NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA

PRACTICE RECORD/LOG BOOK FOR SENIOR RESIDENCY TRAINING

FACULTY OF FAMILY MEDICINE

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NATIONAL POSTGRADUATE MEDICAL COLLEGE OF NIGERIA.

FACULTY OF FAMILY MEDICINE

PRACTICE RECORD/LOG BOOK
FOR SENIOR RESIDENCY TRAINING IN FAMILY MEDICINE

2020 EDITION

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Introduction

Building on the competence and expertise acquired during Part I training, the Trainee continues to demonstrate competence in the diagnosis and management of common health problems presenting at the primary and secondary care levels; acquire skills in providing such clinical care. In particular he strengthens expertise in appropriate pre-operative, intra-operative and post-operative management of the surgical, gynaecological and maternal care in different settings including **Resource-limited Settings** where there may be need to improvise and be innovative.

Expected Competencies

Please bear in mind that the goal in this phase training is to demonstrate advanced competences as in Part I, with more emphasis on Communication, Academics, Management And Leadership Skills, and Creative Thinking.

During this phase of training the trainees must demonstrate in-depth cognitive knowledge for:

1. Practice of integrated, comprehensive family medicine in child health, general adult medicine, maternal health, surgical, mental health and other special units (e.g. medical care of the elderly, lifestyle, etc.).
2. Consolidation of office procedural skills.
3. Further development in managed-care.
4. Day-to-day running and management of the various units of the family medicine department.
5. Training and supervision of junior residents.
6. Clinical audit/research with minimal supervision by the Consultant.
7. Leadership in service delivery, teaching and resource management.

Within this period the candidate will also receive lectures that will augment his capacity as a practice manager.

The Trainee is expected to submit a **Practice Record/Log Book** of activities to qualify for the Part Two Final FMCFM examination. The Practice Record/Log Book is designed to empower the Senior Residents to direct and document their continued training and acquisition of skills after a successful completion of the Junior Residency Training stage.

This Practice Record/Log Book is for general Senior Residency Training including Emergency Medicine, Integrated Family Medicine, Integrated Surgery in family medicine, Maternal Health and New born care in family medicine, Integrated Rural Posting and Tutelage/Practice management.

The activities to be documented in this Practice Record/Log Book should be performed over a period of at least eighteen months following success at the Part One FMCFM examination.

The Resident is advised to carry the Practice Record/Log Book with him on all clinical and other assignments, so that it can be kept up to date as a compendium.

The levels of competence to be evaluated in this practice record/log book include:

1) Ability to select cases of deep scientific value, manage and write them up in publication format.
2) Proficiency in presenting clinical cases to an audience, identifying diagnostic and management problems/dilemmas.
3) Proficiency in addressing academic/professional topics using appropriate presentation tools.
4) Proficiency in essay writing.
5) Thought organization and fluency in addressing academic, clinical, management, leadership issues in viva voce settings
6) Proficiency in Modeling and Assessment of different Clinical Skills.
7) Use of the Clinical Summary and Reasoning Protocol.
8) Setting Higher Cognition Level Objective Questions from Completed Clinical Summary and Reasoning Protocol.
9) Proposal Presentation Seminar.
10) Departmental Dissertation Mock Examination.

When cases have been managed, operations performed, procedures carried out, lectures given/received, etc., he should enter the date and other appropriate data, including Hospital Number (In-patient or out-patient) as appropriate in the space provided. He should use the **CASE/ACTIVITY RECORD FORM** to report surgical and other procedures.
The Supervising Consultant will check knowledge and competence and assess as appropriate. He may demand that the resident sees and manage additional cases, perform more operations, carry out more procedures, etc. or have additional tutorial.

The Practice Record/ Log Book should be valued and meticulously kept for Part II Competency Rating by candidates. The trainee is therefore advised to submit records of his/her best performance at any skill or activity.

Grading of Performance
This involves an assessment of the quality of the trainee's performance at an index activity. Five levels of grading are recommended. These grades are also applicable to the sections involving formal assessment:
A: **Excellent** B: **Very good** C: **Good** D: **Fair** E: **Poor**
To qualify for the examination, the trainee should score an average of at least Grade B in each of the sections.
A performance rated 'Grade E' will be regarded as not having been done.

