2025

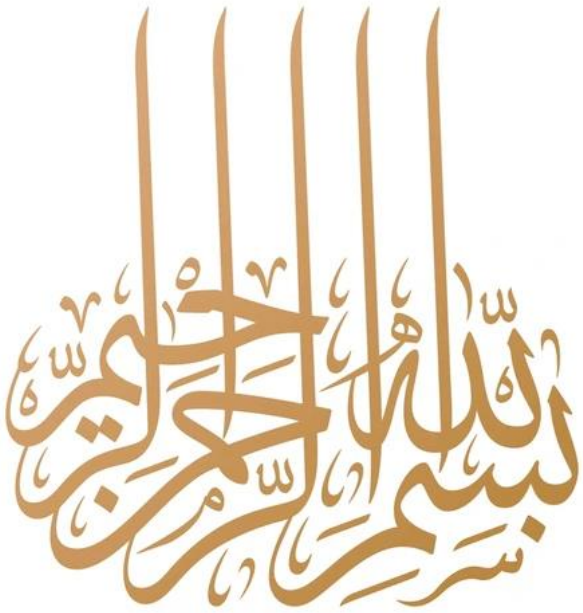
Second Year MBBS

Early Clinical Exposure

Department of Medical Education

Log Book

Log Book



Dedicated to Hazrat Muhammad (S.A.W)

Mission and Vision of RMU

To impart evidence based research oriented medical education

To provide best possible patient care

To incultate the values of mutual respect and ethical practice of medicine

Early Clinical Exposure is a groundbreaking initiative that will revolutionize the way we educate our future healthcare professionals. In embracing this innovative approach, we aim to provide students with invaluable hands-on experience from the very beginning of their medical journey. By immersing in clinical settings early on, students will develop a deeper understanding of patient care, clinical decision-making, and the intricacies of the healthcare system.

This curriculum not only enriches the academic experience but also cultivates essential skills such as communication, empathy, and teamwork—qualities that are integral to becoming competent and compassionate physicians. I encourage both students and faculty to embrace this transformative initiative wholeheartedly. Together, let us embark on this journey towards excellence in medical education and patient care.

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The Early Clinical Exposure program is an integral part of the medical curriculum, introducing clinical skills to 1st and 2nd-year MBBS students. By bridging theoretical knowledge with practical application, it fosters communication, professionalism, and patient-centered care while providing an understanding of clinical environments. The accompanying logbook serves as a structured tool to document skill acquisition and monitor student progress, enhancing reflective learning and assessment.

In the 1st year, students focus on acquiring foundational skills such as hand hygiene, basic life support, injection administration, and musculoskeletal, cardiovascular, and respiratory system examinations. These essential skills lay the groundwork for patient safety, aseptic techniques, and clinical assessment, ensuring students are comfortable in healthcare settings and capable of engaging with patients confidently.

The 2nd year builds upon these basics, introducing more advanced skills such as abdominal, neurological, and thyroid examinations, catheterization, and assessments of the renal and dermatological systems. These skills sharpens students' diagnostic abilities and prepares them for advanced clinical training in subsequent years, ensuring they develop into competent, empathetic physicians equipped for high-quality patient care.

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Introduction

Early clinical exposure helps students understand the relevance of their preclinical studies by providing real-world contexts. This can enhance motivation and engagement by showing students the practical application of their theoretical knowledge. Early exposure allows students to begin developing essential clinical skills from the start of their education. This includes not only technical skills but also crucial soft skills such as communication, empathy, and professionalism. Direct interaction with patients early in their education helps students appreciate the complexities of patient care, including the psychological and social aspects of illness. Early exposure to various specialties can aid students in making informed decisions about their future career paths within medicine.

Early clinical experiences contribute to the development of a professional identity, helping students see themselves as future physicians and understand the responsibilities and ethics associated with the profession. This can help reduce the anxiety associated with clinical work by familiarizing students with the clinical environment. It can build confidence in their abilities to interact with patients and healthcare professionals. Engaging with real-life clinical situations early on encourages the development of critical thinking and problem-solving skills, which are essential for medical practice. It helps bridge the gap between theoretical knowledge and practical application, leading to a more integrated and holistic approach to medical education. It allows students to observe and understand how healthcare systems operate, including the challenges and limitations faced in different settings.: Early patient interaction emphasizes the importance of patient-centered care from the outset, underscoring the importance of treating patients as individuals with unique needs and backgrounds. Practical experiences can enhance long-term retention of knowledge as students are able to connect theoretical learning with clinical experiences.: Early clinical experiences often involve working in multidisciplinary teams, which fosters a sense of collaboration and understanding of different roles within healthcare.

In summary, early clinical exposure in medical education is pivotal for the holistic development of medical students, providing them with a strong foundation of practical skills, professional attitudes, and a deep understanding of patient-centered care.

Vision

1. To create a seamless integration of theoretical knowledge and clinical skills, where students can apply classroom lessons in real-world healthcare settings from the start of their education. This approach aims to break down the traditional barriers between preclinical and clinical phases of medical training.
2. To shape well-rounded healthcare professionals who are not only clinically competent but also empathetic, ethical, and communicative. It emphasizes the development of soft skills, such as empathy, teamwork, and patient communication, alongside hard clinical skills.
3. To foster a culture of innovation and adaptability in future healthcare professionals. As medicine is a rapidly evolving field, students should be prepared to continually update their knowledge and adapt to new technologies and treatments.
4. To instill a strong foundation in patient-centered care, where students learn to put the needs and values of patients at the forefront of their clinical decision-making process.
5. Encouraging students to develop their professional identity from the outset of their training, helping them to understand and embody the roles, responsibilities, and ethical standards of the medical profession.
6. To promote understanding and collaboration among different healthcare disciplines, recognizing that modern healthcare is a team effort requiring coordinated multi-disciplinary approaches.
7. Encouraging an inclination towards scientific inquiry and research, integrating research skills early in the module to foster a mindset of evidence-based practice.
8. To equip students with a global perspective on health, understanding both local and international health challenges, and preparing them for a career in an increasingly interconnected world.

Mission

The mission of the early clinical module is to profoundly transform medical education by integrating clinical experiences from the very beginning. This approach aims to enrich the learning process, making it more relevant and engaging by immediately applying theoretical knowledge to real-world clinical settings. It focuses on developing essential clinical skills, fostering empathy, and ensuring patient-centered care.

The module is designed to nurture a strong professional identity and ethical grounding in students, preparing them for the realities of a career in medicine. It encourages adaptability, resilience, and a commitment to lifelong learning in the face of the ever-evolving field of healthcare. By exposing students to a variety of medical specialties and healthcare environments early on, it also aids them in making more informed career choices. Overall, this module seeks to produce well-rounded, competent, and compassionate healthcare professionals ready to meet the challenges of modern medicine.

