PHILOSOPHY BEHIND, AND GUIDELINES FOR, THE USE OF THIS LOG BOOK

The central philosophy of the log book is to direct clinical skills acquisition by trainees in a structured quantifiable manner. The onus is on the trainee and his/her trainers not only to perfect the stated skills but also to study around the underlying principles. This log book is designed to document and monitor the clinical skills competencies of trainees during the prescribed period of training prior to presenting for the Part 1 Fellowship examination in Paediatrics.

The log book is based on the contents of the Curriculum. It is the responsibility of training institutions seeking accreditation for training to provide facilities that will ensure that trainees are exposed to all the contents of the log book. Availability of a minimum number of the resources and facilities for procedures included in this log book will guide the accreditation status to be attained by training institutions.

All members of the Faculty, including Fellows, Trainers and Trainees must ensure that this log book is conscientiously utilized to monitor the progress and training of Residents in order to achieve excellence in our chosen specialty. **The use of the log book is guided by the principles of honesty, openness, accountability and transparency. Its abuse, as a mere 'access document' or object of patronage of residents by Consultants, must be avoided by all concerned. It could also be used to monitor the appropriateness of assessment by trainers.** Properly used, the log book should be a guide to both residents and consultants on the progress and state of preparedness of the individual resident at any point in time, and the collective effectiveness of the programme in the particular institution, over a given period. *Regular formative evaluation (observation of performance and specific feedback) of clinical skills should be an integral part of resident's clinical postings. This will ensure that the residents' ultimate performance at summative examinations will correctly reflect the trainer's assessment grades as documented in the log book.* Activities should be graded as soon as possible after performance to ensure accurate assessment.

1. Upon commencement of residency training, each Resident must obtain the log book. It is the responsibility of the Resident to ensure that it is kept safe and intact throughout the period of training.
2. It is the Resident's responsibility to document acquired skills in the log book.
3. When he thinks he has acquired a requisite level of knowledge and competence in each subject area, it is the responsibility of the Resident to present himself to the Consultant/Trainer for Assessment.

4. The Consultant will then assess the Resident and complete the necessary column in respect of his own judgment as to the level of competence demonstrated by the Resident and sign his/her name in the appropriate column.
5. It is important that the assessment takes place continuously throughout the posting. Both Resident and Consultant must avoid a situation where this log book is completed in a rush in the last days of the posting.
6. Depending on the institution's accreditation status, it is expected that if a procedure is not available in your department you should arrange to have it done, assessed and signed up elsewhere.
7. If there are competency areas identified, taught and assessed in a particular training institution that is not contained in the log book, the Programme Coordinator could add on such areas in the blank pro-forma.
8. The log book will therefore serve as evidence of training and will be used in determining the readiness of a resident for examinations. Thus, using the guidelines for grading / scoring, the trainee and his/her trainers should be able to assess the logbook for themselves ever before submission.
9. It is expected that the logbook should be submitted to College along with the examination form.
10. Residents are advised to collect and start filling another logbook after submission of the first one.

NOTE TO SUPERVISING CONSULTANTS

Resident's clinical postings are viewed holistically, from the points of view of the learner, the patient, other health professionals in the Health team, the training institutions, the teachers, the assessors (examiners) and the Faculty/ College. Please rate the performance of the trainee for the procedure(s) or competencies carried out under your supervision **fairly** and **sincerely**. Kindly use the prescribed rating below. This involves an assessment of the trainee's knowledge of the principles and practice of an index procedure, as well as the competence and dexterity of the trainee in carrying out the procedure. Five levels of grading are recommended. These grades are also applicable to the sections involving formal assessment:

SCORING OF COMPETENCIES

A=Performance impeccably meets standards (Excellent)

B=Performance is very good (Very good)

C=Performance meets standards (Good)

D= Performance below standards (Below average)

E= Performance well below standards (Poor)

VALIDITY PERIOD: The completed log book will remain valid for a period of 24 months from date of submission.
Secretary, Faculty Board of Paediatrics

CORE LEVELS OF COMPETENCES TO BE EVALUATED. The core levels of competence to be evaluated in this log book include:

A. PROFICIENCY IN HISTORY TAKING SKILLS
B. PROFICIENCY IN PHYSICAL EXAMINATION IN DIFFERENT CONTEXTS
C. CLINICAL SUMMARY MAKING
D. CLINICAL REASONING
E. MANAGEMENT ORDERING AND INSTRUCTIONS
F. LEGIBLE DOCUMENTATION
G. UNIT CASE PRESENTATION
H. PRACTICAL PROCEDURES AND INVESTIGATIONS
I. DIAGNOSTIC PROCEDURES
J. THERAPEUTIC PROCEDURES
K. ESSAYS
L. ACADEMIC ACTIVITIES

A. Proficiency in History Taking Skills, with particular emphasis on;

a. Courtesy to subject / persons involved in history taking.
b. Mastery of, and compliance with, the sequence of history taking.
c. Thoroughness and timeliness in enquiry of each aspect of history.
d. Appropriateness and congruence of affect to the context of history taking.
e. In-process appreciation of the value of information obtainable from each aspect of history.
f. Explanation of the need for, and value of direct questioning for review of systems.

	SPECIFIC ASPECTS OF HISTORY	**Score**	**Supervisor's Name**	**Signature**
i	Subjects Identity [Bio-social data]			
ii	Presenting Complaints [PC]			
iii	History of Presenting Complaints [HPC]			
iv	Treatment History			
v	Past Medical History			
vi	Pregnancy and Delivery History			
Vii	Neonatal History			
viii	Nutritional History			
ix	Immunization History			
x	Developmental History			
xi	Pre-morbid Personality			
xii	Family and Social History			
xiii	Review of Systems			
xiv	Totality of History			

B. **Proficiency in Performance of Physical Examination in different Contexts: ability to:**

a. Exhibit appropriate courtesy to subject / persons involved in the physical examination
b. Obtain informed consent for skill performance
c. Sequentially and correctly perform a gentle flowing examination
d. Be thorough and timely in the performance of each segment of examination
e. Exhibit appreciation of the value of information obtainable from each aspect of examination

	SPECIFIC EXAMINATION AS DESIRED	Score	Supervisor's Name	Signature
i	General examination only			
ii	Central Nervous System only			
iii	Cardiovascular system only			
iv	Digestive System only			
v	Endocrine system only			
vi	Genitourinary system only			
Vii	Haematologic system only			
viii	Musculoskeletal system only			
ix	Respiratory system only			
x	Combined Digestive and Genitourinary systems (Abdomen)			
xi	Combined Cardiovascular and Respiratory systems (Chest)			
xii	Combined Central nervous and Musculoskeletal systems			
xiii	Combined Endocrine and Haematologic systems			
xiv	Body Regions, Head, Neck, Mouth			
xv	Body Regions, Spine			
xvi	Body Regions, Perineum			
xvii	Body Regions, Limbs			
xviii	Body Organs, Ear (including Auroscopy), Nose, Throat			
xix	Body Organs, Eye (including Ophthalmoscopy)			
xx	Body Organs, Heart			
xxi	Body Organs, Liver			
xxii	Body Organs, Kidneys			
xxiii	Body Organs, Spleen			
xxiv	Body Organs, Skin			
xxv	Body Organs, Lymph nodes			
xxvi	Abnormal Masses, Solid, Cystic,			
xxvii	Developmental assessment			

C. Proficiency in Cohesive, Clinical Summary making

SPECIFIC ASPECT OF SUMMARY	Score	Supervisor's Name	Signature
Identify and quantify all symptoms obtained from presenting complaints, history of presenting complaints and review of systems			
Identify and quantify all other aspects of history obtained			
Identify and quantify all signs elicited			
Identify and interpret all bedside investigations carried out			
Discuss all or any part of the information immediately, at the bedside, or elsewhere			
Use the structured clinical summary and reasoning protocol			

D i. Group Clinical Reasoning Meetings

	CASE PRESENTED AND ANALYSED	DATE	RESIDENT'S SCORE	SUPERVISOR	SIGNATURE
1					
2					
3					
4					
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Dii. Scoring of Individual Resident's use of the Clinical Summary and Reasoning protocol in Group Clinical Reasoning Meetings

