Title/Subject: Patient Type/Clinical Condition Logs and Procedure/Skills Log Policy

Applies to: ⊠ faculty ⊠ students　　　　　☐ staff　　　⊠ Clerkship Directors and Coordinators

⊠ Policy ☐ System　　　　⊠ Process/Procedure　　　☐ Guideline/Standard　　☐ Position Description

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- **Introduction**

- **Historical/Contextual Overview:**

During the clinical years, students need to develop the clinical competencies required for graduation and post-graduate training.

These competencies are evaluated in many different ways: by faculty observation during rotations, by oral examinations, by written examinations and by the USMLE Step 2 examinations (CK & CS) or the school's final examinations. In order to develop many of these competencies and meet the objectives required for graduation, the school needs to ensure that each student sees enough patients and an appropriate mix of patients during their clinical terms. For these reasons, as well as others discussed below and to meet accreditation standards, the school has developed this patient type/clinical condition and procedure/skills log policy.

One of the competencies that students must develop during their clinical training involves documentation. Documentation is an essential and important feature of patient care and learning how and what to document is an important part of medical education. Keeping this log becomes a student training exercise in documentation. The seriousness and accuracy with which students maintain and update their patient log will be part of their evaluation during the core rotations.

Not only by the number of diagnoses they log, but by how conscientious and honest they keep their log and document their patient encounters. All of these features of documentation – seriousness, accuracy, conscientiousness and honesty – are measures of professionalism.

- **Reason for the Policy/Process:**

Evaluation of:

- Course/clerkship evaluation: Demonstrate student exposure to patients with medical problems that support course objectives.

- Clerkship faculty/site evaluation: Demonstrate level of student involvement in the care of patients.

- Student evaluation: Demonstrate student exposure to and participation in targeted clinical procedures.

- Program evaluation: Demonstrate student exposure to patient populations in both inpatient and outpatient settings.

- Site evaluation: Demonstrate suitability of a particular practice or site as a location for student education.

- Student self-evaluation: Quantify for students, the nature and scope of their clinical education and highlight educational needs for self-directed learning.

- Student education: To use in conversation with clerkship directors about the experience, can be used as a point of discussion about the students accomplishment of educational objectives that are illustrated by the review of clinical data from their experiences.

- **Scope:** This policy applies to students who are completing the clinical portion of their education (ex: clerkship students).

- **Policy/Process Statement:** Students are expected to document all required patient types/clinical conditions and   all required procedure/skills in a timely manner. This is not an exercise in recreational data gathering. There is   sound rationale for collecting these data. The Clerkship Directors are monitoring the data on an ongoing basis to insure that students are meeting clerkship objectives. The Curriculum Committee, Education Directors, Regional Campus Deans, and Clerkship Directors review the data to insure comparability between sites.   Annually, the data is reviewed by Academic Affairs, Curriculum Committee, and the Core Clinical Committees to insure that the clinical experiences are meeting the objectives of the clerkship and to assess the comparability of experiences at various sites.

- **Procedure**

Patients ≠ Encounters!
Record only clinically relevant interactions, for example:
(If you talk to the patient or touch the patient, you should log the encounter)

- History (full or partial)
- Physical exam (full or partial)
- Procedures (observed, assisted, or performed)

For example: Elicitation of information from the patient about his/her illness and/or treatment (Taking a History); and/or performance of one or more physical examination maneuvers (doing a physical exam); and/or performance of a medical/surgical procedure.

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Last Updated: Reviewed 09.08.21
Authority: Curriculum Committee
Responsible University Office: Office of Academic Affairs
Responsible University Administrator: Senior Associate Dean of SA and Assistant Dean of AA, Clinical Curriculum
Review/Revision Schedule: Annually in July or August
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Outpatient Guidelines

- You must talk to or lay hands on the patient to record the encounter
- Don't record observed H&P's
- **Exception:** observation of a procedure

Inpatient Guidelines

- A student will only enter additional encounters on the same patient during their hospital stay if the patient's condition/circumstances change sufficiently to warrant a new examination, procedure, or reassessment or a new diagnosis arises

Note: Same Patient but change of setting (nursing home to hospital) even same day = new encounter (If you see a patient in the morning at the clinic, they are admitted to the hospital and you round on them that night, that is two encounters. Document both).