Aim and Objectives

1. To provide students with the opportunity to start developing essential clinical skills, such as basic patient examination, history taking, and simple procedural skills.
2. To bridge the gap between theoretical knowledge and its practical application. This helps students understand how their preclinical learning is relevant to clinical settings.
3. To instill a sense of professionalism and an understanding of medical ethics from the very beginning of medical training. This includes aspects such as patient confidentiality, empathy, and communication skills.
4. To emphasize the importance of patient-centered care, helping students understand the patient's perspective, and the impact of illness on patients and their families.
5. To introduce students to the workings of the healthcare system, including the roles of various healthcare professionals and the challenges faced in delivering effective care.
6. To encourage students to engage in reflective practice and self-assessment, fostering a habit of lifelong learning and continuous improvement in their professional skills.
7. To expose students to the multidisciplinary nature of healthcare, teaching them the value of teamwork and collaboration with other healthcare professionals.
8. To provide exposure to a range of clinical environments, such as hospitals, primary care clinics, and community health centers, to give students a broader understanding of different aspects of healthcare.
9. To allow students to explore various medical specialties early in their education, aiding in informed career decision-making later on.
10. To help students build confidence in their clinical abilities and reduce the anxiety associated with transitioning from theoretical learning to clinical practice.
11. To cultivate empathy and compassion towards patients, which are key components of effective patient care.
12. To encourage the development of critical thinking and problem-solving skills essential for clinical practice.

Outcomes

1. Early clinical experiences can help students understand the clinical relevance of the basic sciences they are studying. This integration of theoretical knowledge with practical application can deepen their understanding and retention of key concepts.

2. Engaging with patients and healthcare professionals early in their training helps students develop effective communication skills, which are crucial for patient care and interprofessional collaboration.
3. Students get an opportunity to start developing essential clinical skills, such as history taking, physical examination, and clinical reasoning, from the beginning of their medical education.
4. Early clinical exposure can increase students' motivation and interest in their studies by providing a clear context for the relevance of their coursework to their future roles as doctors.
5. Interacting with patients and healthcare teams early in their training can aid students in forming their professional identity and understanding the roles and responsibilities of being a physician.
6. Exposure to real-world clinical scenarios can help students develop critical thinking and decision-making skills.
7. Students begin to encounter and learn to manage the emotional and ethical challenges inherent in medical practice earlier, which can prepare them for the realities of their profession.
8. Exposure to various medical specialties and settings can aid students in making informed decisions about their future career paths.
9. Long-term, students trained with early clinical exposure may develop into more competent and empathetic physicians, potentially leading to better patient outcomes.
10. Engaging in clinical settings early can spark an interest in clinical research, leading to contributions in medical science.

Guidelines for Using the Clinical Skills Logbook

This logbook serves as a vital tool for students to document their progress in learning core clinical skills during their Early Clinical Exposure (ECE) rotations. Each skill included in the logbook is linked to an Entrustable Professional Activity (EPA)**,** representing a key clinical task that students must demonstrate competently.

Each skill is assessed according to Miller's Pyramid, a widely used framework for evaluating clinical competence. Miller's Pyramid has four progressive levels:

- **Knows**: The student understands the theoretical knowledge related to the skill.
- **Knows How**: The student can explain how the skill should be performed.
- **Shows**: The student demonstrates the skill in a simulated or clinical setting.
- **Does**: The student performs the skill independently and effectively in real-life scenarios.

Students are expected to actively engage with their assigned skills during clinical rotations. For each skill, the logbook outlines specific steps to be performed, ensuring a structured and standardized approach to learning. The clinical facilitator plays a critical role in this process, teaching the skill, assessing the student's performance, and providing constructive feedback.

After the assessment, the facilitator will record the student's level of achievement by marking the relevant category: "Not Done," "Done," or "Well Done." Detailed comments from the facilitator can further guide the student in refining their techniques. Students should proactively seek feedback, clarify doubts, and practice under supervision to build their confidence and competence in core skills.

To ensure thorough documentation, students must obtain their facilitator's signature for each skill after it is completed. The facilitator's responsibilities extend beyond assessment; they include coaching students on the correct techniques, addressing errors, and ensuring understanding through active questioning and demonstration. This logbook needs to be certified by Department of Medical Education at the end of each block.

Students are encouraged to regularly review their progress in the logbook, use it as a reflection tool, and identify areas for improvement. By adhering to this process, the logbook not only serves as a record of competency but also reinforces a culture of self-directed learning and accountability in clinical practice.

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Clinical Skills
Block 4

GIT Module

Skill-1: Perform Abdominal Examination
Skill-2: Interpret an Abdominal X-Ray
Skill-3: Interpret CT Scan Abdomen
Skill-4: Managing Dehydration
Skill-5: Surface Marking of Abdominal viscera

Renal Module

Skill-6: Surface Marking of Kidney & Urinary Bladder.
Skill-7: Identify A Urinary Catheter and Explain Its Usage
Skill-8: Interpret CT Scan Pelvis for Kidney and Urinary Bladder.
Skill-9: Urine Sample Testing & Interpretation

Certificate of Completion

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GIT Module Skills

Skill-1: Perform Abdominal Examination

Entrustable Professional Activity: Demonstrate steps of abdominal examination.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before starting • Introduce yourself to the patient. • Ask the patient for permission to examine his abdomen. • Say to the examiner that you would normally expose the patient from nipples to knees, but that in this case you are going to limit yourself to exposing the patient to the groins. • Position the patient so that he is lying flat on the couch. with his arms at his side and his head supported by a pillow. • Ensure that the patient is comfortable.			
General inspection • From the end of the couch, observe the patient's general appearance (age, state of health, nutritional status, and any other obvious signs). • Inspect the abdomen. Look for any obvious distension, localised masses, scars, and skin changes. • Ask the patient to lift his head to the abdominal muscles.			
Palpation of the abdomen • Ask the patient if he has any abdominal pain and fix upon his face as you palpate his abdomen. Palpate with the palmar surface of your fingers whilst sitting or kneeling beside the patient. • Light palpation - Begin by examining the segment furthest away from any pain or discomfort and systematically palpate the four quadrants and the umbilical area. look for tenderness, guarding, and any masses. • Deep palpation - For greater precision. Describe and localise any masses.			
Palpation of the organs • Liver - Ask the patient to breathe in and out and, starting in the right lower quadrant, feel for the liver edge using the flat of your hand or the tips of your fingers. The liver edge. if felt, can be described in terms of regularity, nodularity and tenderness. • Gallbladder- Palpate for tenderness over the gallbladder region that is at the tip of the right ninth rib. • Spleen - Palpate for the spleen as for the liver, again starting in the right lower quadrant.			