REASONING SEQUENCE	**Case no. 1**	**Case no. 2**	**Case no. 3**	**Case no. 4**	**Case no. 5**	**Case no. 6**
Patient's Name (Initials)						
Hospital number						
Date						
Number of Symptoms						
Other Aspects of History						
Number of Signs						
Bedside Investigations						
Systems Involved						
Pathologic Processes						
Structural Abnormalities						
Functional Abnormalities						
Functional Diagnosis						
Anatomic Diagnosis						
Pathologic Diagnosis						
Required Investigations						
Aetiologic Diagnosis						
Differential Diagnosis						
Required Treatment						
Other Interventions						
Preventive Measures						
Cumulative Score						
Consultant's Name						
Consultant's Signature						

Diii. Proficiency in Clinical Reasoning in different contexts

SPECIFIC ASPECT OF CLINICAL REASONING	Score	Supervisor's Name	Signature
Identify all important (positives first, significant negatives last) information obtained.			
Immediately appreciate the "big picture" (system & pathologic process) involved in disease			
Apply symptoms and signs to identify specific abnormal system or organ structure			
Apply symptoms and signs to identify specific abnormal system or organ function			
Relate identified abnormalities to known pathologies in diseased system ("big picture" in mind).			
Identify appropriate investigations that will confirm or exclude any relationships between obtained symptoms and signs			
Use epidemiologic knowledge to associate identified abnormality or pathology to aetiologic agents/factors			
Evaluate the correctness of the conclusions drawn by matching clinical evidence with diagnosis			
Project on the possible outcome of any interventions instituted			
Consider the Level of Prevention applicable for the case in view.			

E MANAGEMENT ORDERING AND INSTRUCTIONS

SPECIFIC INSTRUCTIONS	Score 1	Score 2	Supervisor 1	Supervisor 2	Signature 1	Signature 2
Blood transfusion (2)						
Exchange blood transfusion (2)						
Intravenous fluids for severe dehydration (2)						
Peritoneal dialysis (2)						
Monitoring in acute/chronic renal failure (2)						
Nutritional instructions in kwashiorkor (2)						
Monitoring in an unconscious child (2)						

F. LEGIBLE, ACCURATE, TIMELY, AND APPROPRIATE WRITTEN DOCUMENTATION.

SPECIFIC DOCUMENTATIONS	Score 1	Score 2	Supervisor 1	Supervisor 2	Signature 1	Signature 2
Full clerking (2)						
Clinical summary/reasoning sheet (2)						
Discharge summary (2)						
Referral letter writing (2)						
Response to referral letter (2)						
Mortality reports (2)						

G. UNIT CASE PRESENTATION

	CASE PRESENTED AND ANALYSED	DATE	SCORE	SUPERVISOR	SIGNATURE
1					
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H. PRACTICAL PROCEDURES AND INVESTIGATIONS

1. **By the end of the training period, trainees should be able to perform the following procedures confidently and competently and request the appropriate investigations. Trainees will:**

a. Know the appropriate indications for practical procedures and investigations.
b. Know the contraindications and complications of procedures.
c. Know the guidelines for obtaining informed consent.
d. Know the guidelines for undertaking investigations and procedures.
e. Know the guidelines for providing sedation and pain relief for practical procedures.
f. Know the relevant anatomical markers for procedures.
g. Know and practice scrupulous aseptic techniques.
h. Be aware of safety issues for patients and staff in relation to investigations of body fluids and radiation.
i. Be able to interpret results and respond appropriately.
j. Be able to record results and document procedures legibly and accurately.
k. Be able to give appropriate medical information when requesting investigations.
l. Know that results should be requested for and retrieved promptly.
m. Understand common age-appropriate normal ranges or appearances.
n. Be able to use all equipment required to undertake common procedures and investigations.
o. Be able to explain the investigation results to the parents and/or the child.
p. Be aware of the role of complex investigations e.g. Computerised Axial Tomography or Magnetic Resonance Imaging & their potential complications.
q. Be aware of the factors that are likely to influence the anxiety of the child, parent and doctor and know how to enlist the help of nursing and other staff (e.g. social workers) as well as more senior paediatric staff when necessary.
r. Be receptive to feedback from the patients and caregivers on the effect of medication/treatment.
s. Understand the importance of post mortem investigations and appreciate the socio-cultural factors at play in the local practice setting.
t. Know the guidelines for obtaining consent for post mortems.