1. Upon passing the Part One examination, 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. When he thinks he has acquired a requisite level of competence in each subject area, it is the responsibility of the Resident to present himself to his Consultant/Trainer.
3. It is the Resident's responsibility to enter each completed activity into the log book immediately and obtain the required assessment endorsements.
4. The Consultant will then assess the Resident and complete the necessary column in respect of his own judgment as to the level of knowledge and 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 Practice Record/Log Book is completed in a rush in the last days of the posting**.
6. If there are competency areas identified, taught and assessed in a particular training institution that is not contained in the Practice Record/Log Book, the Training Coordinator should feel free to add such areas.

All members of the Faculty including Fellows, Trainers and Trainees must ensure that this Practice Record/Log Book is conscientiously utilized to monitor the progress and training of our Residents in order to achieve excellence in the specialty of Family Medicine.

Guiding Courses while training and completing the Practice Record/Log book

Emergency Medicine ***FAM 931***

Course Description: This course focuses exclusively on the care of children and adults with emergent conditions including in-faculty formal didactic presentations as well as critical care lecture series and participating in focus learning courses in advanced cardiac life support (ACLS), advanced life support (ALS), neonatal resuscitation (NRP) and advanced trauma life support (ATLS).Resident works in the Emergency Adult and Children Emergency Department.

Integrated Family Medicine ***FAM 932***

Course Description: This course provides an opportunity for Residents to function as Family Physicians in a busy outpatient setting, developing continuity with their patients and sharpen their office medicine skills, provide care within a medical home, maintain responsibility for their patients' care, thereby acquiring the skills needed to deliver continuing and comprehensive care emphasizing patient education and maintaining health as well as treating disease. Residents will spend time in the Family Medicine Clinic (FMC) participating in a regular continuity of care clinic and several block rotations. The FMC experience They also continue to receive support to care and improve care from team members including social workers, pharmacists, nursing staff, and faculty physicians.

The Resident will participate in caring for the communities in which they live and apply the bio-psycho-social model of care to their patients integrated into the chronic disease management. They learn how communities affect patients and vice versa, how patients engage with their communities, and physicians immerse knowledge of communities in the care of patients. Residents visit community agencies, and learn about social determinants of health.

Resident continues with the goal of developing team-building skills superintends over Inpatient service admitting patients from all different ages and with a wide variety of medical and surgical conditions work as a team with other specialists to care for patients on this unit assuming care of all inpatients from the evening and overnight hours and weekends.

The exposure prepares the residents to manage patients with chronic diseases and learn different approaches to systematic care for chronic illnesses, within the patient-centred model, including didactics on chronic disease, wellness, and motivational interviewing.

Integrated Surgery in Family Medicine ***FAM 933***

Course Description: This course emphasizes on the diagnosis and management of surgical disorders and emergencies in the context of the family with application of family medicine tools, and the need for timely referral for specialized care. All Emergency General Surgery are handled to achieve competency in the diagnosis and management of a wide variety of surgical problems typically encountered by family physicians, in an underserved area. Such problems may also include patients with respiratory failure, sepsis, multi-system trauma, peri-operative complications, and acute neurological injuries.

Maternal Health and Newborn Care in Family Medicine ***FAM 934***

Course Description: This course provides the capacity to work with others in providing care to newborns, infants, and obstetric patients; care for critically ill infants in the Neonatal Intensive Care Unit with pediatric residents, neonatologists, and neonatal nurse practitioners in the context of the family. The residents strengthen their techniques of prenatal care, management of labour and delivery, and postpartum care. They will also work in the delivery and operative room for newborn resuscitations, gain experience triaging obstetrics patients, performing deliveries, resuscitating and evaluating newborns, assisting and perform caesarean deliveries, and perform procedures for newborn infants. These must involve the relevant family medicine tools and social networking; Residents may use the opportunity to do or complete the Advanced Life Support for Obstetrics (ALSO) course.