• Kidneys - Position the patient close to the edge of the bed and ballot each kidney using the technique of deep bimanual palpation. • Aorta - Palpate the descending aorta between the thumb and the index of your right hand at a point midway between the xiphisternum and the umbilicus.			
Percussion • Percuss the liver area, also remembering to detect its upper border (usually found in the fourth intercostal space). • Percuss the suprapubic area for undue dullness (bladder distension). • If the abdomen appears distended, test for shifting dullness (ascites). Shifting dullness can be tested for by percussing down the right side of the abdomen. If on area of dullness is detected, keep two fingers on it and ask the patient to roll over to his left. Re-percuss the area which should now sound tympanic.			
Auscultation • Auscultate in the mid abdomen for abdominal sounds. listen for 30 seconds before concluding that they are normal, hyperactive, hypoactive. or absent. • Listen over the abdominal aorta for aortic bruits suggestive of arteriosclerosis or an aneurysm. • Listen for renal artery bruits 2.5 cm above and lateral to the umbilicus - a bruit suggests renal artery stenosis			
After the examination • Cover the patient up. • Thank the patient. • Ask the patient if he has any questions or concerns. • State that you would test the urine and order some key investigations, e.g. ultrasound scan. CBC, LFTs, U&Es, and clotting screen. • Summarise your findings and offer a differential diagnosis.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-2: Interpret an Abdominal X-Ray

Entrustable Professional Activity: Interpret a normal abdominal X-ray
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
The X-ray • Name. age, and sex of the patient. • Date of the X-ray. • Confirm size of area covered. • PA or AP (They are usually PA.) • Supine (usual), erect, or lateral decubitus (Look at gastric air bubble and fluid • levels.) • Penetration (lumbar vertebrae should be visible)			
Interventions or artefacts • Make a note of any clearly visible interventions or artefacts			
Skeleton Inspect the: • Lower rib cage., Lumbar vertebrae, Sacrum and sacroiliac joints ,Pelvis, Hip joints and femora.			
Organs Inspect the: • Liver, Spleen: usually not visualised, Kidneys: about three vertebrae in size, the left kidney is higher than the right, Bladder: not visualised if empty, Prostate: only visualised if calcified. Stomach, Small bowel, Large bowel.			
Gas, fluid levels, and faecal matter • Gas: depending on its amount and distribution, intraluminal gas may be normal but intramural or extraluminal gas should be considered abnormal. The small intestine should not be greater than 3 cm in diameter. the colon 5 cm in diameter, and the caecum 9 cm in diameter. • Look for gas under the diaphragm (pneumoperitoneum), even though this is best visualised on an erect chest X-ray • Fluid levels: a fluid level in the stomach and caecum is a normal finding, but multiple fluid levels in the colon should be considered abnormal. • Faecal matter: the amount and distribution of faecal matter can be revealing of underlying pathology			
Abnormal calcification • Calculi (kidneys, ureters, bladder, gall bladder, and biliary tree). • Pancreas. • Kidneys. • Abdominal aorta and arteries • Costal cartilages, although note that calcification of the costal cartilages is a benign finding in the older age population			
• Summarise your findings			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-3: Interpret CT Scan Abdomen

Entrustable Professional Activity: Identify abdominal organs on a CT scan.
Miller's Level: Knows How

Task	Assessment		
	Not Done	**Done**	**Well Done**
Patient and Imaging Details • Patient Information: Name, age, sex, and clinical history. • Date and Time: Confirm the date and time the CT scan was performed. • Scan Type: Verify the type of CT (contrast or non-contrast). • Slices: Confirm axial, coronal, sagittal, and 3D reconstructed views. • Region Covered: Ensure complete visualization of the abdomen and adjacent regions as needed.			
Liver and Gallbladder • Liver: Right upper quadrant, with visible hepatic lobes and segments. • Gallbladder: Adjacent to the liver, evaluate its size and position.			
Spleen • Location: Left upper quadrant, homogenous in density, crescent-shaped.			
Pancreas • Location: Retroperitoneal structure across the epigastrium, slightly anterior to the splenic vein.			
Kidneys and Ureters • Kidneys: Bean-shaped structures on either side of the spine, retroperitoneal. • Ureters: May be faintly visible, traveling from kidneys to the bladder.			
Stomach and Intestines • Stomach: Left upper quadrant, identifiable by rugal folds when distended. • Small Intestine: Centrally located loops with thinner walls. • Large Intestine: Peripheral location, identifiable by haustra.			
Vascular Structures • Abdominal Aorta: Midline anterior to the vertebral bodies. • Inferior Vena Cava (IVC): Right of the aorta. • Portal Vein: Posterior to the pancreas.			
Adrenal Glands • Location: Superior and medial to the kidneys, triangular in shape			
Musculoskeletal Structures • Spine: Vertebral bodies visible in the midline. • Ribs, Pelvis, and Hip Joints: Surrounding the abdominal cavity.			
Peritoneum and Retroperitoneum • Peritoneal Cavity: Look for normal absence of free air or fluid. • Retroperitoneum: Containing kidneys, adrenal glands, and portions of the aorta and IVC.			
Lymph Nodes • Normal-sized nodes are typically less than 1 cm and not prominent.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-4: Managing Dehydration

Entrustable Professional Activity: Assess dehydration in an infant/young child and explain the procedure for making homemade ORS.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Patient Preparation and Settings • Ensure the caregiver is present and understands the assessment process. • Maintain a calm and reassuring environment for the child to reduce stress. • Gather required equipment: a weighing scale, thermometer, and a source of clean water for ORS preparation.			
General Inspection • Appearance: Observe the child's alertness, activity level, and interaction with the environment. A lethargic or irritable child may indicate dehydration. • Eyes: Sunken eyes are a classic sign of dehydration. • Tears: Absence of tears while crying may suggest significant fluid loss. • Mouth and Tongue: Assess for dryness or stickiness.			
Vital Signs • Heart Rate: Increased heart rate (tachycardia) can indicate dehydration. • Respiratory Rate: Look for rapid or shallow breathing, often a sign of severe dehydration. • Capillary Refill Time: Prolonged refill time (>2 seconds) indicates poor perfusion and dehydration.			
Skin and Turgor • Skin Elasticity: Pinch the skin on the abdomen or thigh and observe how quickly it returns to its normal position. Slow return (>2 seconds) suggests dehydration. • Dryness: Assess the dryness of the skin, particularly in the extremities.			
Urine Output and Diapers • Urination Frequency: Reduced or absent urination is a critical indicator. • Diaper Weight: Fewer wet diapers than usual suggests fluid deficit.			