If your supervisor's name does not show up, choose "other" and include supervisor name in the comments section.

- **Compliance:**

Clerkship Director Responsibility – Monitor and Review students patient encounters regularly, at a minimum for mid rotation and end of rotation (If, for example, the OB/GYN Clerkship Director notices that you are not experiencing enough vaginal deliveries, steps can be taken early in the clerkship to remedy the situation).

Discuss encounters with the students:

- Identify if students are meeting course objectives
- Identify areas needing supplementation
- Identify learning needs
- Address difficulties in meeting clerkship objectives.

Monitoring

At a minimum, logs will be reviewed during interim evaluations. This will allow students to focus subsequent clinical encounters to maximize the chance of a direct clinical experience with patients with the conditions on the required list for that clerkship/course. During the meeting each student's overall clinical experiences will be discussed, including a review of the Clinical Log. If needed, a student's subsequent clinical rotation will be modified to the extent possible to maximize the chance of direct clinical experiences with patients with the conditions listed above. If despite these efforts it is determined later in the clerkship that a student might not get a direct clinical experience with a patient for the requirement, an indirect experience will be created. Examples of indirect experiences are below in order of preference:

- a simulated experience can count toward the requirement.

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- A case review or module may be completed in place of a direct experience

a clinical discussion about the topic with the resident or attending or the clerkship director The extent of the interaction will be documented in the Clinical Log.

Student Responsibility - Document all required patient type/clinical conditions and document all required procedures/skills. Document information in a timely manner. You are strongly encouraged to enter data on a daily basis and are required to do so <u>on a</u>   <u>weekly basis by 7 AM each Monday.</u>

- **Exceptions:** N/A

- **Non-compliance:** <u>Failure to do so is considered unprofessional</u>   <u>behavior and will be so noted by your</u> <u>clerkship director.</u> **Completion of encounter/procedure logs is a barrier requirement for all required clinical courses. Failure to complete logs will result in 69/F for the course.**

- **Resources and Tools:**

Encounter Information

Make sure the **Date** you enter is the date you actually saw the patient. Be sure to pick the correct **Clerkship/Course** and your **Supervisor**. If your supervisor's name does not show up, choose "other" and include supervisor name in the comments section.

Enter **Patient information** (see below) and up to six **diagnoses** from the list. If the problem was not on the list, there are "Other xxx problems" for every category. Use these, but only if you cannot find something that "fits."

Select the **Visit Level of Care** that indicates most accurately your interaction and involvement with the patient during this encounter based on the clerkship syllabus.

- **Minimal: Min. Pt. contact** - The student has minimal contact with patient, which amounts to less than doing an Hx or PE. An example might be that your faculty calls you into the exam room to listen to an interesting murmur. This is equivalent to observation and discussion of the diagnosis or patient type.

- **Moderate: Hx and/or PE -** The student performs either a problem-focused or complete   Hx and/or PE but has no role in the diagnosis or treatment of the patient. Or engaged in diagnosis or treatment with minimal engagement in H&P.   This is more than observation but moderate interaction.

- **Full: Hx and PE + (DDx and/or Tx) -** The student performs a history and physical exam and is involved in the diagnosis and treatment of the patients under supervision of the resident or attending physician.

This includes ongoing management of hospitalized patients. For most patient types, this would likely be the expectation of involvement so that students have the exposure to the full spectrum of the clinical condition.