Integrated/Rural Posting ***FAM 935***

Course Description: The course enables the Resident demonstrate ability to provide integrated care to populations in underserved areas with unmet needs and work effectively in resource limited health care settings. He gains capacity and skill to assess patients needing emergency surgical intervention, carry out life-saving emergency and common medical and surgical procedures, and show competence in the diagnosis and management of common maternal health problems presenting at the primary and secondary care level.

Tutelage/ Practice Management ***FAM 936***

Course description: This course introduces the candidate into management in medical practice and encompasses leadership, career development, patient safety, and preparation for practice. The Residents spend time shadowing the Proprietor and other members of the healthcare team, augmenting with lectures focused on improving healthcare systems, to learn their roles. It equips him with requisite knowledge of management applications in Medical Practice, setting up a Medical Practice in Nigeria, Partnership in Medical Practice, Medical Records and Informatics in Medical Practice and writing a business plan.

Practice Management Course Contents and Lectures

Course	***Title***	***Lectures***
FAM 936	***Introduction to Management in Medical Practice***	• *The Concept and Importance of Management including management as a science;* • *Principles of Management and Case studies in contemporary applications of management principles (Planning, Organising, Leading and Controlling Processes of Management)* • *Technical, Supervisory and Conceptual roles of the Manager;* • *Frontline, Middle Level and Top level hierarchical managerial structures.*
	Management Applications in Medical Practice	• *Financial Management including Book keeping, Cost accounting, Financial statements and Budgeting;* • *Human Resources Management (HRM) with processes of Recruitment, Selection, Placement, Staff development, Compensation, Discipline, Staff appraisal and Legal issues in HRM;* • *Stock management, record keeping, taking, valuation, tracking and monitoring;* • *Facility Management, planning, monitoring, maintenance and repairs;* • *Marketing Management and concept of marketing, Customer behaviour in health care, Marketing mix and Legal aspects in marketing of medical practice in Nigeria.*
	Setting up a Medical Practice in Nigeria:	• *Conceptual planning for a new practice,* • *Legal requirements in setting up a medical practice in Nigeria,* • *Steps in setting up a practice.*
	Partnership in Medical Practice	• *The concept of partnership,* • *Ownership structures in medical practices in Nigeria,* • *Models of partnership and Partnership Laws in Nigeria.*
	Medical Records and Informatics in Medical Practice	• *Use of ICT in medical practice,* • *Electronic medical records (EMR),* • *ICT and research in medical practice.*
	Writing a Business Plan:	• *Concept of Business Plan,* • *Features of a business plan.*

Period of Validity

The completed Practice Record/Log book will remain valid for a period of 24 months from the date of submission.

CASE/ACTIVITY RECORD FORM

(USE MANY COPIES)

This form should be used in recording and reporting individual Medical, Surgical, Child Health, Gynaecology and Maternal Health encounters/activities as earlier laid out in this Practice Record/Log book.

PATIENT INFORMATION

HOSPITAL NUMBER: ……………………………...

NAME……………………………………………… AGE: …………………… SEX: …………

DATE OF PRESENTATION: …………………… DATE OF DISCHARGE……………………

Summarised History and Physical Findings:

____

____

____

____

____

____

____

____

____

____

____

____

Clinical Impression:

____

Investigation(s): ____

____

Definitive Diagnosis:

Summary of Treatment:

Medical/ Non-operative

Management

Surgical Management:

Pre-operative

Operative

Post operative

Others including Follow-up/Continuity of Care:

Remarks and Lessons acquired:

Doctor's Name, Signature & Date

Rating/Scoring

Candidate MUST exhibit a thorough grounding in the theory, practice ability to perform independently and transfer knowledge.

Global Competency Rating Scale:

1 – Poor: 2- Fair 3 – Average 4 – Good 5 – Excellent

Narrative____

____

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____

____

____

____

Supervising Consultant's Name ____

Sign____

Date____

Evaluation of core levels of competence

i. Ability to select cases of deep scientific value and to write them up in publication format.