Weight Measurement
• Measure and compare the child's weight with recent records to estimate the fluid loss percentage. A weight loss of:
  ○ Mild Dehydration: 3-5%
  ○ Moderate Dehydration: 6-9%
  ○ Severe Dehydration: ≥10%			

Hydration Status Classification			

• Mild Dehydration: Normal behavior, slightly dry mouth, normal eyes, tears present. • Moderate Dehydration: Irritability, dry mouth, sunken eyes, reduced tears, prolonged capillary refill. • Severe Dehydration: Lethargy, no tears, deeply sunken eyes, prolonged skin turgor return, cold extremities			
Homemade ORS • **Ingredients:** o 1 liter of clean drinking water. o 6 level teaspoons of sugar. o ½ level teaspoon of salt. • **Equipment:** o Clean container or bottle. o Measuring spoons. • **Procedure** o Prepare Water: Boil or use clean drinking water to ensure safety. Let it cool. o Mix Ingredients: o Add 6 level teaspoons of sugar to the water. o Add ½ level teaspoon of salt. o Stir Thoroughly: Ensure all the sugar and salt dissolve completely. o Check Taste: The solution should taste mildly salty, similar to tears. Adjust if necessary.			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Skill-5: Surface Marking of Abdominal viscera

Entrustable Professional Activity: Mark abdominal viscera on the surface.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**

Patient Positioning and Landmarks
• Position: Ensure the patient is in the supine position for marking.
• Reference Planes: Identify the following anatomical planes:
  ○ Midline (Linea Alba).
  ○ Transpyloric Plane (L1 vertebral level).
  ○ Subcostal Plane (below the costal margin).
  ○ Intertubercular Plane (L5 level, between iliac tubercles).
  ○ Midclavicular Lines.			

Surface Markings of Viscera **Liver** • Superior Border: Right 5th rib in the midclavicular line to the xiphoid process and across to the left 5th rib. • Inferior Border: Right costal margin to the midline at the transpyloric plane. **Gallbladder** • Location: Tip of the right 9th costal cartilage (midclavicular line). **Stomach** • Cardia: Left of the midline, 2.5 cm below the xiphisternum. • Pylorus: 2.5 cm to the right of the midline at the transpyloric plane. • Greater Curvature: Extending from the left 5th intercostal space (near the midclavicular line) to the transpyloric plane. **Spleen** • Location: Posteriorly between the 9th and 11th ribs on the left side, behind the midaxillary line. **Pancreas** • Head: Right of the midline, just below the transpyloric plane. • Body and Tail: Crosses the midline to the left, extending towards the spleen. **Kidneys** • Right Kidney: Hilum at the level of L1, superior pole near the 12th rib. • Left Kidney: Hilum at the level of L1, superior pole slightly higher than the right. **Small Intestine** • Duodenum: C-shaped curve in the epigastrium around the head of the pancreas. • Jejunum and Ileum: Centrally located within the abdomen.			

Large Intestine • Caecum: Right iliac fossa. • Ascending Colon: Extends vertically along the right side of the abdomen. • Transverse Colon: Passes horizontally across the umbilical region. • Descending Colon: Extends vertically along the left side of the abdomen. • Sigmoid Colon: In the left iliac fossa. **Bladder** • Empty Bladder: Located within the pelvis, just above the pubic symphysis. • Full Bladder: Rises into the suprapubic region.			
Summary of Surface Markings • Confirm accurate localization of abdominal viscera using anatomical landmarks. • Note any discrepancies or challenges in identifying the viscera.			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Renal Module Skills

Skill-6: Surface Marking of Kidney & Urinary Bladder.

Entrustable Professional Activity: Palpate & surface mark of kidney & urinary bladder.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Patient Position: The patient should be in the supine position for surface marking, with the abdomen exposed for proper visualization of landmarks. **Key Anatomical Landmarks:** 1. Midline: Drawn along the vertebral column to guide lateral measurements. 2. Costal Margin: Used to identify the upper extent of the kidneys. 3. Iliac Crest: Helps locate the inferior extent of the kidneys. 4. Pubic Symphysis: Guides surface marking of the bladder. 5. Umbilicus: Reference point for a distended bladder.			
Kidney **Right Kidney** • Extent: The right kidney extends from the lower border of the 11th thoracic vertebra (T11) to the upper border of the 3rd lumbar vertebra (L3). • Superior Pole: Located at the level of the 11th rib, slightly below the left kidney. • Inferior Pole: Located approximately 3 cm above the iliac crest at the L3 level. • Hilum: Found at the level of the 1st lumbar vertebra (L1), 2.5 cm lateral to the midline. **Left Kidney** • Extent: The left kidney extends from the upper border of the 11th thoracic vertebra (T11) to the 2nd lumbar vertebra (L2). • Superior Pole: Located at the level of the 11th rib and slightly higher than the right kidney. • Inferior Pole: Located approximately 3 cm above the iliac crest at the L2–L3 level. • Hilum: Found at the level of the 1st lumbar vertebra (L1), 2.5 cm lateral to the midline. **Surface Marking Steps for Kidneys** 1. Superior Point: 2.5 cm lateral to the spinous process of T11. 2. Inferior Point: 2.5 cm lateral to the spinous process of L3. 3. Oblique Line: Draw an oblique line joining these two points on both sides.			

Urinary Bladder **Empty Bladder** • Located entirely within the pelvic cavity. • Superior Border: Corresponds to the upper border of the pubic symphysis. **Full Bladder** • Extends upwards into the hypogastric region, reaching the level of the umbilicus in extreme distension. • Apex: Lies behind the pubic symphysis. • Base (Trigone): Oriented posteriorly, in contact with the rectum in males or the vagina in females. • Neck: Positioned at the pelvic floor, leading into the urethra. **Surface Marking Steps for Bladder** 1. Empty Bladder: Mark just above the pubic symphysis. 2. Full Bladder: Mark a dome-shaped structure in the suprapubic region, potentially rising to the umbilicus during extreme distension.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-7: Identify A Urinary Catheter and Explain Its Usage

Entrustable Professional Activity: Identify a urinary catheter and explain its use.
Miller's Level: Knows How

Task	Assessment		
	Not Done	**Done**	**Well Done**
Types of Urinary Catheters 1. **Foley Catheter (Indwelling Catheter):** o Features a balloon at the tip to hold it in place within the bladder. o Connected to a drainage bag for continuous urine collection. o Common sizes: **10–22 French (Fr)** for adults. 2. **Intermittent Catheter (In-and-Out Catheter):** o Used for one-time drainage of the bladder. o Does not have a balloon and is not left in place. 3. **Suprapubic Catheter:** o Inserted directly into the bladder through the abdominal wall. o Used when the urethral route is not feasible. 4. **Condom Catheter (External Catheter):** o A sheath placed over the penis, connected to a drainage bag. o Non-invasive and used for males with incontinence. 5. **Three-Way Catheter:** o Includes an extra lumen for continuous bladder irrigation or medication delivery. o Used postoperatively for procedures such as transurethral resection of the prostate (TURP).			
Indications 1. **Retention:** o Acute urinary retention. o Chronic urinary retention not responsive to other treatments. 2. **Monitoring Urine Output:** o Critical care settings. o During or after major surgeries. 3. **Incontinence:** o For patients with severe incontinence unmanageable by other means. 4. **Surgical/Procedural Use:** o To ensure an empty bladder during abdominal or pelvic surgeries. 5. **Irrigation and Drainage:** o Post-surgical blood clot evacuation from the bladder.			