2 Proficiency/Exposure in Investigative Procedures and Specimen Collection; ability to

a. Perform task correctly.
b. Interpret results correctly for self, parents and child.
c. Identify and discuss common points of error and indications for repeat testing.
d. Identify resources for quality control and verification of competence.
e. Discuss applications for general paediatrics, including analysis of strengths, limitations and costs.

	INVESTIGATIVE PROCEDURES AND SPECIMEN COLLECTION	Proficiency Required	Exposure Needed	Score	Supervisor' Name	Signature
	Collection techniques and proper handling for:					
i	Abscess fluid	X				
ii	Blood culture	X				
iii	Complete blood count with differentials	X				
iv	Conjunctival scraping		X			
v	Conjunctival swab,bacterial	X				
vi	Growth Hormone assay		X			
vii	Hair collection (tinea)	X				
viii	Joint fluid	X				
ix	Nasal smear for PMNs and Nasopharyngeal wash	X				
x	Newborn blood screen (PKU)	X				
xi	Pleural fluid	X				
xii	Rectal swab	X				
xiii	Sexual assault specimens	X				
xiv	Skin scrapings, fungal, scabies,	X				
xv	Spinal fluid	X				
xvi	Throat swab	X				
xvii	Tracheal aspirate (including child with tracheostomy)		X			
xviii	Thyroid function tests		X			
xix	Urethral culture, adolescent male	X				
xx	Vaginal and cervical cultures	X				
	Perform and interpret:					
xxi	Complete blood count with automated equipment & print out		X			
xxii	Complete blood count with differentials - with manual method	X				
xxiii	Smear for RBC morphology	X				
xxiv	Wright stain for WBC and platelets	X				
xxv	CSF cell count	X				
xxvi	Haematocrit and ESR	X				
xxvii	Gram stain: CSF, Urethral smear, Urine	X				
xxviii	KOH preparation: hair, skin, vaginal	X				
xxix	Nasal smear for PMNs	X				

xxx	Rapid tests: Group A strep antigen, Mononucleosis, Pregnancy,	X				
xxxi	Stool tests: occult blood, Wright stain for PMNs, ova, Pin worm,					
xxxii	Throat culture, selective media for Group A presumptive diagnosis	X				
xxxiii	Urinalysis, dipstick and microscopic, Urine culture colony count	X				
xxxiv	HIV screening (rapid test)	X				

I. DIAGNOSTIC PROCEDURES

By the end of the training period trainees should be able to perform the following diagnostic procedures independently:

Proficiency or Exposure to Diagnostic and Screening Procedures, implying ability to

a. Perform task correctly.
b. Interpret results for self, parents and child.
c. Identify and discuss common sources of error and indications for repeat testing.
d. Discuss applications for general paediatrics, including analysis of strengths, limitations and costs.

	DIAGNOSTIC AND SCREENING PROCEDURES	**Proficiency Required**	**Exposure Needed**	**Score**	**Supervisor's Name**	**Signature**
I	Attention Deficit Hyperkinetic Disorder; home & school questionnaires	X				
Ii	Anthropometric Assessment	X				
Iii	Behavioural screening questionnaire (Eyberg Child Behaviour Inventory)	X				
Iv	Blood pressure measurement, -Doppler, -Sphygmomanometer	X				
V	Blood Glucose estimation by glucometer	X				
Vi	Developmental Screening test	X				
vii	Language screening test (e.g., Early Language Milestone Screening Test)	X				
viii	Lung function tests (Peak Flow Rate)	X				
Ix	GIT endoscopy		X			
X	Gynaecologic examination, pre-pubertal, post-pubertal	X				
Xi	Hearing screening, general, pure tone audiometry	X				
xii	Interpretation of endocrine function tests	X				
xiii	Jejunal biopsy		X			
xiv	Oral Glucose Tolerance Test	X				
xv	Percutaneous liver biopsy		X			
xvi	Pleural biopsy		X			

xvii	Renal biopsy		X			
xviii	Skin fold thickness measurement	X				
xix	Tuberculin Skin Test	X				
xx	Tympanometry		X			
xxi	Urethral catheterisation	X				
xxii	Urine for reducing substances	X				
xxiii	Visual Screening, Acuity, Colour	X				

