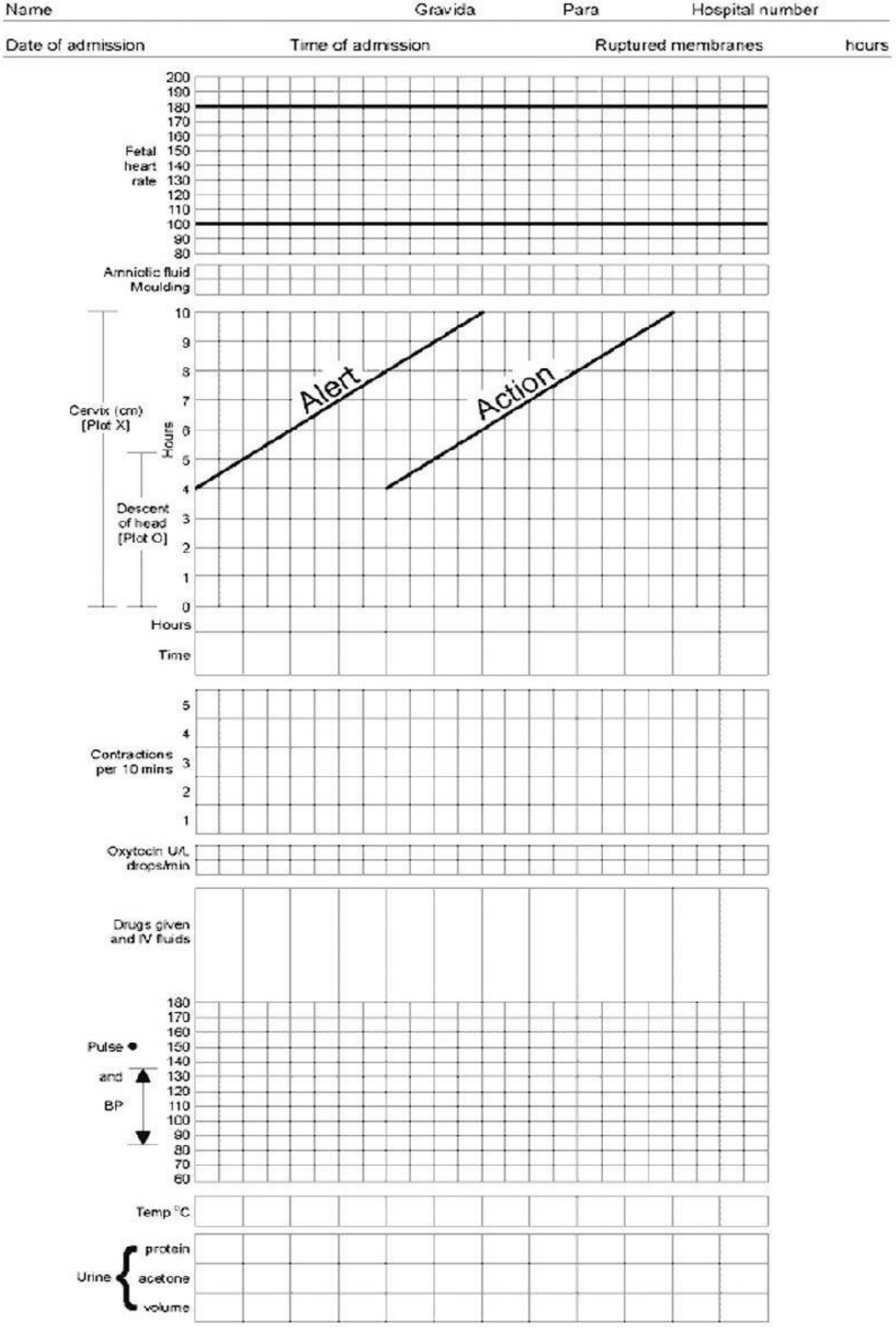
Activity 4b. Antenatal case history record

Activity 5a. Gynaecological case history record

Activity 5b. Gynaecological case history record

Activity 6: Normal Labor case record

WHO Modified Partograph



WHO LABOUR CARE GUIDE

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N																	
	Pain relief	N																	
	Oral fluid	N																	
	Posture	SP																	
BABY	Baseline FHR	<110, ≥160																	
	FHR deceleration	L																	
	Amniotic fluid	M+++, B																	
	Fetal position	P, T																	
	Caput	+++																	
	Moulding	+++																	
WOMAN	Pulse	<60, ≥120																	
	Systolic BP	<80, ≥140																	
	Diastolic BP	≥90																	
	Temperature °C	<35.0, ≥ 37.5																	
	Urine	P++, A++																	
LABOUR PROGRESS	Contractions per 10 min	≤2, >5																	
	Duration of contractions	<20, >60																	
	Cervix [Plot X]	10																	
		9	≥ 2h																
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.