Insertion Steps 1. **Preparation:** o Ensure sterile equipment: catheter, lubricant, antiseptic solution, gloves. o Position the patient supine with the perineum exposed. 2. **Aseptic Technique:** o Clean the perineal area. o Apply lubricant to the catheter tip. 3. **Insertion:** o Insert gently through the urethra into the bladder until urine begins to flow. o Inflate the balloon (if using a Foley catheter) with sterile water to secure it. 4. **Drainage Bag:** o Connect the catheter to a drainage bag, ensuring it is below the level of the bladder to prevent backflow.			
Care and Maintenance • Ensure proper hygiene around the catheter insertion site. • Keep the drainage bag below bladder level to avoid backflow and infection. • Replace long-term catheters according to clinical guidelines to prevent infections.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-8: Interpret CT Scan Pelvis for Kidney And Urinary Bladder.

Entrustable Professional Activity: Identify kidney and urinary bladder on CT Scan abdomen
Miller's Level: Knows How

Task	Assessment		
	Not Done	**Done**	**Well Done**
Patient Preparation and CT Settings 1. Preparation: Ensure the patient has adequate hydration. Contrast medium may be administered for better visualization of soft tissues. 2. **CT Phases:** o Non-contrast Phase: To detect calcifications, stones, or fat-containing lesions. o Corticomedullary Phase (30–70 seconds): For vascular anatomy. o Nephrographic Phase (80–120 seconds): To evaluate the renal parenchyma. o Excretory Phase (3–5 minutes): To assess urinary tract excretion and bladder filling.			
Kidneys 1. **Location:** o Right Kidney: Found between T12 and L3 vertebral levels. ▪ Lower than the left kidney due to the liver. o Left Kidney: Found slightly higher, between T11 and L2 vertebral levels. 2. **Shape and Appearance:** o Reniform (bean-shaped) structure. o Smooth outer contour with a central hilum containing renal vessels, ureter, and lymphatics. 3. **Cortex and Medulla:** o On a contrast-enhanced CT, the cortex appears brighter than the medulla during the corticomedullary phase. 4. **Renal Pelvis and Ureters:** o Visible as a central, hypodense (dark) area in the kidney hilum. o Ensure no dilation (suggestive of hydronephrosis) or filling defects (indicative of stones or clots). 5. **Landmarks to Identify the Kidneys:** o Retroperitoneal position, lateral to the vertebral column.			

○ Right kidney is posterior to the liver, and left kidney is posterior to the spleen.			
Urinary Bladder 1. **Location:** ○ Found in the pelvic region, anterior to the rectum in males and the uterus/vagina in females. ○ Posterior to the pubic symphysis. 2. **Shape and Appearance:** ○ When full: Ovoid or round shape with thin walls. ○ When empty: Irregular and thickened walls. 3. **Contents:** ○ Normally hypodense (dark) due to urine. ○ Hyperdense areas may indicate stones, blood clots, or contrast material. 4. **Bladder Wall:** ○ Uniform thickness: <5 mm when distended; thickened walls may indicate inflammation or malignancy. 5. **Landmarks to Identify the Bladder:** ○ Central location in the pelvis. ○ Lies inferior to the peritoneal reflection and posterior to the pubic bone.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-9: Urine Sample Testing & Interpretation

Entrustable Professional Activity: Test a urine sample using a dipstick
Miller's Level: Knows How

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before starting • Introduce yourself to the patient. • Take a very brief history from him. • Explain that you are going to lest his urine and explain why. • Ensure that the urine specimen is fresh and that it has been appropriately collected.			
The equipment • Urine dipstick and urine dipstick bottle. • A pair of gloves. • o A pen and paper (or the patient's case notes).			
The procedure • Put on the gloves. • Check that the urine is a mid-stream sample. • Inspect the colour and appearance of the urine. • Stir the urine bottle 10 ensure that the urine is mixed. • Check the expiry date on the urine dipstick jar. • Briefly immerse the urine dipstick into the urine specimen. • Tap off any excess urine from the dipstick. • Hold the strip horizontallv. • Read each colour pad at the designated time printed on the dipstick bottle colour chart. • Report and record the results. • Discard the used urine dipstick and the gloves. • Wash your hands			
After testing the urine • Explain the results to the patient. • Document the results in the patient's notes. • If abnormal, suggest obtaining a second sample of urine or sending the urine for laboratory analvsis. • Thank the patient.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Block 5

Reproduction Module

Skill-10: Examine A Pregnant Woman

CNS Module

Skill-11: Examination of Gait & Coordination
Skill-12: Examination of Cranial Nerves
Skill-13: Examination Motor and Sensory Systems of Upper Limb
Skill-14: Examination of Sensory and Motor system in the Lower Limb
Skill-15: Interpretation of Normal CT brain
Skill-15: Assessment of Glasgow Coma Scale

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Reproduction Module Skills
Skill-10: Examine A Pregnant Woman

Entrustable Professional Activity: Examine a pregnant woman
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before examining the patient • Introduce yourself to the patient. • Explain the examination and ensure consent • Indicate that you would weigh the patient, take her blood pressure (preeclampsia), dipstick her urine (pre-eclampsia. gestational diabetes) and ask her to empty her bladder. • Position the patient so that she is lying supine (she can sit up if she finds lying supine uncomfortable). • Ask her to expose her abdomen. • Ensure that she is comfortable.			
General inspection & Inspection of the abdomen • Carry out a general inspection from the end of the couch • Abdominal distension and symmetry. • Linea nigra. • Striae gravidarum. • Scars.			
Palpation of the abdomen Facing the mother. determine the: • Size of the uterus. • liquor volume (normal, polyhydramnios, oligohydramnios). • Number of foetuses. • Size of the foetus(es). • lie.			
Symphyseal-fundal height (SFH) • Using a tape measure, measure from the mid·point of the symphysis pubis to the top of the uterus. from 20 to 38 weeks of gestation. the SFH in centimetres approximates to the number of weeks of gestation ± 2.			
Auscultation • Listen to the foetal heart by placing a Pinard stethoscope over the foetus' anterior shoulder and estimate the heart rate (usually 110-160 bpm). Ensure that your hands are free from the abdomen.			
After the examination • Cover the patient up. • Thank the patient. • Summarise your findings.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

CNS Module Skills

Skill-11: Examination of Gait & Coordination

Entrustable Professional Activity: Examine Gait & Coordination.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Position: standing			
General inspection • Limb and body posture, resting tremor			
Gait • Instability, ataxia, wide-based/narrow-based • Arm swing • Walk heel to toe: unable to with a midline cerebellar lesion • Walk on toes (L4/5) and heels (S1)			
Romberg's test			
Cerebellar signs (sitting) • Upper limb tone, rebound of outstretched arms, hyporeflexia • Dysdiadochokinesis • Nose to finger coordination • Intention/rest/postural tremor • Nystagmus (fast phase towards side of lesion; away in VIII lesion) • Dysarthria/slurred speech			
Lower limb (supine) • Tone • Heel to shin co-ordination • Reflexes			
Thank patient and offer to redress			
Level of Satisfaction			

Comments:_____
_____
Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-12: Examination of Cranial Nerves