J. THERAPEUTIC PROCEDURES

By the end of the training period trainees should be able to perform the following therapeutic procedures independently: **The objectives for therapeutic technical skills include:**

1 **Proficiency in Life Saving Skills**

a. Paediatric Advanced Life Support (Faculty certification required)

b. Neonatal Advanced Life Support (Faculty certification required)

2 **Proficiency in, or Exposure to, Therapeutic and Technical Procedures implies ability to:**

a. Perform task correctly

b. Counsel subjects and caregivers about indications, contraindications and complications

c. Obtain informed consent for invasive procedures and sedation

d. Provide developmentally appropriate pain management, as needed

e. Discuss ethical, legal and financial issues

f. Provide accurate, timely, and appropriate written documentation.

	THERAPEUTIC PROCEDURES: GENERAL PAEDIATRICS	**Proficiency Required**	**Exposure Needed**	**Score**	**Supervisor's Name**	**Signature**
i	Abscess, Aspiration	X				
ii	Abscess, Simple Incision & Drainage	X				
iii	Arterial puncture	X				
iv	Central Venous line, Set up, use, care	X				
v	Cerumen removal	X				
vi	Cut down	X				
vii	Heimloch manoeuvre	X				
viii	Injection / Medication delivery, endo-tracheal, IM, SC, ID, IT, rectal, aerosol	X				

ix	Intravenous line placement	X				
x	Intraosseous line placement	X				
xi	Liquid nitrogen treatment for molluscum / warts	X				
xii	Subungal haematoma, drain	X				
xiii	Universal precautions	X				
xiv	Venipuncture	X				
xv	Wound care (simple)	X				

	THERAPEUTIC PROCEDURES: EMERGENCY PAEDIATRICS	**Proficiency Required**	**Exposure Needed**	**Score**	**Supervisor's Name**	**Signature**
i	Rehydration therapy	X				
ii	Oxygen delivery systems, Select and use	X				
iii	Cardiopulmonary resuscitation	X				
iv	Burn, Management of 1st. & 2nd;degree	X				
v	Burn, Acute stabilisation of major burn		X			
vi	Use of the nebulizer	X				
vii	Seizure management	X				

	THERAPEUTIC PROCEDURES: NEONATOLOGY	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Breast pump use	X				
ii	Circumcision, with EMLA, penile block		X			
iii	Exchange transfusion	X				
iv	Newborn resuscitation	X				
v	Umbilical artery catheterisation	X				
vi	Umbilical vein catheterisation	X				
vii	Tracheal intubation					
viii	Naso-gastric intubation					

	THERAPEUTIC PROCEDURES: ANAESTHESIA	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Anaesthesia, Conscious sedation		X			
ii	Anaesthesia, Digital blocks		X			
iii	Anaesthesia, Local	X				
iv	Anaesthesia, Topical	X				

	THERAPEUTIC PROCEDURES: CARDIOLOGY	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Cardiogram (Electro) Perform		X			
ii	Cardiogram (Electro) Interpret	X				
iii	Cardioversion / Defibrillation		X			
iv	Pericardiocentesis		X			
v	Physiologic monitoring, automated, cardiac, BP, TPR,	X				
vi	Pulse oximetry	X				

	THERAPEUTIC PROCEDURES: NEUROLOGY	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Cervical spine immobilisation	X				
ii	Lumbar puncture	X				
iii	Ventriculo- peritoneal shunt external taps		X			
iv	Subdural tap	X				
v	Ventricular tap	X				

	THERAPEUTIC PROCEDURES: DIGESTIVE SYSTEM	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Gastric suction / Lavage	X				
ii	Gastric tube placement, Oro-gastric / naso-gastric	X				
iii	Gastrostomy tube replacement		X			
iv	Inguinal and umblical hernia, simple reduction	X				
v	Paracentesis abdominis	X				
vi	Tooth, temporary reinsertion		X			
vii	Electrogastrography		X			

