LOG BOOK

Residency training program

MS (Cardiovascular & Thoracic Surgery)

Discipline: Cardiovascular & Thoracic Surgery

Faculty: Surgery

Bangabandhu Sheikh Mujib Medical University

Shahbag, Dhaka

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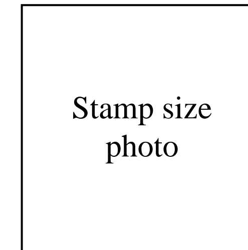
Personal details of the Resident



Name of the resident:

University Registration No.:

BMDC Registration No:

Date of entry in the program:

Session:

Date of birth:

Father's name:

Mother's name:

Address for communication:

Permanent address:

Telephone No.

E-mail:

Nationality:

National ID No.

Passport No. (For foreign student)

Profile of the teachers/supervisors

Name	Designation	Discipline	Specimen Signature	Specimen Initial

General information

1. The log book (Daily Training Record) is a day to day record of the clinical and academic works done by the resident
2. The log book will be a pre-requisite for appearing in the phase I summative examination
3. This log book has to be maintained by all the residents throughout the period of training
4. The resident will obtain the log book from the course-coordinator of the parent discipline immediately after joining
5. The resident will make the required entries in the logbook on the same day of the event and get it signed by the supervisor
6. It is the responsibility of the resident to keep the logbook safe and secured
7. Entries in the log book will be block-wise

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 in Surgery before entering the final part (part B). In this context it is expected that the students will be able to (i) acquire knowledge [of common surgicall conditions, emergencies, & rehabilitations], (ii) acquire skills [diagnostic, clinical and decision making] and (iii) develop attitude [caring, learning, & ethical]. The components of the objectives are as follows: The resident should

- acquire sufficient theoretical knowledge (the "core" knowledge defined in the syllabus)
- be able to take full history and be competent in performing a full physical examination
- formulate a working diagnosis
- decide whether the patient requires ambulatory care or hospitalization or referral to other health professionals
- become competent in interpreting and evaluate the presenting symptoms and physical signs
- be able to interpret and evaluate the laboratory reports lying with the patients
- to know the cardinal features of disorders commonly encountered in clinical practice
- plan investigations and interpret them
- formulate management plan for common surgical condition
- decide and implement suitable treatment
- maintain follow up of patients
- maintain records of patients
- present the patient's clinical data in both detailed and salient form highlighting the problem(s).
- competent and confident enough to handle common emergencies and common chronic conditions including rehabilitation

- develop skill of good prescribing
- establish appropriate doctor-patient relationship
- be able to maintain the ethical and professional standard
- be able to advise the community on promoting health and preventing illness
- well conversant with commonly prescribed drugs
- develop sufficient expertise in performing the enlisted procedures:[the list is not exhaustive and the level of performance may vary]

  1. Aseptic principles and practices with emphasis on hand wash and universal precaution
  2. Basic Surgical Skills [Knot tying, Suturing, Anastomosis, Haemostasis, Wound management]
  3. Pleural fluid aspiration
  4. Abdominal paracentasis
  5. Nasogastric tube placement
  6. Urethral Catheterization
  7. Venepuncture
  8. Fingerstick blood sugar testing & Blood glucose monitoring
  9. Arterial blood gas sampling
  10. Pulse oximetry
  11. Use of nebuliser
  12. Various routes of drug administration
  13. Cannula insertion
  14. Collection, storage and transportation of pathological specimens with accompanying notes
  15. Water seal drainage
  16. Spirometry & Lung function test
  17. Electrocardiography
  18. Echocardiography
  19. Cardiac catheterization & Coronary angiography
  20. Plain and contrast CXR, CT scan and MRI of the chest
  21. CV line insertion
  22. Insulin and infusion pump
  23. CPR/BLS and endotracheal intubation
  24. Peritoneal dialysis
  25. Safe blood transfusion