Entrustable Professional Activity: Examine of Cranial nerves
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Expose: face, neck and shoulders • Position: sitting			
General inspection • Patient comfort • Obvious asymmetry • Scars, rashes, ptosis, wasting, involuntary movements			
CN I • ask about smell/taste • Test olfaction in one nostril at a time and occlude the opposite side • Use non-irritating stimulants, e.g. cloves **CN II** • History (ask if patient wears glasses – if yes, they should wear them) • Visual acuity (with Snellen chart) and near vision • Visual fields • Colour vision (Ishihara plates) • Light reflex (direct and consensual): approach patient's eye laterally and shine torch while asking patient to look into the distance • Swinging flashlight test: to assess for relative afferent pupillary defect (pupils constrict less when bright light is swung from unaffected eye to the affected eye) • Accommodation reflex: ask the patient to look in the distance and then at the tip of their nose • Offer to perform a fundoscopy **CN III, IV, VI** • Test eye movements in all directions in an 'H' pattern: ask if any double vision • Observe for nystagmus • Assess for saccadic eye movements (ask patient to make quick horizontal and vertical eye movements)			
CN V • Motor • Ask patient to open mouth and move from side to side while you provide resistance (pterygoids) • Ask patient to clench forehead and cheek, then palpate the masseter and			

• temporalis muscle and observe muscles for atrophy • Jaw reflex (offer to perform) • Sensory • Light touch (cotton), temperature (cold tuning fork), pain (disposable pin) • in optic, mandibular and maxillary areas (bilaterally) • Corneal reflex (offer to perform) **CN VII** • Ask patient to raise eyebrows, screw up eyes, show teeth, puff out cheeks • Test sensation on anterior 2⁄3 of tongue **CN VIII** • Grossly check hearing by whispering five numbers in one ear while occluding • tragus of opposite ear. Repeat for other ear but use different numbers. • Rinne test, Weber test • Offer to do auriscopy			
CN IX • Central movement of uvular with torch • Gag reflex (offer to perform) • Taste in posterior 1⁄3 tongue (offer to perform) **CN X** • Test swallowing and presence of dysphagia • Test speech and presence of hoarse voice • Palatal elevation (ask patient to say 'ah') CN XI • Sternocleidomastoid function (ask patient to turn head to left and palpate the right sternocleidomastoid and repeat for alternate side) • Trapezius: ask patient to shrug shoulders and palpate trapezius **CN XII** • Wasting/fasciculation of tongue (signs of lower motor neuron disease) • Side movement of tongue (a purely upper motor neuron lesion will cause deviation of tongue away from side of lesion; unilateral paralysis from a lower motor neuron lesion will cause deviation towards affected side) • Ask the patient to push the tongue into each cheek to check power			
Thank patient			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Skill-13: Examination Motor and Sensory Systems of Upper Limb

Entrustable Professional Activity: Examine the Sensory and Motor System in the Upper Limb

Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Expose: arms • Position: sitting			
General inspection • Wasting, fasciculation, asymmetry, abnormal movements • Pronator drift • Neuropathic ulcers, burns, trauma			
Tone • Rigidity (flexion/extension elbow), spasticity (supinator catch)			

Power
• Grades:
  • 0 – no movement
  • 1 – flicker of contraction
  • 2 – movement if gravity eliminated,
  • 3 – can overcome gravity but not resistance
  • 4 – moderate movement against resistance,
  • 5 – normal power
• Shoulder abduction (C5/6)
• Elbow flexion (C5/6)/ extension (C7/8)
• Wrist flexion (C6/7)/ extension (C7/8)
• Finger flexion (C7/8)/extension (C7/8)/finger abduction (C8/T1)/finger adduction (C8/T1			

Reflexes • Biceps (C5/6), supinator (C5/6), triceps (C7/8)			
Coordination • Dysdiadochokinesis, finger–nose test, intention tremor			
Sensation • Identify upper limb dermatomes and test all components of sensation • Light touch (cotton wool), pain (neurotip) • Vibration (128 Hz tuning fork) – over distal interphalangeal joint of finger. • If absent, test wrist, elbow, shoulder • Proprioception – hold distal interphalangeal joint of finger and move it up and down. Ask patient to inform you in			

which direction they believe you are moving the joint. Perform this after an open eye demonstration • Test proximally if abnormal			
Thank patient and offer to redress			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Skill-14: Examination of Sensory and Motor system in the Lower Limb

Entrustable Professional Activity: Examination of Sensory and Motor system in the Lower Limb

Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Expose: legs • Position: supine			
General inspection • Wasting, fasciculation, asymmetry, abnormal movements			
Tone • Rigidity, spasticity, clonus (dorsiflex ankle with knee bent and also move patella sharply down on extended knee)			

Power
• Grades:
  • 0 – no movement,
  • 1 – flicker of contraction,
  • 2 – movement if gravity eliminated,
  • 3 – can overcome gravity but not resistance,
  • 4 – moderate movement against resistance,
  • 5 – normal power
• Hip
  • Hip flexion (L2/3)/extension (L5, S1/2)
  • Hip abduction (L4/5, S1)/adduction (L2/3/4)
• Knee flexion (L5, S1)/extension (L3/4)
• Ankle
  • Plantar flexion (S1/2)/dorsiflexion (L4/5)
  • Eversion (L5, S1)/inversion (L5, S1			

Reflexes • Knee reflex (L3/4) • Ankle reflex (S1/2) • Babinski reflex (extensor plantar response L5, S1/2): indicates upper motor neuron lesion to corticospinal tract or is a primitive reflex in infants			
Coordination • Heel–shin test • Foot tapping – rapid foot tapping with sole against your hand			
Sensation			

• Light touch (cotton wool), pain (neurotip) • Vibration (128 Hz tuning fork), – over hallux; if absent, test malleolus of ankle, knee, hip • Proprioception – hold distal interphalangeal joint of toe and move it up and down. Ask patient to inform you which direction they believe you are moving the joint. Perform this after an open eye demonstration. • Test proximally if abnormal • Temperature			
Gait and Romberg's test			
Thank patient and offer to redress			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Skill-15: Interpretation of Normal CT brain

Entrusable Professional Activity: Identify parts of the brain on Normal CT Scan.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Patient Preparation and CT Settings **Preparation:** • Ensure the patient is adequately hydrated. Contrast medium may be administered if needed for better visualization of vascular structures. **CT Phases:** • Non-contrast Phase: To assess the brain parenchyma, detect calcifications, or hemorrhages. • Contrast Phase (if applicable): For better delineation of vascular structures, tumors, or abscesses.			
Brain Parenchyma **Cortex and White Matter:** • The cortex should appear hypodense (darker) compared to the underlying white matter which appears hyperdense (lighter) in non-contrast images. • Atrophy: Loss of sulci and widening of the gyri may suggest cerebral atrophy (e.g., Alzheimer's or age-related changes). • White Matter Lesions: Areas of hypodensity in the white matter may indicate demyelinating conditions or chronic ischemia. **Gray Matter:** • The gray matter appears slightly darker than the white matter. • Abnormalities: Localized hypodensities in the gray matter may indicate ischemia, infarcts, or neurodegenerative changes.			
Ventricular System **Position and Size:** • The lateral ventricles should be symmetric and appear hypodense compared to surrounding brain tissue. • The third ventricle should also be symmetric, with no visible dilation. • The fourth ventricle should be normal in size, located in the cerebellopontine angle. **Ventriculomegaly:** • Enlargement of the ventricles may suggest hydrocephalus or normal pressure hydrocephalus (NPH). • Look for signs of communicating or non-communicating hydrocephalus based on ventricular enlargement and flow dynamics.			
Basal Ganglia and Thalamus **Position and Size:** • The basal ganglia and thalamus should be symmetric and of normal size. • Hypodensities may suggest ischemic changes, infarcts, or degenerative diseases (e.g., Parkinson's disease).			