Abbreviations: **Y** – Yes, **N** – No, **D** – Declined, **U** – Unknown, **SP** – Supine, **MO** – Mobile, **E** – Early, **L** – Late, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

Activity 7: Obtaining a Pap smear in a simulated environment

- **Steps of taking Pap Smear:**

SCORE CARD (PHASE III, Part 1)

Name of activity	Date of activity completed (DD/MM/YY)	Attempt at Activity (F, R, Re)	Rating (B,M,E)	Decision of Faculty (C, R, Re)	Initial of faculty	Feedback Initial of learner and date
4a. Antenatal case history record						
4b.Antenatal case history record						
5a.Gynaecological case history record						
5b. Gynaecological case history record						
6. Normal Labor case record						
7. Obtaining a PAP smear in a simulated environment						

Phase- 3

Part - 2

Activity 8a. Antenatal case history record

Activity 8b. Antenatal case history record

Activity 8c. Antenatal case history record

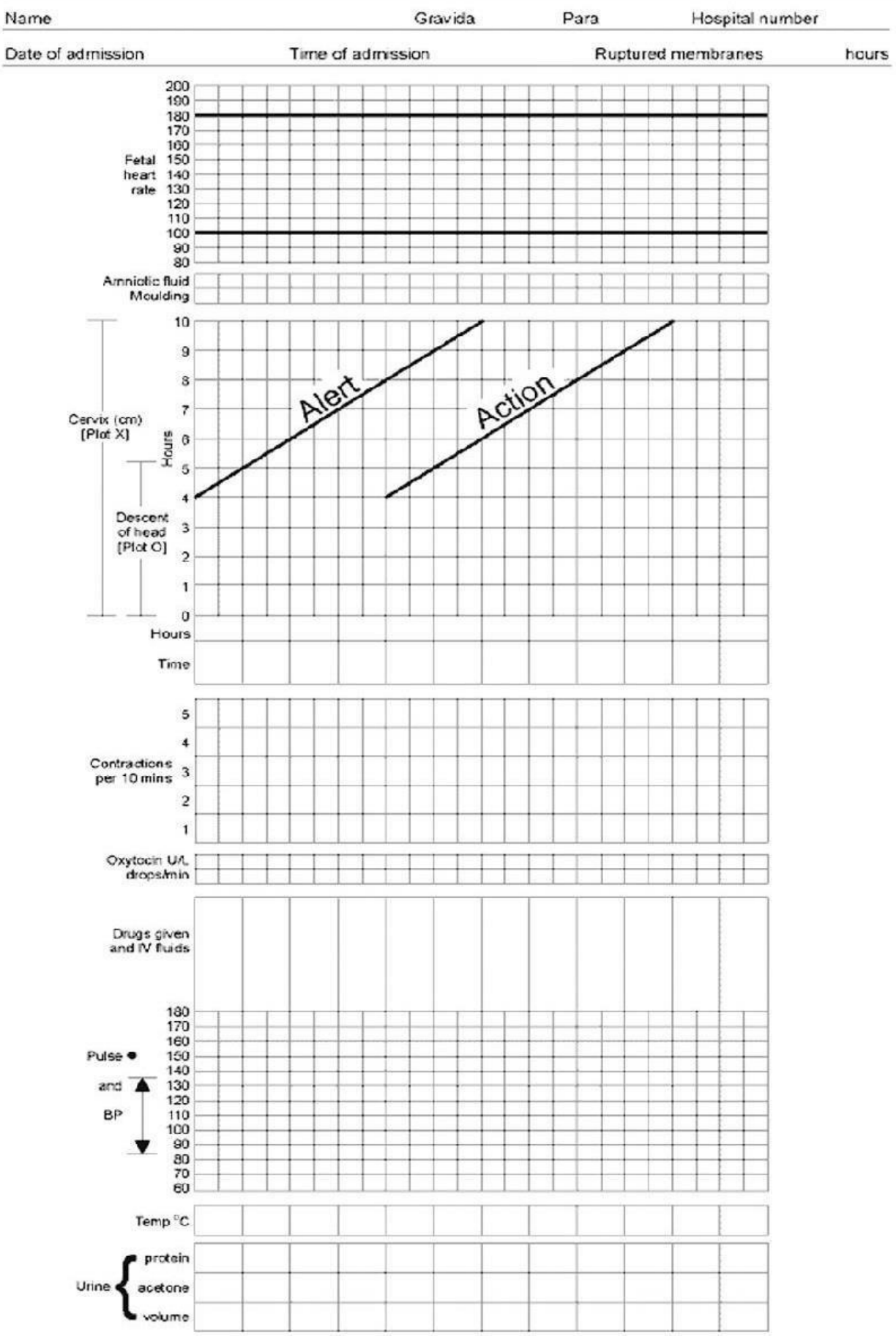
Activity 8d. Antenatal case history record