Case Write-Up Assessment

	Case no 1	**Case no 2**	**Case no 3**	**Case no 4**
Name (Initials only)				
Hospital number				
Diagnosis				
Scientific value of selected case				
Introduction/Use of literature/Background				
Completeness of report				
Correctness of conclusions				
Editorial accuracy				
Cumulative grade				
Endorsed by				

ii. Proficiency in presenting clinical cases to an audience, identifying diagnostic and management

Problems/Dilemmas

Clinical Meeting/Grand Round Presentation

	Case no 1	Case no 2	Case no 3	Case no 4
Name (Initials)				
Hospital number				
Diagnosis				
Date				
Scientific value of selected case				
Completeness of report				
Adequacy of modes of display				
Identification of diagnostic or management issues				
Adequacy of discussion of management options				
Communication skills				
Cumulative grade				
Endorsed by				

iii. Proficiency in addressing academic/professional topics using appropriate presentation tools.

Seminar topics

	Title 1:	Title 2:	Title 3:	Title 4:
Date				
Introduction				
Use of literature				
Quality of outline				
Quality of contents				
Quality of display				
Mastery of subject				
Mastery at interactive session				
Communication skills				
Cumulative grade				
Endorsed by				

iv **Proficiency in essay writing**.

	Essay question:	**Essay question:**	**Essay question:**	**Essay question:**
Date				
Outline				
Introduction				
Quality of contents				
Conclusion				
Cumulative grade				
Endorsed by				

v. Thought organization and fluency in addressing academic, clinical, management, leadership issues in viva voce settings.

Formative / Mock Assessment of Proposal, Viva Voce and Dissertation

<table>
<tr><td rowspan="2">Clinical Problems</td><td>Cardiovascular system</td><td>Central Nervous System</td><td>Digestive System</td><td>Endocrine System</td></tr>
<tr><td>Genitourinary System</td><td>Haematologic System</td><td>Musculo-skeletal System</td><td>Respiratory System</td></tr>
<tr><td rowspan="2">Social Networking</td><td colspan="2">The Patient in the Family, Cultural, Ethnic and Community Contexts</td><td>Primary Health Care</td><td></td></tr>
<tr><td colspan="2">Health Care for Family with Chronic Diseases / Disabilities and Terminal Illness</td><td>The Endangered/Distressed Family</td><td></td></tr>
</table>

Teaching Issues	Leadership Issues	Ethical Issues	Management Issues	Organizational Issues	Creative Thinking

MOCK VIVA	**Date**	**Clinical Problem**	**Social Networking**	**Ethical issue**	**Leadership issue**	**Teaching issue**	**Manage-ment issue**	**Organizational Issues**	**Creative Thinking**	**Cumulative grade**	**Assessor**	**Signature**
Mock Viva 1: Titles & Scores												
Mock Viva 2: Titles & Scores												
Mock Viva 3: Titles & Scores												
Mock Viva 4: Titles & Scores												

vi Assessment of individual resident's use of the clinical summary and reasoning protocol. In clinical reasoning meetings

Reasoning Sequence	**Case 1**	**Case 2**	**Case 3**	**Case 4**
Patient's Name (Initials only)				
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				

vii Setting higher cognition level objective questions from completed clinical summary and reasoning protocol.

S/N.	Case Presented, Discussed, Analysed and used by Senior Resident to set Objective Questions	Meeting Date	Case Coverage	Clarity of Questions	Cognition Levels	Overall Score	Supervisor	Signature
1								
2								
3								
4								
5								
6								

viii Proposal presentation Seminar

Proposal Seminar	Date	Introduction	Rationale	Study Design	References	Mastery of Subject	Communication skills	Cumulative grade	Assessor	Signature
Scores										

ix Departmental Dissertation Mock Examination

Mock Defense:	Date	Summary	Introduction and Literature Review	Objectives and Study Design	Presentation of Results and Discussion	References	Mastery of subject	Cumulative grade	Assessors	Signatures
Scores										

CERTIFICATION

We hereby certify that the documentation contained in this Practice Record/Log Book is correct.

DEPARTMENTAL STAMP/SEAL

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