Hemorrhages: • Small, hyperdense areas within the basal ganglia may suggest acute hemorrhage.			
Cerebellum and Brainstem **Position and Size:** • The cerebellum should be symmetric and positioned below the occipital lobe. • The brainstem should appear intact with no visible abnormal densities. • Atrophy: Loss of cerebellar volume may indicate degenerative conditions like cerebellar ataxia or multiple system atrophy.			
Cerebral Arteries and Venous Structures **Vascular Structures:** • The major arteries (e.g., middle cerebral artery) and venous structures (e.g., superior sagittal sinus) should be clearly visible if contrast is used. • Aneurysms, stenosis, or hemorrhages: Any irregularities in vessel size, shape, or enhancement may suggest vascular pathologies such as aneurysms, arteriovenous malformations (AVMs), or venous thrombosis.			
Pituitary Gland: • The pituitary gland should be well-defined and positioned within the sella turcica. • Abnormalities such as pituitary tumors or enlargement may be identified.			
Skull and Calvarium: • The skull bones should appear dense and intact without fractures. • Look for any signs of trauma, fractures, or calcifications in the calvarium.			
Summary of Findings • Correlate CT findings with clinical and laboratory data to support the diagnosis. • Provide a structured report focusing on any abnormalities in the brain parenchyma, ventricles, vascular structures, and surrounding tissues. • Recommend further imaging or intervention (e.g., MRI, angiography) if required for definitive diagnosis.			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Skill-16: Assessment of Glasgow Coma Scale

Entrustable Professional Activity: Assess Glasgow Coma Scale of a patient.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction: • Introduce yourself to the patient. • Confirm the patient's identity (name, age, and any other identifiers). • Explain the purpose of the assessment (assessing consciousness level) and gain consent. • Position the patient in a comfortable and safe position, preferably lying or sitting.			
General Inspection: • Observe the patient's level of consciousness (e.g., awake, drowsy, or unresponsive). • Look for any abnormal movements or posturing. • Check for any signs of trauma, bruising, or facial asymmetry.			
Assess Eye Opening (E): • **4 points**: Eyes open spontaneously. • **3 points**: Eyes open to verbal command. • **2 points**: Eyes open to painful stimulus. • **1 point**: No eye opening. • Observe if the patient opens their eyes spontaneously or in response to verbal or painful stimuli (e.g., nail bed pressure or sternal rub).			
Assess Verbal Response (V): • **5 points**: Oriented and converses normally. • **4 points**: Confused conversation but able to answer questions. • **3 points**: Inappropriate words or random speech. • **2 points**: Incomprehensible sounds. • **1 point**: No verbal response. • Ask the patient simple questions to assess orientation, such as "What is your name?" or "Where are you?"			
Assess Motor Response (M): • **6 points:** Obeys commands for movement. • **5 points:** Purposeful movement to painful stimulus. • **4 points:** Withdrawal from pain (non-purposeful). • **3 points:** Abnormal flexion (decorticate posturing). • **2 points:** Abnormal extension (decerebrate posturing). • **1 point:** No motor response.			

• Ask the patient to move limbs if they are able, or apply a painful stimulus to assess their motor response.			
Calculate the Total GCS Score: • Total Score = Eye Opening (E) + Verbal Response (V) + Motor Response (M). • A score of 15 indicates full consciousness. • A score of 9–12 suggests moderate impairment, and 3–8 indicates severe impairment (coma).			
Thank the Patient: • Thank the patient for their cooperation. • Offer to make the patient comfortable and ensure safety following the assessment.			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Block 6

Special Senses Module

Skill-17: Examination of Smell
Skill-18: Examination of Hearing
Skill-19: Examination of Vision.

Endocrinology Module

Skill-20: Examination of the Thyroid Gland.
Skill-21: Measurement of Blood Glucose Levels.

Certificate of Completion

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Special Senses Module Skills
Skill-17: Examination of Smell

Entrustable Professional Activity: Examine the nose and sense of smell
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Position: sitting			
History • Duration of complaint • Runny nose • Reduced ability to smell • Change in shape • Previous trauma/polyps			
Arrange adequate lighting			
General inspection • Congenital deformities, shape, swelling, ulceration			
Palpation • Nasal bones and cartilage and nasal septal area for tenderness, deformities and crepitus			
Anterior rhinoscopy • Examine the vestibule by tilting tip of nose • Examine nasal cavity using Thudichum's nasal speculum: identify any ulceration, swellings, excoriations			
Thank patient and offer to redress			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-18: Examination of Hearing

Entrustable Professional Activity: Examine the sense of Hearing
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before starting • Introduce yourself to the patient. • Explain the examination and ask for his consent to carry it out. • Sit him so that he is facing you and ensure that he is comfortable.			
The history • Name, age. and occupation, if this information has not already been provided. • Ask the patient if there has been any loss of hearing. If there has been loss of hearing, assess its: • Characteristics (bilaterality, onset, duration, severity, impact on the patient's life). • Associated features (tinnitus. vertigo. pain. discharge. weight loss). • Possible causes (trauma. infection, antibiotics. family history). • Impact on the patient's lire.			
Hearing • Test hearing by rubbing your fingers together into the ear at various distances, whilst distracting or occluding the other ear.			
Tuning fork tests • Use a 512 Hz tuning fork, and not the larger 128 Hz or 256 Hz tuning forks used for neurological examinations. • The Rinne test. Place the base of the vibrating tuning fork on the mastoid process of each ear. Once the patient can no longer "hear"" the vibration. Move the tuning fork in front of the ear. If the tuning fOlk can be heard, air conduction is better than bone conduction. and there is therefore no conductive hearing loss. The test is said to be positive. If the tuning fork cannot be heard, there is a conductive hearing loss, and the test is said to be negative. • The false negative Rinne test: if the Rinne test is performed on a deaf ear, it may appear negative because the vibration is transmitted to the opposite ear. • The Weber test. Place the vibrating tuning fork in the midline of the skull. If hearing is normal, or if hearing loss is			

symmetrical. the vibration should be heard equally in both ears. • If there is conductive deafness in one ear, the vibration is best heard in that some ear (since there is no background interference). • If there is sensorineural deafness in one ear, the vibration is best heard in the other ear.			
Auroscopy • Examine the pinnae for size, shape, deformities, pre·auricular sinuses. look behind the ears for any scars. • Palpate the pre-auricular, post-auricular, and infra-auricular lymph nodes. • Affix a speculum of appropriate size onto the auroscope. • Gently pull the ear 50 as to straighten the ear canal and, holding the auroscope like a pen, introduce it into the external auditory meatus. • If examining the right ear, use your right hand to hold the auroscope. If examining the left ear, use your left hand. • Through the auroscope. inspect the ear canal and the tympanic membrane.			
After examining the ear • Ask the patient if he has any questions or concerns. • Thank the patient. • Summarise your findings and offer a differential diagnosis			
Level of Satisfaction			

Comments:_____
_____

Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-19: Examination of Vision.

