Department of Infectious Diseases
3rd Year MBBS Clinical Rotation Logbook

Hospital: Holy Family Hospital Duration:_____ to _____

Timetable: 1 Week (4 days a week)

Academic activity				
Day	**08:30 – 09:30**	**09:30 – 10:30 am**	**Teacher/ Facilitator**	**Evening duty 2:0 – 5:0 pm**
Monday	Student Gathering and Orientation to Infectious Disease components in 3rd year, MBBS, including medical ethics	Introduction to different Infectious Disease symptomatology (Fever, Chills, Malaise, Myalgia, cough, dyspnea, chest pain, sputum production, diarrhea, vomiting, abdominal pain, lymphadenopathy)	HOD	Nil
Tuesday	Small Group Interactive session (Common Infectious Diseases presentation e.g., Dengue, Malaria, Tuberculosis)	Art of History Taking, Importance of history, Contents of history, Presenting Complaint History of Present illness. Systemic Inquiry, Past Medical History, Family History, Occupational History, Personal History, Travel History, Blood transfusion history Developmental+ Obstetrics History.	HOD AP/Senior Registrar	Whole batch in Ward
Wednesday	Vital Signs (Pulse, Blood Pressure, Temperature, Respiratory Rate)	Infection Prevention and Control Workshop (including PPE, Hand washing techniques, Mask, Patient Safety Protocols)	HOD AP/Senior Registrar	Nil
Thursday	Small Group Interactive session (Focus on perfecting History Taking components)	Ward OSCE exam	HOD AP/Senior Registrar	Whole Batch in Ward.
Friday & Saturday	No Ward Rotation			
*All students will be regularly evaluated by attendance and participation.				

Department of Infectious Diseases
Clinical Training Program Week 1

No.	Date	Topic	Attendance Morning	Sign
1				
2				
3				
4				
5				
6				
7				
8				

Hospital _____Unit _____Duration from _____to _____

Self-Directed Learning

Date	Topic Observed/Self-Learned	Faculty Remarks	Signature

EPA's History and Examination

EPA	Task	Learning Objectives	EPA Level /Supervision level	Level Achieved
History Taking	Students should be able to obtain a comprehensive history	Students should be able to demonstrate art of history taking including all components of history.	3	
Vital Signs examination	Perform and record Vital signs examination	Students should be able to demonstrate accurate methods of Pulse examination, record accurate blood pressure, temperature recording, and respiratory rate measurement	3	
Educate basic disease/ problem information to patients and families.	Practice explaining basic problem information to patients and families	Students should be able to communicate effectively with patients and families, to provide basic disease/ problem information and establish rapport with them.	2	
Able to Describe Infection Prevention and Control	Practice Methods of infection prevention and control.	Students should be able donn and doff personal protective equipment, perform proper hand washing technique.	3	
EPA level 1 = Observation **EPA Level 2 = Direct supervision** **EPA Level 3= Supervision available** **EPA Level 4= Performs independently**				

ASSESSMENT

OSCE:

Total stations: 5

Each station mark: 10

Sr. No	Skill/Competency	Findings	Diagnosis	Marks Obtained	Total Marks	Signature
1	Structured history taking with emphasis on infectious diseases					
2	Structured History of Fever					
3	Structured History of Cough					
4	Structured History of abdominal pain					
5	Structured History of Diarrhea					
6	Infection Prevention and Control Principles					
7	Vital Signs recording					

Continuous Internal Assessment

CIA			**Total Marks: 30**
Histories and Logbook 20 marks	Attendance 10 marks		
If 5 Histories and Logbook are completed 20 marks	>90%	10marks	
less than 5 histories and Logbook is not completed			
0 marks	<80%	0 marks	

Total number of Histories = _____5_____

Logbook entries : Yes/ No

Average score = _____

Percentage of Attendance = _____

Average score of attendance =_____

Total CIA marks = Av. of Hx & Logbook + Av. of Attendance =_____/ 30

Ward test marks = OSCE + AV OSCE = _____/ 70

Total Marks = Ward test + CIA = _____ Percentage _____

In charge AP/SR _____ Signature: _____

Name Head of Unit: _____ Signature: _____

Table of Specifications

This table outlines the content areas, their relative importance, and the assessment methods used.

Content Area	Importance (Weightage)	Assessment Methods	Specific Topics
History Taking	40%	OSCE stations, Logbook entries	Components of history, Presenting complaint, History of present illness, Systemic inquiry, Past medical history, Family history, Occupational history, Personal history, Travel history, Blood transfusion history, Developmental and Obstetrics history
Physical Examination	30%	OSCE stations, Logbook entries	Vital monitoring
Infection Prevention and Control	10%	OSCE station, Logbook entries	PPE donning and doffing, Hand washing techniques, Patient safety protocols
Clinical Skills & Procedures	10%	Logbook entries	IV/IM/SC/Intradermal injections, IV line maintenance, Blood transfusion observation, Oxygen therapy, Progress note writing (SOAP format)

OSPE Exam for Third Year MBBS (Infectious Diseases)

General Instructions:

- The OSPE will consist of 5 stations.
- Each station is designed to assess specific clinical skills and competencies relevant to Infectious Diseases.
- The total duration of the OSPE is 50 minutes (10 minutes per station).
- Students will rotate through each station.
- Read the instructions carefully at each station before proceeding.
- Observe standard infection control practices at all stations.

Station 1: History Taking (Fever)

- **Duration:** 10 minutes
- **Objective:** To assess the student's ability to take a structured history of fever.
- **Scenario:** A patient presents with a 3-day history of fever.
- **Tasks:**

1. Take a detailed history from the patient (simulated). Include:
   - Onset, duration, and pattern of fever
   - Associated symptoms (e.g., chills, rigors, sweating)
   - Other relevant symptoms (e.g., headache, body aches, cough, diarrhea)
   - Past medical history, medications, allergies
   - Travel history
2. Summarize the key points of the history.

