Logbook

(Undergraduate Competency Based Curriculum)

Surgery & Allied subjects

Logbook

Department of Surgery

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 of Surgery & Allied subjects 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 Report

Professional Year	Number attended	Number conducted	Percentage of Attendance	Signature of HOD
Second Professional				
Third professional- part I				
Third Professional Part II				

Small group session

Professional Year	Number attended	Number conducted	Percentage of Attendance	Signature of HOD
Third professional- part I				
Third Professional Part- II				

Bedside clinics

Professional Year	Unit From (date) To (date)	Number attended	Number conducted	Percentage of Attendance	Signature of Unit Head	Signature of HOD
Second Professional Posting 1						
Third Professional Part I Posting 2						
Third Professional Part II Posting 3						
Posting 4						

PHASE II

CLINICAL POSTING 1 (4 WEEKS)

Duration: From……to…….

UNIT:

Planned Activities:

1.	Overview of History taking
2.	Overview of General survey
3.	Assessment of Vital signs
4.	History taking of Gastrointestinal system
5.	Examination of Abdomen
6.	History taking of Genitourinary system
7.	CNS (history taking and examination)
8.	Examination of Higher mental function and speech, Cranial nerves, Motor system, Sensory system, Cerebellum, spine
9.	Learner doctor method

Learner doctor method

- One patient will be allotted to the student at the beginning of the clinical posting.
- The patient will be assessed at the admission and follow up.
- The student will take notes on the following aspects of patient's progress in hospital.
  (History taking, physical examination, assessment of change in clinical status, communication and patient education)

Case1	Case 2	Case 3

Signature of learner

Signature of faculty

Date:

List of clinical cases presented/attended in posting 1

Sl. No.	Diagnosis	System

Signature of learner **Signature of faculty**

Date:

PHASE III
PART 1

CLINICAL POSTING 2 (4 WEEKS)

Duration: From……to…….

UNIT:

Bedside Clinics in Surgery

Competencies Addressed	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
1. Demonstrate and document the correct clinical examination of thyroid swellings and discuss the differential diagnosis and their management						
2. Demonstrate the correct technique to palpate the breast for breast lump on a patient						
3. Demonstrate the correct examination of the lymphatic system						
4. Demonstrate and document the correct clinical examination of swelling in the submandibular region and discuss the differential diagnosis and management						
5. Demonstrate and document the correct clinical examination obstructive jaundice and discuss the differential diagnosis and their management						

TUTORIALS in Surgery

Competencies Addressed	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
1. Operative Procedure Superficial Parotidectomy						
2. Specimen : Thyroid						
3. Operative Procedure :Thyroidectomy						
4. Instruments: Suture Materials And Needles						
5. INSTRUMENTS: General Surgical Instruments						
6. Operative Procedure : Feeding Jejunostomy						
7. Chest X-Ray						
8. Instruments: Drains						
9. Operative Procedure : Modified Radical Neck Dissection						
10. Operative Procedure : Intercostal Drainage						

SEMINARS Presented

Competencies Addressed	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
1. Surgical Wound Closure and Anastomosis (Sutures, Knots And Needles)						
2. Cleft Lip and Palate						
3. Thyroid Cancer						
4. Hyperparathyroidism						
5. Surgical Wound Closure and Anastomosis(Sutures, Knots And Needles)						
6. Congenital heart disease						

Learner doctor method

- One patient will be allotted to the student at the beginning of the clinical posting.
- The patient will be assessed at the admission and follow up.
- The student will take notes on the following aspects of patient's progress in hospital.
  (History taking, physical examination, assessment of change in clinical status, communication and patient education, choice of investigations, basic procedures and, continuity of care)

Case1	Case 2	Case 3

Signature of learner

Signature of faculty
Date:

List of clinical cases presented/attended in posting 2

Sl. No.	Diagnosis	System

Signature of learner **Signature of faculty**

Date:

Small group discussions

Sl. No.	Topic	Date of Activity	Presented/Observed	Faculty signature

PHASE III
PART 2

CLINICAL POSTING 3 (8WEEKS)

Duration: From……to…….

UNIT:

Bedside Clinics in Surgery

Competencies Addressed	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
1. Demonstrate the correct technique to examine the patient with disorders of stomach.						
2. Describe and demonstrate clinical examination of abdomen. Order relevant investigations. Describe and discuss appropriate treatment plan.						
3. Demonstrate and document the correct clinical examination of thyroid swellings and discus the differential diagnosis with management.						
4. Demonstrate the correct examination of the vascular system and enumerate and describe the investigations of vascular disease.						
5. Describe the applied anatomy, clinical features, investigations and principles of management of Hydrocele.						
6. Demonstrate the correct technique to palpate the breast for breast swelling in a mannequin or equivalent.						
7. Counsel the patient and obtain informed consent for treatment of malignant conditions of the breast.						
8. Demonstrate the correct technique to examine the patient with hernia and identify different types of hernias.						