Entrustable Professional Activity: Examine the eye and test the Vision.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before starting • Introduce yourself 10 the patient. • Explain the examination and ask for his consent to carry it out. • Ensure that he is comfortable.			
Visual acuity • Snellen chart. Asess each eye individually, correcting for any refractive errors (glasses, pinhole). If the patient cannot read the Snellen chart, either move him closer or ask him to count fingers. If he fails to count fingers. test whether he can see hand movements and, if he cannot, test whether he can see light. • Test types (or fine print). Again, assess each eye individually, correcting for any refractive errors. • Ishihara plates. Indicate that you could use Ishihara plates to test colour vision specifically.			
Visual fields • Confrontation test: Sit at 1 cm from the patient. Cover your left eye with your left hand and ask the patient to cover his right eye and to fix his gaze upon your right eye. Starting at a distance, bring an equidistant moving finger into each of his upper and lower temporal fields. Then change hands and test his upper and lower nasal fields. Compare the patient's visual field to your own. Test the other eye. • Visual inattention test: Ask the patient to fix his gaze upon you and simultaneously bring a moving finger into each of the patient's right and left visual fields. In some parietal lobe lesions, only an ipsilateral finger is perceived by the patient. Mapping of central visual field defects. Indicate that you could use a red pin to delineate the patients blind spot and any central visual field defects.			
Pupillary reflexes • Inspection: Inspect the pupils for size and shape, • Pupillary reflexes: Ask the patient to fixate on a distant object and, using a pen torch, test the direct and consensual pupillary reflexes. If the consensual pupillary reflex is absent, there is a relative afferent pupillary defect, or Marcus Gunn pupil.			

• Accommodation reflex: Test the accommodation reflex by asking the patient to focus on a distant object and then on a finger held at 30 cm from his face.			
Eye movements • Inspection. look for a squint • Cover test: indicate that you could perform a cover test to look for a concomitant squint. • Eye movements: Fix the patient's head and ask him to track your finger through an "H" pattern. Ask him to report any double vision. • Nystagmus: look out for nystagmus at the extremes of gaze. You can do this as part of eye movements or separately by filting the patient's head and asking him to track your finger through a cross pattern			
Fundoscopy • Explain the procedure, mentioning that it may be uncomfortable. Darken the room andvask the patient to fixate on a distant object (or to "look over my shoulder"). State to the examiner that, ideally, the pupils should have been dilated using a solution of 1% cyclopentolate. • Red reflex: Test from a distance of 1m by looking through the ophthalmoscope. An absent red reflex is usually caused by a cataract. • Fundoscopy: Use your right eye to examine the patient'S right eye, and your left eye to examine the patient's left eye. If you use your left eye to examine the patient'S right eye, you may appear more caring than the examiner might like to see. look at the optic nerve head, the vessels, and the macula. Describe any features according to protocol.			
After the examination • Ask the patient if he has any questions or concerns. • Thank the patient. • Summarise your findings and offer a differential diagnosis.			
Level of Satisfaction			

Comments:_____

_____

Facilitator Name: _____

Designation: _____

Unit, Department, Hospital: _____

Date and Sign: _____

Endocrinology Module Skills
Skill-20: Examination of the Thyroid Gland.

Entrustable Professional Activity: Examine the Neck and Thyroid Gland.
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Wash hands			
Introduction • Introduce self • Confirm identity • Explain purpose of exam and gain consent • Expose: neck and up to infraclavicular region • Position: sitting			
General inspection • Site, size, shape, surrounding structures, scars (collar scar), asymmetry • Water test: goitre • Tongue test: thyroglossal cyst			
From behind • Palpation • Pain, pulsatility • Compressibility, consistency • Temperature • Fluctuation, fluid thrill • Water test • Lymph nodes			
From front • Percussion – retrosternal goitre • Tracheal deviation • Carotid pulse • Translucency • Auscultation from bruits			
Thyroid status • General appearance: clothes, weight, behaviour • Hands: pulse, thyroid acropachy, sweaty/dry skin, tremor, onycholysis, palmar erythema, other autoimmune disorders: vitiligo, hyperpigmented palmar creases • Face: eyebrow, hair, complexion • Eyes: exophthalmos, chemosis, lid retraction, lid lag, ophthalmoplegia, proptosis • Leg: pretibial myxoedema, ankle reflexes, proximal myopathy			
Thank patient and offer to redress			
Level of Satisfaction			

Comments:_____
_____
Facilitator Name: _____
Designation: _____
Unit, Department, Hospital: _____
Date and Sign: _____

Skill-21: Measurement of Blood Glucose Levels.

Entrustable Professional Activity: Measure blood glucose levels in patient
Miller's Level: Shows

Task	Assessment		
	Not Done	**Done**	**Well Done**
Before starting • Introduce yourself to the patient. • Explain the procedure and ask for his consent to carry it out. • Establish when he last ate (fasting blood glucose is usually carried out in the morning before the patient has had anything to eat or drink).			
The equipment • In a tray gather: • A pair of gloves. • An alcohol wipe. • A glucose monitor. • A Test strips. • A spring loaded pricker. • A lancet. • Cotton wool.			
The procedure • Ask the patient to wash and dry his hands, or use an alcohol wipe to clean the finger that you are going to prick. • Massage the finger from its base to its tip to increase its perfusion. • Turn on the glucose monitor and ensure that it is calibrated. • Check that the test-strips have not expired. • Insert a test·strip into the glucose monitor. • Load the lancet into the pricker and prick the side of the finger. • Squeeze the finger to obtain a droplet of blood. If no or insufficient blood is obtained, prick the finger again. If this happens, be sympathetic to the patient's plight. • Place the drop of blood on the test-strip, so as to cover the sensor entirely. • Give the patient some cotton wool to stop any bleeding. • Recold the reading on the monitor.			
After the procedure • Tell that patient their blood glucose and explain its significance and any further action that needs to be taken, e.g. fasting blood glucose, glucose tolerance test, laboratory measurement. • Ask the patient if he has any questions or concerns. • Thank the patient.			
Level of Satisfaction			

Comments:_____
_____
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Unit, Department, Hospital: _____
Date and Sign: _____