- Be able to interpret the following lab data and investigation reports

1. ECG
2. X-ray
3. CT scans of chest/CT Angiogram
4. MRI/ MRA
5. Electrolyte reports (Blood & urine)
6. ABG Analysis
7. Echocardiography, Cardiac catheterization, CAG/PAG
8. Duplex Study of carotid & peripheral vascular disease
9. Renal function test
10. Liver function test
11. Urine R/M/E & CS
12. Coagulation profile
13. Barium studies of upper GIT
14. Ultrasonography
15. Blood Culture
16. Tuberculin test
17. Thyroid function test
18. Thyroid screening test
19. Viral markers of hepatitis
20. Immunological tests for collagen vascular disease
21. Thyroid related Immunoglobulin

The objectives of the training may be achieved through different modes like

- Ward duties
- Emergency duties
- OPD duties
- Academic sessions: Journal club, clinical meeting, Grand round, Case presentation session, Morbidity/mortality review meeting/medical audit
- Seminars, conferences, workshops
- Lectures
- Bed side teaching
- Tutorials
- Small group discussions

Rotations for the Residents of MS (Cardiovascular & Thoracic surgery)

Section A: Case records (POMR) of the patients managed by the resident

Block…………………………………………………………………….

Supervisor………………………………………………………………..

SL. No.	Date	Name of patient (age & sex)	Date of admission with hospital Reg. No., Ward & Bed No	Diagnosis/ Problem	Grading	Signature of supervisor
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Grading: Excellent: 4, good: 3, satisfactory: 2, unsatisfactory: 1

Section B: Procedures

Block…………………………………………………………….

Supervisor…………………………………………………………

Sl. No.	Date	Name of patient with age & sex	Diagnosis/Indication	Procedure performed	Performance of the candidate	Signature of supervisor
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Key for performance of the candidates:

- Observer status - O
- Assistant status - A
- Performance under supervision - Ps
- Performed independently - PI

Section C: OPD consultation

Block…………………………………………………………….

Supervisor…………………………………………………………

SL. No.	Date	Patients Name, age, Sex with Hospital Reg. No.	Consultation	Problem/diagnosis	Management	Signature of the supervisor
1.			1st FU			
2.			1st FU			
3.			1st FU			

Section C: OPD consultation

Block…………………………………………………………….

Supervisor………………………………………………………….

SL. No.	Date	Patients Name, age, Sex with Hospital Reg. No.	Consultation	Problem/diagnosis	Management	Signature of the supervisor
4.			1st FU			
5.			1st FU			
6.			1st FU			

Section C: OPD consultation

Block…………………………………………………………….

Supervisor………………………………………………………….

SL. No.	Date	Patients Name, age, Sex with Hospital Reg. No.	Consultation	Problem/diagnosis	Management	Signature of the supervisor
7.			1st FU			
8.			1st FU			
9.			1st FU			

Section C: OPD consultation

Block…………………………………………………………….

Supervisor………………………………………………………….

SL. No.	Date	Patients Name, age, Sex, with Hospital Reg. No.	Consultation	Problem/diagnosis	Management	Signature of the supervisor
10.			1st FU			
11.			1st FU			
12.			1st FU			

Section D: Emergency encountered

Block…………………………………………………………….

Supervisor………………………………………………………….

Sl. No.	Date	Name of the patients (age & sex), ward, Bed, PIN	Problem/Diagnosis	outcome	Signature of the supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Section E: Journal clubs

Block…………………………………………………………….

Supervisor………………………………………………………….

Sl. No.	Date	Topic/article	Source/ Re-source person	Performance level	Signature of supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Key for performance of the candidates:

Attended - A
Presented himself – PH

Section F: Case presentation in clinical meeting, grand & ward round

Block…………………………………………………………….

Supervisor………………………………………………………….