Date Observed/Performed

Clerkship   Emergency Medicine
                                                     Family Medicine Clerkship
                                                     Internal Medicine Clerkship
                                                     Obstetrics & Gynecology Clerkship
                                                     Pediatric Clerkship
                                                     Psychiatry Clerkship
                                                     Surgery Clerkship

Is this patient new to YOU?   Y/N
Supervisor   (choose name from list)
Setting   Clinic (Outpatient)
                                                     Hosptial (Inpatient)
                                                     Emergency room
                                                     Simulation
Specific Location (i.e. name of clinic/hospital)   (text box)
Level of Involvement   Minimal: Min. Pt. contact
                                                     Moderate: Hx and/or PE
                                                     Full: Hx and PE + (DDx and/or Tx)
                                                     Under 18
Patient Age   Over 18
                                                     Over 70

Patient Gender   M/F
Patient Race   American Indian
                                                     Asian
                                                     Black
                                                     Hispanic/Latino
                                                     Pacific Islander
                                                     White
                                                     Other

Diagnosis   1$_{stnd}$ DX

                                               2$_{rd}$ DX 3

Notes   DX

Procedure Information   (text box)

There is a long list of procedures to select. You must pick both the **Procedure/Skill**   and the   **Level of Involvement.**   you   had with the procedure. **Procedure/Skills Levels of Responsibility**

1. **Be present and OBSERVE** - At early stages it is the privilege of the trainee to be present and observe what he or she will be expected to do at the next stage. Gradually the trainee can start doing parts of the activity.

2. **Act with DIRECT SUPERVISION** - At this stage the trainee may carry out the full activity independently. The supervisor is in the room watching and can intervene or take over at any time deemed necessary. This has been called "proactive supervision" or "routine oversight." Part of this level can include coactivity—that is, the activity is done collaboratively with a senior individual.

3. **Act with INDIRECT SUPERVISION** - At this stage the trainee may carry out the full activity independently with a supervisor not present in the room but available within minutes. This has been called "reactive supervision" or "responsive oversight." It includes the availability of supervision by telephone for advice. Reactive supervision may develop from checking all findings related to the trainee's performance, through checking key findings.

4. **Act WITHOUT SUPERVISION** - At this stage the trainee may carry out the full activity with no supervisor available on short notice. The trainee reports post hoc the same or the next day. This stage gradually extends into fully and mature unsupervised practice, but as long as the trainee is in training, he or she acts under "clinical oversight" or "backstage supervision." This stage marks the grounded trust that should allow for certification to take full responsibility for an entrustable professional activity. At the UME level, this may only include foundational skills such as vital signs, taking a history, performing a physical exam.

5. **PROVIDE SUPERVISION -** This level is awarded when a senior trainee may act in a supervisory role for more junior trainees. The trainee must have shown the ability to provide supervision.

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Clerkship	Emergency Medicine
	Family Medicine Clerkship
	Internal Medicine Clerkship
	Obstetrics & Gynecology Clerkship
	Pediatric Clerkship
	Psychiatry Clerkship
	Surgery Clerkship
Supervisor	
Setting	Clinic (Outpatient)
	Hosptial (Inpatient)
	Emergency Room
	Simulation
Specific Location (i.e. name of clinic/hospital)	(text box)
Level of Involvement	Be present and OBSERVE
	Act with DIRECT SUPERVISION
	Act with INDIRECT SUPERVISION
	Act WITHOUT SUPERVISION
	PROVIDE SUPERVISION
	Under 18
	Over 18
Patient Age	Over 70
Patient Gender	M/F
Patient Race	American Indian
	Asian
	Black
	Hispanic/Latino
	Pacific Islander
	White
	Other
Procedure	1^{st}_{nd}
	2_{rd}
	3
Notes	(text box)

Use **Notes**   to remind yourself of some interesting aspect of the encounter or to specify a diagnosis when you had

to   select "other" from the problem list because the real problem was not there.

● **Revision History:**

Date of Change	Authority	Summary of Changes	Document Location
Nov 2013	Curriculum Committee	Created and approved	Academic Affairs shared drive
08.08.2018	Curriculum Committee, Core Clinical Subcommittee	Moved to new policy template. Reviewed by Core Clinical Subcommittee, no changes.	Academic Affairs Google Drive, Core Clinical folder
4.10.18	Curriculum Committee, Core Clinical Subcommittee	Updating policy based on evaluation and log task force recommendations. For review and approval by core clinical subcommittee and CC.	
11.8.19	OAA	Updated policy template format and edited some incorrect language. No content changes made.	Sent to CC administrator and EQI.

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