- **Assessment:**
  - Completeness of history (2 marks)
  - Logical organization of history (2 marks)
  - Relevant questioning and probing (2 marks)
  - Communication skills and rapport (2 marks)
  - Summary of key points (2 marks)

Station 2: Complete History Taking Pattern with emphasis on Infectious Diseases

- **Duration:** 10 minutes
- **Objective:** To assess the student's ability to take a structured history with emphasis on identifying infectious disease risks and red flags.
- **Scenario:** A 30-year-old female presents with 3 days of fever, headache, and myalgia.

1. Presenting Complaint

Fever pattern:

- Onset, duration, maximum temperature
- Continuous vs. intermittent
- Associated chills/rigors

Epidemiologic clues:

- Recent sick contacts
- Animal/insect exposure
- Daycare/workplace outbreaks

2. Systemic Review

Infection-focused symptoms:

- **Respiratory:** Cough, sputum, pleuritic pain
- **GI:** Diarrhea (bloody?), nausea/vomiting
- **Neurologic:** Neck stiffness, photophobia
- **Skin:** Rash (macular/papular/petechial)

3. Past Medical History

Immunocompromise risks:

- HIV, diabetes, immunosuppressants
- Asplenia, cancer chemotherapy

Vaccination status:

- Influenza, COVID-19, meningococcal
- Travel vaccines (yellow fever, typhoid)

4. Exposure History

Travel:

- Locations (malaria/dengue/Zika zones)
- Rural vs. urban stay
- Unsafe food/water

Occupational:

- Healthcare worker (TB/meningitis risk)
- Veterinarian (zoonoses)

High-risk behaviors:

- Unprotected sex (HIV/HBV/HCV)
- IV drug use (endocarditis)

5. Medication History

Recent antibiotics (C. difficile risk)
Prophylaxis adherence (malaria/HIV PEP)

Assessment:

- **Epidemiologic risk identification** (4 marks)
- **Infection-focused review** (3 marks)
- **Vaccination/exposure history** (2 marks)
- **Clinical correlation** (1 mark)

Station 3: Vital Signs Recording

- **Duration:** 10 minutes
- **Objective:** To assess the student's ability to accurately measure and document vital signs, recognizing abnormal values requiring urgent intervention.
- **Scenario:** A 55-year-old male patient with fever for 1 week requires routine vital sign monitoring

Tasks:

1. **Measure and Document:**
    - **Blood Pressure:** Correct cuff size, Patient position (seated/supine, arm at heart level)
    - **Pulse:**
        - Rate, rhythm, volume, character, radio radial and radio femoral symmetry or delay
        - Capillary refill time (<2 sec)
    - **Respirations:**
        - Count for 30 sec (unnoticed by patient)
        - Pattern (regular, Cheyne-Stokes)
    - **Temperature:**
        - Oral/axillary method (document route)
2. **Identify Abnormalities:**
    - Hypertension (BP >140/90 mmHg)
    - Tachycardia (HR >100 bpm)
    - Fever (>38°C)

3. **Clinical Correlation:**
    - Link findings to potential causes (e.g., tachycardia → pain vs. hemorrhage)
    - State actions for critical values (e.g., notify physician if SBP <90 mmHg)

Assessment:

- **Measurement accuracy** (4 marks)
- **Documentation completeness** (3 marks)
- **Abnormality recognition** (2 marks)
- **Clinical response** (1 mark)

Station 4: Infection Prevention (Hand Hygiene)

- **Duration:** 10 minutes
- **Objective:** To assess the student's ability to perform proper hand hygiene techniques according to WHO guidelines.
- **Scenario:** You are preparing to perform a sterile procedure on a patient.

Tasks:

1. **Demonstrate proper hand hygiene:**
    - **Handwashing with soap and water:**
        - Wet hands with clean, running water
        - Apply soap and lather for 20 seconds
        - Cover all surfaces:
            - Palms → backs → between fingers → thumbs → fingertips → wrists
        - Rinse thoroughly and dry with single-use towel
    - **Alcohol-based hand rub:**
        - Apply palmful of product
        - Rub hands covering all surfaces until dry (~20-30 seconds)
2. **Explain when each method is indicated:**
    - **Soap and water:**
        - Visibly dirty hands
        - After using restroom
        - Before eating
        - After exposure to C. difficile or norovirus
    - **Alcohol-based rub:**
        - Before/after touching patient
        - Before aseptic procedures
        - After contact with body fluids

3. **Identify common missed areas** (thumbs, fingertips, wrists).

Assessment:
- Technique (soap/water or alcohol rub) (5 marks)
- Timing (minimum 20 seconds) (2 marks)
- Knowledge of indications (2 marks)
- Identification of high-risk areas (1 mark)

Station 5: Paediatric Fever Counselling
- **Duration:** 10 minutes
- **Objective:** To assess ability to educate parents about childhood fever management
- **Scenario:** Parents of a 3-year-old with 103°F fever seek advice

Tasks:
1. Explain fever physiology:
   - "Fever helps fight infection - we treat for comfort, not numbers"
2. Demonstrate medication dosing:
   - Show proper acetaminophen dosing using syringe
   - "Never use aspirin in children"
3. Teach warning signs:
   - "Bring to ER if neck stiffness, purple rash, or trouble breathing"

Assessment:
- Medication teaching accuracy (3 marks)
- Danger sign recognition (3 marks)
- Parental reassurance skills (2 marks)
- Teach-back of dosing (2 marks)