	THERAPEUTIC PROCEDURES: MUSCULO-SKELETAL SYSTEM	Proficiency Required	Exposure Needed	Score	Name of supervisor	Signature
i	Arthrocentesis, Large knee effusion, Large ankle effusion		X			
ii	Immobilisation techniques for common fractures and sprains	X				
iii	Ingrown toe nail treatment		X			
iv	Paronychia incision & drainage	X				
v	Reduction of nursemaid elbow		X			
vi	Reduction of phalangeal dislocation		X			
vii	Skin scraping	X				
viii	Wood's lamp examination of the skin, UV light 3600 3800A	X				

	THERAPEUTIC PROCEDURES: EAR, NOSE AND THROAT	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Foreign body removal (simple), Nose, Ear, Conjunctival	X				
ii	Suctioning, nares, oropharynx, trachea, tracheostomy,	X				

	THERAPEUTIC PROCEDURES: OPHTHALMOLOGY	Proficiency Required	Exposure Needed	Score	Supervisor's Name	Signature
i	Contact lens removal	X				
ii	Eye irrigation, Lid eversion, Patch	X				
iii	Fluorescein eye exam		X			

	THERAPEUTIC PROCEDURES: IMMUNOLOGY	Proficiency	Exposure	Score	Supervisor's	

		Required	Needed		Name	Signature
i	Allergy shot, Administration		X			
ii	Immunisation administration (PO,SC,IM)	X				
	THERAPEUTIC PROCEDURES: RESPIRATORY SYSTEM	**Proficiency Required**	**Exposure Needed**	**Score**	**Supervisor's Name**	**Signature**
i	Chest tube placement	X				
Ii	Endotracheal intubation	X				
iii	Inhalation equipment, clinic aerosol, nebulizer, metered dose	X				
iv	Pneumatic otoscopy	X				
v	Pulmonary Pressure Detector, place and read	X				
vi	Pulmonary function tests, peak flow meter, spirometry	X				
vii	Thoracocentesis	X				
viii	Tracheostomy tube, replacement	X				
ix	Ventilation, bag-valve-mask	X				
x	Ventilation support, initiation	X				

	THERAPEUTIC PROCEDURES: UROGENITAL SYSTEM	**Proficiency Required**	**Exposure Needed**	**Score**	**Supervisor's Name**	**Signature**
i	Bladder Catheterisation	X				
ii	Bladder, Suprapubic aspiration	X				
iii	Genital wart treatment		X			
iv	Paraphimosis reduction	X				
v	Peritoneal dialysis		X			
vi	Haemodialysis		X			
vii	Sexual abuse, examination and evaluation	X				

K. ESSAYS WRITING - Essays on contemporary clinical and social issues. Essay topics will be sent to training institutions periodically. Residents are to submit to their supervising consultants who will assess and send same to the Faculty Training Coordinator. Residents are to come to the examinations with bound copy of the essays which will be submitted at the start of the oral examination.

	ESSAY TOPIC	DATE	Score	ASSESSSOR	SIGNATURE
1					
2					
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4					
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10					

L. OTHER ACADEMIC ACTIVITIES

	ACTIVITY	Minimum number of activity	Actual attendance/ Presentation	Score	Supervisor	Signature
1	Weekly Clinical Meetings – attendance	72				
	Weekly Clinical Meetings – presentation	6				
2	Mortality Meetings – attendance	72				
	Mortality Meetings – presentation	6				
3	Management of Unit Statistics (Compilation, Analysis, Presentation, Submission and Filing of Admission and other patient data)	16				
4	Journal Club Meetings – attendance	16				
	Journal Club Meetings – presentation	4				
5	Clinical Practice Audit Sessions – attendance	6				
	Clinical Practice Audit Sessions – presentation	1				

CERTIFICATION

We hereby certify that the documentation contained in this log book is correct.

DEPARTMENTAL STAMP

Resident Doctor's Name	Signature	Date

Head of Department's Name	Signature	Date

COLLEGE / FACULTY RECEPTION AND VERIFICATION

Name of Receiving Officer	Designation	Signature	Date
Name of Verifying Officer	Designation	Signature	Date