Sl. No.	Date	Patient's name (age & sex) Ward/bed, PIN	Diagnosis/ Problem	Level of performance	Signature of supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Key for performance of the candidates:

Attended – A
Presented himself – PH

Section-G: Case based learning

Block-

Supervisor-

Date	Case	Learning	Comment	Signature of Supervisor

Section-H: Soft Skill

Block-

Supervisor-

Serial No	Soft Skill	Performance	Signature of Supervisor	Remarks

Key for performance of the candidate:
Observer status-
Assistant status-
Performed under supervision
Performed Individually-

Section I: Presentation/attendance in seminars, symposium/workshops, conferences.

Block…………………………………………………………….

Supervisor………………………………………………………….

Sl. No	Date	Topic/article	Source/Re-source person	Performance level	Signature of supervisor
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Key for performance of the candidates:

Attended - A

Presented himself – PH

Section J. Lectures attended

Block……………………………………………………………………………………………

Supervisor…………………………………………………………………………………

Sl. No.	Date	Topic	Lecturer	Signature

Section K. Interpretation of lab data and investigation reports

Block…………………………………………………………….

Supervisor………………………………………………………….

Sl. No.	Items	Abnormality	Interpretation	Signature of supervisor

Section L. Leave record

Duration	From	To	Reason	Signature of Supervisor

Section M. Summary Records: PAY1

Events	Performed					Signature of the Year-manager1
	Block 1	Block 2	Block 3	Block 4	Total	
A) Case records(POMR)						
B) Procedures						
C) OPD consultation						
D) Emergency encountered						
E) Journal clubs						
F) Case presentation in clinical meeting, grand & ward round						
G) Case Based Learning						
H) Soft Skills						
I) Presentation/ attendance in seminars, symposium/ workshop, conferences						
J) Lectures attended						
K) Data Interpretation						

Section N. Summary Records: PAY2

Events	Performed					Signature of the Year-manager2
	Block 1	Block 2	Block 3	Block 4	Total	
A) Case records(POMR)						
B) Procedures						
C) OPD consultation						
D) Emergency encountered						
E) Journal clubs						
F) Case presentation in clinical meeting, grand & ward round						
G) Case Based Learning						
H) Soft Skills						
I) Presentation/ attendance in seminars, symposium/ workshop, conferences						
J) Lectures attended						
K) Data Interpretation						

Section O. Summary Records: Phase- A completion

Events	Performed			Signature of the Course coordinator
	PAY1	PAY2	Total	
A) Case records(POMR)				
B) Procedures				
C) OPD consultation				
D) Emergency encountered				
E) Journal clubs				
F) Case presentation in clinical meeting, grand & ward round				
G) Case Based Learning				
H) Soft Skills				
I) Presentation/ attendance in seminars, symposium/ workshop, conferences				
J) Lectures attended				
K) Data Interpretation				

Section P. **CERTIFICATE OF ACCURACY**

I certify that the information contained in the Logbook (Daily Training Record) is a true and accurate record of my training experiences.

Trainee's signature: .... Date: ....

Section Q. CERTIFICATION of satisfactory completion of the log book

I, to the best of my knowledge, certify that

Dr. ………

has satisfactorily completed this logbook as required by the university

……………………………………………….
Signature of the Course coordinator

Name:

Discipline:

Date:

Portfolio

One in 1st block:

- Quality improvement plan

One in each block:

- Best Case Note (POMR)
- Best referral letter
- Best discharge summary

Assignment

- Reflective essay
- SDL plan
- Case based learning exercise
- problem solving Exercise
- Reflective Case study
- Critical incident report
- presentation in
  - Seminar
  - Symposium
  - Workshop
  - Clinical meeting
  - grand round
  - Journal club

At least one in whole phase-A

- Best procedure log performed
- written/audio record of a communication
- Case report.

Optional:

- Research report/summary
- Contribution to department/University/society
- Patient education material
- Drug information
- Soft ware, algorithm
- Diary of learned materials by date (continuous thought Phase-A)

- Use captioning
- Storage & Filing should be
  - Orderly chronologically
  - Records need face up.