Activity 9a. Gynaecological case history record

Activity 9b. Gynaecological case history record

Activity 10a. Normal labor case record

WHO modified Partograph



WHO LABOUR CARE GUIDE

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N															
	Pain relief		N															
	Oral fluid		N															
	Posture		SP															
BABY	Baseline FHR		<110, ≥160															
	FHR deceleration		L															
	Amniotic fluid		M+++, B															
	Fetal position		P, T															
	Caput		+++															
	Moulding		+++															
WOMAN	Pulse		<60, ≥120															
	Systolic BP		<80, ≥140															
	Diastolic BP		≥90															
	Temperature °C		<35.0, ≥ 37.5															
	Urine		P++, A++															
LABOUR PROGRESS	Contractions per 10 min		≤2, >5															
	Duration of contractions		<20, >60															
	Cervix [Plot X]	10																
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		7	≥ 3h															
		6	≥ 5h															
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MEDICATION	Oxytocin (U/L, drops/min)																	
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	PLAN																	
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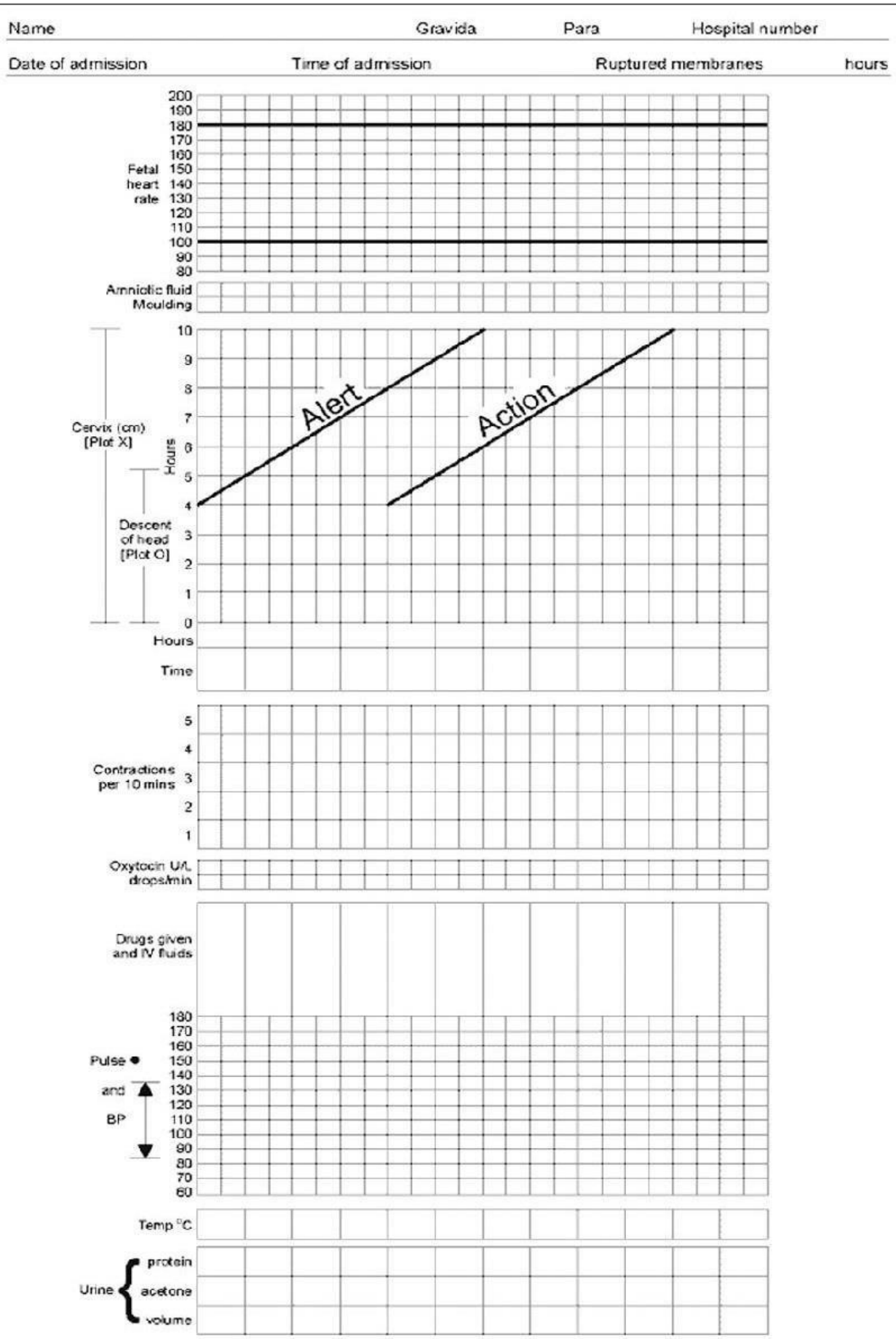
Activity 10b. Normal labor case record