Clinical posting activities (8+4 weeks)

Place	Activities
OPD	• Observe and record new and follow up cases in OPD(3hrs)
Post Admission day ward rounds	• Follow up of assigned cases(1hr) • Bedside clinics, SGD, DOAP (1hr) • SDL, Discussion and closure (1hr)
OT	• Observe OT procedures and document in the logbook with Discussion(3hrs)
Ward	• Follow up of assigned cases(1hr) • Bedside clinics, SGD, DOAP(1hr) • SDL, Discussion and closure (1hr)
Ward	• Follow up of assigned cases(1hr) • Bedside clinics, SGD,DOAP(1hr) • SDL, Discussion and closure (1hr)
Ward	• Follow up of assigned cases(1hr) • Bedside clinics, SGD, DOAP(1hr), • SDL, Discussion and closure (1hr)

TUTORIALS

Sl. No.	Topics	Date of activity	Faculty feedback (Present/ Attended)	Signature of Faculty
1	Specimen: Carcinoma Breast			
2	Operative procedure: Modified Radical Mastectomy			
3	X-Ray: Mammogram			
4	Specimen: Appendix			
5	Operative procedure: Appendectomy			
6	X-Ray: Erect Abdomen			
7	Instruments: Retractors			
8	Instruments: Dissecting instruments			
9	Specimen: Testicular tumor			
10	Operative procedure: Orchidectomy			
11	Specimen: Hydatid cyst			
12	Specimen: Gall stones			
13	Specimen: Urinary calculi			
14	X-Ray: KUB			
15	Specimen: Carcinoma colon			
16	Operative procedure: Hemi colectomy			
17	X-Ray: Intestinal obstruction			
18	Specimen: Carcinoma Rectum			
19	Operative procedure: APR			
20	Specimen: Carcinoma Stomach			
21	Operative procedure: Billroth 2			
22	X-Ray: Hollow viscus perforation			
23	Instruments: intestinal clamps			
24	Specimen: Trichobezoar			
25	Operative procedure: Gastrostomy			
26	Specimen: Hydronephrosis			
27	Operative procedure: TURP			
28	X-Ray: IVP			
29	Specimen: RCC			
30	Operative procedure: Jaboulay's procedure			

SEMINAR

Sl. No.	Topics	Date of activity	Faculty feedback (Present/ Attended)	Signature of Faculty
1	Testicular tumors			
2	Carcinoma penis			
3	Benign prostatic hypertrophy			
4	Carcinoma prostate			
5	Renal tumors			
6	Ano rectal diseases			
7	Appendicitis			
8	Biliary disorders			
9	Peptic ulcer disease			
10	Carcinoma stomach			
11	Inguinal hernia			
12	Carcinoma breast			
13	Benign breast disease			
14	Pancreatitis			
15	Organ transplantation			
16	Carcinoma bladder			
17	Urolithiasis			
18	Hepatocellular carcinoma			
19	Occlusive arterial disease			
20	Varicose viens			
21	Carcinoma stomach			
22	Gall bladder stone			
23	Hydrocele			
24	Cholecystitis			

Learner doctor method

- One patient will be allotted to the student at the beginning of the clinical posting.
- The patient will be assessed at the admission and follow up.
- The student will take notes on the following aspects of patient's progress in hospital.

  (History taking, physical examination, assessment of change in clinical status, communication, patient education, choice of investigation, basic procedures, continuity of care, decision making, management and outcome)

Case1	Case 2	Case 3

Signature of learner

Signature of faculty
Date:

List of clinical cases presented/attended/participated in case discussions in posting 3

Sl. No.	Diagnosis	System

Signature of learner **Signature of faculty**

Date:

Small group discussions

Sl. No.	Topic	Date of Activity	Presented/ Observed	Faculty signature

CLINICAL POSTING 4 (4WEEKS)

Duration: From……to…….

UNIT:

List of clinical cases presented/attended/participated in case discussions in posting 4

Sl. No.	Diagnosis	System

Signature of learner **Signature of faculty**

Date:

Small group discussions

Sl. No.	Topic	Date of Activity	Presented/ Observed	Faculty signature

Self-directed learning sessions

Sl. No.	Topic	Date of Activity	Participated	Faculty signature

Expected AETCOM Competencies

Expected Competencies	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
1.						
2.						
3.						
4.						
5.						
6.						