WHO Modified Partograph



WHO LABOUR CARE GUIDE

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N																
	Pain relief		N																
	Oral fluid		N																
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BABY	Baseline FHR		<110, ≥160																
	FHR deceleration		L																
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WOMAN	Pulse		<60, ≥120																
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	Diastolic BP		≥90																
	Temperature °C		<35.0, ≥ 37.5																
	Urine		P++, A++																
LABOUR PROGRESS	Contractions per 10 min		≤2, >5																
	Duration of contractions		<20, >60																
	Cervix [Plot X]	10																	
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		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

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Activity 11a: Obtaining a Pap smear in a simulated environment

- **Steps of taking Pap Smear:**

Activity 11b: Obtaining a Pap smear in a simulated environment

- **Steps of taking Pap Smear:**

Activity 12: Counseling for breast feeding in a simulated environment

Activity 13: Counseling for contraception in a simulated environment

Activity 14: Caesarean Section and informed consent

Activity 15: Insertion and removal of an IUCD

Activity 16: Newborn resuscitation

- **Steps of Neonatal Resuscitation**

Activity 17: Mechanism of conduct of normal delivery and assisted breech vaginal delivery in a simulated environment

SCORE CARD (PHASE III, Part 2)

Name of activity	Date of activity completed (DD/MM/YY)	Attempt at Activity (F, R, Re)	Rating (B,M,E)	Decision of Faculty (C, R, Re)	Initial of faculty	Feedback Initial of learner and date
8a. Antenatal case history record						
8b.Antenatal case history record						
8c.Antenatal case history record						
8d.Antenatal case history record						
9a.Gynaecological case history record						
9b.Gynaecological case history record						
10a. Normal labor case record						
10b. Normal labor case record						
11. Obtaining a Pap smear in a simulated environment						
12. Counseling for breast feeding in a simulated environment						
13. Counseling for contraception in a simulated environment						
14. Caesarian section and informed consent						
15. Insertion and removal of an IUCD						
16. Newborn resuscitation						
17. Mechanism of conduct of normal delivery and assisted breechvaginal delivery in a simulated environment						

Appendix 1

Antenatal Case Record

Patient Identification Data and Demography:

Date:	ANC Reg no:
Name	Husband's name :
Age	Husband's Age
Educational status :	Educational status :
Occupation:	Occupation:
Address :	
Socioeconomic status:	
Booked/Un-booked:	

Chief Complaints:

History of Present Complaints:

History of present pregnancy: (Trimester-wise)

Status of vaccination:

Daily Calorie intake:

Deficit, if any:

Appetite

Bladder

Bowel

Addiction

Domestic Violence

Drug History/ Medication History:

Any Allergies:

Past History:

Medical : Tuberculosis/Epilepsy/Any Other Chronic Illness ; Blood transfusion

History of any Surgery:

General Examination:

Built: Average/Poor/Well

Height: _____ Cms BMI:_____

Weight: _____ Kgs

PR:

RR:

BP:

Pallor:

Edema:

Icterus:

Thyroid :

Breast Examination:

Lymphadenopathy:

Systemic Examination:

Cardiovascular system:

Respiratory system:

Nervous system:

Obstetrical Examination :

Inspection:

Contour of abdomen Flanks : full/not full

Umbilicus: Central/Displaced Inverted/Everted/Flat

Linea nigra: Stria gravidarum:

Any abnormal veins:

Any scar mark

Palpation

Fundal height in weeks:

Symphysio-Fundal Height in centimetres: _____

Abdominal Girth in inches: _____

Fundal Grip:

Right Lateral Grip:

Left Lateral Grip:

1st Pelvic Grip:

2nd Right Lateral Grip:

Uterine contractions: _____ in 10 minutes

Auscultation:

Location, Rate, Rhythm of Fetal Heart Sound

Interpretation based on palpation

Number of fetuses

Lie

Presentation

Liquor: increased/average/reduced

Uterus: relaxed/ contractions if present describe frequency, duration and intensity

Per speculum examination: (if indicated)

Per vaginal examination: (when indicated)

Pelvimetry: (if indicated)

Provisional Diagnosis :

Investigations:

Hb:

ABO Rh:

Urine routine, microscopic:

HIV: (both H&W) HBsAg: (both H&W) VDRL: (both H&W)

OGTT 1st 75 gm:

OGTT 2nd 75 gm:

Thyroid Profile:

Urine culture:

Imaging (USG):Date

Others :

Risk factors identified:

Final diagnosis:

Summary:

Advice:

Follow up :

Plan of delivery:

Appendix 2

Gynecology Case Record

Patient identification data & demography:

Name: Date:

Age:

Address:

Mobile Number:

Consultant Incharge:

Occupation:

Educational status

Income:

Registration Number:

Chief Complaints:

History of Presenting Illness:

History of Past Illness:

Tuberculosis / Hypertension/ Diabetes
Any other relevant Medical History
Any other relevant Surgical History

Personal History:

Diet
Sleep
Appetite
Bladder and Bowel
Addiction

Family History:

Tuberculosis / Hypertension/ Diabetes
Malignancy
Hereditary disease
Others:

Menstrual History:

Cycles: regular/ irregular
Age of Menarche
Frequency of cycle
Amount and duration of flow
Dysmenorrhoea
Other complaints
Last Menstrual Period:

Obstetrical History:

General Examination

General condition:
Pulse:
Temperature:
Blood Pressure :
Respiratory Rate:
Pallor:
Icterus:
Lymphadenopathy:
Cyanosis:
Clubbing:
Pedal Edema:
Thyroid Examination:
Breast Examination:
Spine and gait

Systemic Examination

Respiratory System:

Cardiovascular System:

Central Nervous System:

Per Abdomen Examination

Inspection:

Palpation:

Percussion:

Auscultation:

Local Genital Examination

Per Speculum Examination

Vagina:

Cervix:

Discharge:

If any evidence of utero-vaginal descent perform relevant examintion:

Per Vaginal Examination

Uterus

Size: Normal/ Enlarged, Symmetrical/ Asymmetrical

Direction: Anteverted/ Retroverted

Mobility: Freely Mobile/ Restricted / Fixed

Cervix:

Fornices: free /fullness, tender/ non tender

Right Adnexa: If any mass is felt through the fornices, describe the mass

Left Adnexa:

Pouch of Douglas:

Uterosacral ligaments:

Per-Rectal Examination (if required):

Provisional Diagnosis

Differential Daignosis

S No.	Diagnosis	Points for	Points Against

Investigations:

CBC:
Urine routine and microscopic examination:
Blood group:
HIV :
HBS Ag :
RFT:
LFT:
Blood Sugar :
Urine culture:
Pus culture:

Cervical swab:
Coagulation profile:
X- Ray Chest:
E.C.G:
Pap smear:
USG Abdomen and Pelvis:
CT Scan:
MRI:
Cytology/ FNAC/ Cell Block:
Any other:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

Appendix 3
Labor Case Record

Patient Identification Data and Demography:

Date:	A NC Reg no:
Name	Husband's name :
Age	Age
Educational status :	Educational status :
Occupation:	Occupation:
Address :	
Socioeconomic status:	
Booked/Un-booked:	

Chief Complaints:

History of Present Complaints:

History of present pregnancy: (Trimester-wise)

Status of vaccination:

Menstrual History :

Age at Menarche :

Cycles: regular/ irregular, duration, frequency,

Mention if in lactation amenorrhea or breastfeeding

LMP:

EDD:

Gestational Age :

Obstetric History :

Duration of marriage:

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month & Year, gestational age at delivery	Any high risk factor in pregnancy	Mode of Delivery	Indication if CS or operative delivery	Baby Details (Sex/Apgar/ Weight)	Post partum complications If any	Baby vaccina-tion

Contraceptive History:

Family History:

Twin/Congenital Malformation/ Hypertension/Diabetes Mellitus/Any Other Chronic Illness

Personal History:

Vegetarian/Non-Vegetarian

Daily Calorie intake:

Deficit, if any:

Appetite

Bladder

Bowel

Addiction

Domestic Violence

Drug History/ Medication History:

Any Allergies:

Past History:

Medical : Tuberculosis/Epilepsy/Any Other Chronic Illness ; Blood transfusion

History of any Surgery:

General Examination:

Built: Average/Poor/Well

Height: Cms

Weight: Kgs

PR:

RR:

BP:

Pallor:

Edema:

Icterus:

Thyroid :

Breast Examination:

Lymphadenopathy:

Systemic Examination:

Cardiovascular system:

Respiratory system:

Nervous system:

Obstetrical Examination :

Inspection:

Contour of abdomen Flanks : full/not full

Umbilicus: Central/Displaced Inverted/Everted/Flat

Linea nigra: Stria gravidarum:

Any abnormal veins:

Any scar mark

Palpation

Fundal height in weeks:

Symphysio-Fundal Height in centimeters:

Abdominal Girth in inches:

Fundal Grip:

Right Lateral Grip:

Left Lateral Grip:

1st Pelvic Grip:

2nd Right Lateral Grip:

Superficial Pelvic Grip:

Deep Pelvic Grip:

Uterine contractions:

Auscultation:

Location, Rate, Rhythm of Fetal Heart Sound

Interpretation based on palpation

Number of fetuses

Lie

Presentation

Liquor: increased/average/reduced

Uterus: relaxed/ contractions if present describe frequency, duration and intensity

Per speculum examination: (if indicated)

Mention any swelling/ulcer/skin changes/vesicles

Per vaginal examination: (when indicated)

Cervix: length/dilatation/bag of membranes/discharge/leaking from cervical os/position of the cervix/consistency of cervix/ Status of membranes intact or ruptured

Station of head
Color of liqour if ruptured membranes
Presenting Part and station
Vagina: septum/growth/cyst/tag/dilated varcose veins
Discharge: color/smell/ amount/watery /blood mixed/purulent

Pelvimetry: (if indicated)

Sacral promontory
Anterior surface of sacrum and sacral curve
Side walls paralell or convergent
Sacrosciatic notches
Interischial diameter
Sub pubic angle
Transverse diameter of outlet
Any other finding

Provisional Diagnosis :

Investigations:

Hb:

ABO Rh:

Urine routine, microscopic:

HIV: (both H&W) HBsAg: (both H&W) VDRL: (both H&W)

OGTT 1st 75 gm:

OGTT 2nd 75 gm:

Thyroid Profile:

Urine culture:

Imaging (USG):Date

Others :

Risk factors identified:

Labor Notes:

Labor: Spontaneous / Augmented/Induced

If induced: ARM / Syntocinon / PG/ Foley's/ Prostaglandins

Indication of induction/augmentation:

Stages of Labour	Time Started	Time Finished	Duration Lasted
IV. Stage			
V. Stage			
VI. Stage			

Mode of Delivery:
Normal/Forceps / Ventouse/ Assisted Breech
If operative delivery then mention the indication

Date and Time:

Conducted By:

Assisted By:

Supervised By:

Examination of Placenta:

AMTSL:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
Cried Immediately after Birth- Y/N
Weight
APGAR Score at 1min
APGAR Score at 5min
NICU Admission
Duration of Stay In NICU

WHO LABOUR CARE GUIDE

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N																
	Pain relief		N																
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BABY	Baseline FHR		<110, ≥160																
	FHR deceleration		L																
	Amniotic fluid		M+++, B																
	Fetal position		P, T																
	Caput		+++																
	Moulding		+++																
WOMAN	Pulse		<60, ≥120																
	Systolic BP		<80, ≥140																
	Diastolic BP		≥90																
	Temperature °C		<35.0, ≥ 37.5																
	Urine		P++, A++																
LABOUR PROGRESS	Contractions per 10 min		≤2, >5																
	Duration of contractions		<20, >60																
	Cervix [Plot X]	10																	
		9	≥ 2h																
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y – Yes, N – No, D – Declined, U – Unknown, SP – Supine, MO – Mobile, E – Early, L – Late, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone