



GAZI UNIVERSITY  
FACULTY OF MEDICINE

# CLINICAL SKILLS EDUCATION

LEARNING &  
EVALUATION GUIDES



# **Gazi University Faculty of Medicine**

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# PHASE 1



# GAZİ UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS TRAINING

## LEARNING GUIDE

### HANDWASHING SKILL

**PURPOSE:** To acquire proper hand washing skills

**EQUIPMENTS:** Washbasin, clean water, soap (liquid soap, cleaning solution), paper towel

**PARTICIPANT:**

Our hands are the organs that most frequently come into contact with the external environment and cause the most transmission. For this reason, we must know and remember to wash our hands well.

**While our hands are sparkling, we must repeat the movements described below in order and at least five times.**



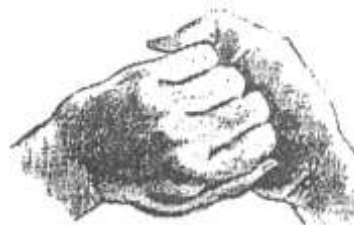
The palms touch each other and rub.



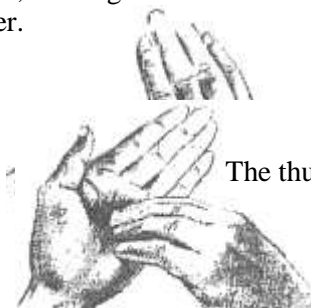
Using the palm, rub the back of the other hand.



While the palms are in contact with each other, the fingers are rubbed between each other.



While the fingers are closed and flexed, the back sides of the fingers are rubbed in contact with the palm of the other hand.



The thumbs are taken in the palm of the other hand and rubbed.

NO	STEPS
1.	Fold the sleeves of your clothing to expose the wrists.
2.	Remove your watch, ring, bracelet, etc.
3.	Open the tap and wet your hands under running water.
4.	Take 2-5 ml of liquid soap on your hand (Use 2-3 times in soap dispensers with automatic pump system).
5.	Foam the soap with a little water.
6.	Foam your hands thoroughly and repeat the rubbing motion by taking your palm in your palm.
7.	Place the back of the left hand in the right palm, rub and repeat five times. Repeat the same movement for the other hand.
8.	Put the right hand on the back of the left hand, rub the fingers between the fingers. Repeat the same movement for the other hand.
9.	Place the back of the right hand fingers in the palm of the left hand, rub. Repeat the same movement for the other hand.
10.	Take the right thumb with the left palm and rub it rotationally five times. Repeat the same movement for the other hand.
11.	Put the insides of the right hand fingertip into the left palm and rub. Repeat the same movement for the other hand.
12.	Wash your hands thoroughly under the water and rinse your hands by draining the foam of the cleanser completely.
13.	Dry your hands with a paper towel.
14.	If the tap is screwed, rinse it by hand running water over the tap screw and turn off the tap while holding your hand with a paper towel that you have dried. Turn off the tap with your elbow in arm taps.
15.	Throw the used towel into the blue (household waste) garbage bag.



# GAZI UNIVERSITY

## FACULTY OF MEDICINE

### CLINICAL SKILLS TRAINING

## LEARNING GUIDE

### HANDWASHING SKILL ASSESSMENT FORM

**Name:** \_\_\_\_\_

**No:** \_\_\_\_\_

**ASSESSMENT CRITERIA:**  
 Using the scoring system below, repeat the skill until all steps are done correctly, in order, without hesitation, and you get full marks from all of them.  
**A - Mastered:** Properly and during the step without hesitation and without the need for the help of the trainer  
**implementation**  
**B - Adequate:** Performing the step correctly and in sequence; but the need for the help of the trainer  
**implementation**  
**C - Needs improvement:** no implementation of the step; incorrectly applied or not applied during

NO	STEPS	
1.	Fold the sleeves of your clothing to expose the wrists.	
2.	Remove your watch, ring, bracelet, etc.	
3.	Open the tap and wet your hands under running water.	
4.	Take 2-5 ml of liquid soap on your hand (Use 2-3 times in soap dispensers with automatic pump system.	
5.	Foam the soap with a little water.	
6.	Foam your hands thoroughly and repeat the rubbing motion by taking your palm in your palm.	
7.	Place the back of the left hand in the right palm, rub and repeat five times. Repeat the same movement for the other hand.	
8.	Put the right hand on the back of the left hand, rub the fingers between the fingers. Repeat the same movement for the other hand.	
9.	Place the back of the right hand fingers in the palm of the left hand, rub. Repeat the same movement for the other hand.	
10.	Take the right thumb with the left palm and rub it rotationally five times. Repeat the same movement for the other hand.	
11.	Put the insides of the right hand fingertip into the left palm and rub. Repeat the same movement for the other hand.	
12.	Wash your hands thoroughly under the water and rinse your hands by draining the foam of the cleanser completely.	
13.	Dry your hands with a paper towel.	
14.	If the tap is screwed, rinse it by hand running water over the tap screw and turn off the tap while holding your hand with a paper towel that you have dried. Turn off the tap with your elbow in arm taps.	
15.	Threw the used towel into the blue (household waste) garbage bag.	



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### APPLYING AND REMOVING STERILE GLOVES

**TOOLS:** Sterile gloves

**PARTICIPANT:**

#### Types of gloves and their uses

**Nylon gloves:** They are made of thin, usually clear nylon. They are used in simple procedures to keep hands clean. Because the gloves are not a tight fit, fine procedures requiring precision cannot be carried out with them. They are more commonly used in the food industry to prevent contamination.

**Examination gloves:** They are made of latex. They are not sterile, come in one size and are sold in packages of many gloves. Because of their tight fit, they are used in our profession very often. Both gloves of a pair are the same.

**Surgical gloves (sterile gloves):** Like the examination glove, they are made of latex. However, the thumbs are slightly retracted to ensure a better fit. Therefore, there are different gloves for your right and left hands. Again, to ensure a better fit, they come in different sizes. Starting from size 7 they increase by half a size and go up to size 8½.



Pay attention to the position of your thumb. Holding the glove by the neck with one hand, advance your other hand into glove until each finger is in its place. Then push hand completely forward.



With your gloved hand, hold other glove by placing fingers under its cuff. Then put glove onto other hand as described in previous step.

NOT: Eldivenlerin ince olduğunu, sert hareketler, keskin cisimler ile delinebileceğini unutmayınız. Hatta eldivenlerin eğer de olsa delik çıkabileceğini anımsayınız.



To remove gloves, grasp neck of opposite glove with fingers and create a fold outwards. Pull glove off by pulling it by the neck.



Insert fingers of ungloved hand between opposite wrist and glove so as to fold glove onto itself. Grasp glove from the inside and slide it off.

NOTE: The most commonly made mistake at this step is to grasp the neck of the glove from the *outside* with ungloved hand



STEP NO	STEPS
1	Wash and dry your hands.
2	Choose a pair of gloves with the appropriate size.
3	Make sure the package is intact and check expiration date.
4	Remove external package without tearing the wrapping inside and place internal package on the table.
5	Open the internal package on the table without touching the glove or the inside of the package.
6	With your dominant hand, pick up the opposite glove by the wrist without touching the outer surface of the glove.
7	Turn glove so the thumb is facing forwards. Insert hand into glove and make sure fingers are in their places. After fingers are in their places, pull glove towards your wrist with the other hand.
8	Insert 2nd and 3rd fingers of gloved hand into the folded neck part of opposite glove and remove it from its package without touching the outer surface with your ungloved hand.
9	Turn glove so the thumb is facing forwards. While advancing your hand in the glove, pull the glove by the neck with your gloved hand and make sure your fingers are in place without touching anything else.
10	Pull up folded neck part of the other glove to cover wrist.
11	After completing the procedure, grasp neck of opposite glove with your dominant hand and pull it off without getting skin in contact with outer surface of glove.
12	Throw the glove you removed into red (medical) waste bag
13	Insert fingers of ungloved hand between opposite wrist and glove so as to fold glove. Grasp glove from the inside and slide it off without touching outer surface.
14	Throw glove into red medical waste bag and the packaging into blue waste bag.
15	Wash and dry your hands.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### WEARING AND REMOVING USED STERILE GLOVES

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

<b>PARTICIPANT:</b>	<b>NO:</b>
<b>COACH:</b>	<b>SIGNATURE:</b>
	<b>DATE:</b>

	STEPS	OBSERVATION		
		1	2	3
<b>1</b>	Washed and dried his/her hands			
<b>2</b>	Chose a pair of gloves with the appropriate size.			
<b>3</b>	Be sure the package was intact and checked expiration date.			
<b>4</b>	Removed external package without tearing the wrapping inside and placed internal package on the table.			
<b>5</b>	Opened the internal package on the table without touching the glove or the inside of the package.			
<b>6</b>	With his/her dominant hand, picked up the opposite glove by the wrist without touching the outer surface of the glove.			
<b>7</b>	Turned glove so the thumb was facing forwards. Inserted hand into glove and make sure fingers were in their places After fingers were in their places, pulled glove towards his/her wrists with the other hand.			
<b>8</b>	Inserted 2nd and 3rd fingers of gloved hand into the folded neck part of opposite glove and removed it from its package without touching the outer surface with his/her ungloved hand.			
<b>9</b>	Turned glove so the thumb was facing forwards. While advancing his/her hand in the glove, pulled the glove by the neck with his/her gloved hand and make sure his/her fingers were in place without touching anything else.			
<b>10</b>	Pulled up folded neck part of the other glove to cover wrist.			
<b>11</b>	After completing the procedure, grasped neck of opposite glove with his/her dominant hand and pulled it off without getting skin in contact with outer surface of glove.			
<b>12</b>	Threw the glove and removed into red (medical) waste bag			
<b>13</b>	Inserted fingers of ungloved hand between opposite wrist and glove so as to fold glove. Grasped glove from the inside and slided it off without touching outer surface.			
<b>14</b>	Threw glove into red medical waste bag and the packaging into blue waste bag.			
<b>15</b>	Washed and dried his/her hands.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### MEASURING PULSE

**TOOLS:** None

**PARTICIPANT:**

STEP NO	STEPS
1	Wash your hands.
2	Inform the patient about the examination and make him/her comfortable.
3	If the patient climbed stairs, walked or is tired etc., tell him/her to rest for 5-10 minutes.
4	Tell patient to take off any clothing that conceals his/her chest wall movements .
5	Stand on the right side of patient.
<b>MEASURING PULSE FROM RADIAL ARTERY</b>	
6	Position the patient so that their right palm faces the ground.
7	Place your 2nd, 3rd and 4th fingers on the radial artery.
8	Palpate the radial artery.
9	After finding the pulse, count the beats for 60 seconds.
10	Note the rate, rhythm and fulness of the beats.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### MEASURING PULSE

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	<u>OBSERVATION</u>		
		1	2	3
	<b>MEASURING PULSE FROM RADIAL ARTERY</b>			
<b>1.</b>	Washed hands.			
<b>2.</b>	Informed the patient about the examination and made him/her comfortable.			
<b>3.</b>	If the patient climbed stairs, walked or is tired etc., told him/her to rest for 5-10 minutes.			
<b>4.</b>	Told patient to take off any clothing that conceals his/her chest wall movements .			
<b>5.</b>	Stood on the right side of patient.			
<b>6.</b>	Positioned the patient so that their right palm faced the ground.			
<b>7.</b>	Placedhis/her 2nd, 3rd and 4th fingers on the radial artery.			
<b>8.</b>	Palpated the radial artery.			
<b>9.</b>	After finding the pulse, counted the beats for 60 seconds.			
<b>10.</b>	Noted the rate, rhythm and fullness of the beats.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### MEASURING ARTERIAL BLOOD PRESSURE

**TOOLS:** Sphygmomanometer, stethoscope

**PARTICIPANT:**

STEP NO	STEPS
1	Measure arterial blood pressure in a quiet, calm environment.
2	Inform patient about the procedure.
3	Make sure that the patient has not exercised, consumed caffeine, smoked cigarettes or used nose/eye drops 30 minutes prior to the measurement.
4	Before the measurement, have the patient sit on a chair (with feet on the ground and arms at level of the heart) for at least 5 minutes.
5	The blood pressure measurement should be done with a calibrated sphygmomanometer and stethoscope. (The cuff size of the manometer system you are using is important. A small cuff should be used for children, and a large one for adults. The cuff should be 2/3rds the length of an arm.)
6	Make sure the patient's arm is completely exposed. (The upper part of the arm should not be constricted by the rolled up sleeve of the patient's garment)
7	Check the brachial and radial pulses of the arm you are going to measure from.
8	Empty the cuff completely so that no air is left in it.
9	Place cuff on arm. <ul style="list-style-type: none"> <li>• 2-3 cm above the elbow,</li> <li>• So that it fits snugly, but does not compress the arm</li> <li>• There should be 1 cm between the cuff and skin of arm.</li> </ul>
10	Place stethoscopes in ears so that ear tips face forward.
11	Tap diaphragm of stethoscope to make sure the system is ready.
12	Place diaphragm on brachial artery without pressing on it. (Do not insert it between cuff and skin so that it will not be under pressure when cuff is inflated)
13	Turn off valve of manometer completely and start inflating cuff. <ul style="list-style-type: none"> <li>• Simultaneously palpate radial pulse.</li> <li>• Inflate an additional 15-20 mmHg after the pulse disappears.</li> </ul>
14	Stabilize the stethoscope on the brachial artery without compressing it and turn on the valve. The pressure should drop by 2-3 mmHg every second.
15	While the pressure drops 2-3 mmHg/sec, <ul style="list-style-type: none"> <li>• Listen for Korotkoff sounds.</li> <li>• The value at which you hear the first sound indicates the systolic blood pressure.</li> <li>• The value at which the sounds disappear indicates the diastolic blood pressure.</li> </ul>
16	Take your stethoscope off.
17	Empty air from cuff.
18	Remove cuff from arm.
19	Write down the values you measured and inform the patient about them.

Note : To repeat measurement from the same arm, you must wait at least 5 minutes.



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### MEASURING ARTERIAL BLOOD PRESSURE

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	<u>OBSERVATION</u>		
		1	2	3
1.	Measured arterial blood pressure in a quiet, calm environment.			
2.	Informed patient about the procedure.			
3.	Made sure that the patient had not exercised, consumed caffeine, smoked cigarettes or used nose/eye drops 30 minutes prior to the measurement.			
4.	Before the measurement, had the patient sit on a chair (with feet on the ground and arms at level of the heart) for at least 5 minutes.			
5.	The blood pressure measurement should be done with a calibrated sphygmomanometer and stethoscope. (The cuff size of the manometer system you are using is important. A small cuff should be used for children, and a large one for adults. The cuff should be 2/3rds the length of an arm.)			
6.	Made sure the patient's arm is completely exposed. (The upper part of the arm should not be constricted by the rolled up sleeve of the patient's garment)			
7.	Checked the brachial and radial pulses of the arm you would measure from.			
8.	Emptied the cuff completely so that no air was left in it.			
9.	Placed cuff on arm. <ul style="list-style-type: none"> <li>• 2-3 cm above the elbow,</li> <li>• So that it fits snugly, but did not compress the arm</li> <li>• There should be 1 cm between the cuff and skin of arm.</li> </ul>			
10.	Placed stethoscopes in ears so that ear tips faced forward.			
11.	Tapped diaphragm of stethoscope to make sure the system was ready.			
12.	Placed diaphragm on brachial artery without pressing on it. (Did not insert it between cuff and skin so that it would not be under pressure when cuff was inflated)			
13.	Turned off valve of manometer completely and started inflating cuff. <ul style="list-style-type: none"> <li>• Simultaneously palpated radial pulse.</li> <li>• Inflated an additional 15-20 mmHg after the pulse disappears.</li> </ul>			
14.	Stabilized the stethoscope on the brachial artery without compressing it and turned on the valve. The pressure should drop by 2-3 mmHg every second.			
15.	While the pressure drops 2-3 mmHg/sec, <ul style="list-style-type: none"> <li>• Listened for Korotkoff sounds.</li> </ul>			
16.	Took his/her stethoscope off.			
17.	Emptied air from cuff.			
18.	Removed cuff from arm.			
19.	Wrote down the values measured and informed the patient about them.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### INTRAMUSCULAR INJECTION

**TOOLS:** Medication, syringe, antiseptic, tampon, gloves

**PARTICIPANT:**

STEP NO	STEPS
1	Wash and dry your hands. Put on gloves.
2	Check the label of the medication you are going to inject and prepare medication and syringe.
3	Imagine a line from the posterior superior iliac spine (the posterior protrusion of the hip bone), to the greater trochanter of the femur. (This line is parallel to the sciatic nerve and is lateral to it)
4	The area you will make the injection is on the upper and outer side of this line, 5-8 cm below the iliac crest.
5	Clean this area with antiseptic solution.
6	With the thumb and 3rd finger of your left hand, hold the skin of this area taut.
7	Hold the syringe in your right hand like you would hold a pen, with a 90 degree angle to the skin.
8	Rapidly and firmly insert the syringe into the skin and advance it towards the muscle. You should reach muscle when $\frac{3}{4}$ ths of the needle is inside.
9	Pull the piston lightly towards yourself; if blood is drawn, quickly pull the syringe out. Replace the needle if possible and repeat procedure.
10	If no blood is drawn when the piston is pulled, slowly inject the medication.
11	When finished, quickly pull the syringe out.
12	Press firmly on the area with a cotton ball soaked in antiseptic solution or gauze.
13	Clean up after yourself: used syringes, needles and any other medical waste goes should be safely disposed of. When finished, take you gloves off and wash your hands.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### INTRAMUSCULAR INJECTION

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	<u>OBSERVATION</u>		
		1	2	3
<b>1</b>	Washed and dried his/her hands Put on gloves			
<b>2</b>	Checked the label of the medication he/she is going to inject and prepared medication and syringe.			
<b>3</b>	Determined a line from the posterior superior iliac spine, to the greater trochanter of the femur			
<b>4</b>	Determined the upper and outer side of this line to make the injection, 5-8 cm below the iliac crest.			
<b>5</b>	Cleaned this area with antiseptic solution.			
<b>6</b>	With the thumb and 3rd finger of his/her left hand, held the skin of this area taut.			
<b>7</b>	Held the syringe in his/her right hand like he/she would hold a pen, with a 90 degree angle to the skin.			
<b>8</b>	Rapidly and firmly inserted the syringe into the skin and advanced it towards the muscle			
<b>9</b>	Pulled the piston lightly towards him/her; if blood was drawn, quickly pulled the syringe out. Replaced the needle if possible and repeated procedure			
<b>10</b>	If no blood was drawn when the piston was pulled, slowly injected the medication			
<b>11</b>	When finished, quickly pulled the syringe out			
<b>12</b>	Pressed firmly on the area with a cotton ball soaked in antiseptic solution or gauze			
<b>13</b>	Cleaned up used syringes, needles and any other medical waste goes should be safely disposed of			
<b>14</b>	Took off his/her gloves and washed his/her hands			





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### SUBCUTANEOUS INJECTION

**TOOLS:** Medication, syringe, antiseptic, tampon, gloves

**PARTICIPANT:**

STEP NO	STEPS
1	Wash and dry your hands and put on your gloves.
2	Determine the area you will do the injection and clean it with a tampon soaked with antiseptic solution by making circular movements from the center towards the periphery.
3	Remove the cap of the syringe and squeeze the skin and subcutaneous tissue of the area you are going to inject with the fingers of your passive hand and pull the tissue away from the body.
4	Hold the syringe as you would a pen or hold it so that it is in your palm pointing downwards.
5	With the needle slant facing upwards, insert into subcutaneous tissue with a 45-90 degree angle.
6	Release the skin and subcutaneous tissue that you are holding with your passive hand.
7	Pull the piston of the syringe towards yourself and make sure you are in subcutaneous tissue. (If blood is drawn, pull the needle out and prepare medication again)
8	Inject medication into subcutaneous tissue.
9	With your passive hand, press lightly with a tampon on the entry point of the needle and pull syringe out with your active hand.
10	Press on the area you injected.
11	After throwing away syringe, needle, cotton etc. into their respective waste bags; take off your gloves and wash your hands.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### SUBCUTANEOUS INJECTION

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	OBSERVATION		
		1	2	3
1	Washed and dried hands and put on gloves.			
2	Determined the area where the injection would be done and cleaned it with a tampon soaked with antiseptic solution by making circular movements from the center towards the periphery.			
3	Removed the cap of the syringe and squeezed the skin and subcutaneous tissue of the area where the injection would be done with the fingers of passive hand and pulled the tissue away from the body.			
4	Held the syringe as you would a pen or hold it			
5	With the needle slanted facing upwards, inserted into subcutaneous tissue with a 45-90 degree angle.			
6	Released the skin and subcutaneous tissue that was holding with passive hand.			
7	Pulled the piston of the syringe towards his / herself and felt that he/she was in subcutaneous tissue. (If blood was drawn, pulled the needle out and prepared medication again)			
8	Injected medication into subcutaneous tissue.			
9	With passive hand, pressed lightly with a tampon on the entry point of the needle and pulled syringe out with active hand.			
10	Pressed on the area injected.			
11	After throwing away syringe, needle, cotton etc. into their respective waste bags; took off gloves and washed hands.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### THROAT CULTURE

**TOOLS:** Sterile swab, tongue depressor, light source

**PARTICIPANT:**

In this exercise, we will learn how to obtain a throat culture for the differential diagnosis of viral and bacterial nasopharyngeal infection and the appropriate technique to send it to the laboratory.

STEP NO	STEPS
1	Inform the patient about the procedure.
2	Have the patient look at the light source.
3	Tell patient to take deep breaths from the mouth.
4	Take the throat swab out of its tube with your dominant hand, making sure not to contaminate the cotton tip.
5	Press on the patient's tongue with the depressor while he/she is breathing.
6	Swipe the swab on the right tonsil, left tonsil and pharyngeal mucosa with your other hand.
7	If there is exudate/pseudomembrane on the tonsils, firmly rub the edges so that they are partially lifted and obtain samples.
8	Pull out the swab without touching the oral mucosa or saliva with it.
9	Carefully place the tip of the swab into tube.
10	Send the sample to the laboratory as soon as possible.
11	If you cannot send the sample immediately, or it must be transported a long distance, use a transport medium (e.g. Stuart).



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### THROAT CULTURE

**EVALUATION CRITERIAS:**

Using the grading system below, repeat the skill until all steps will be completed correctly, appropriately and without a pause.

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

<b>STEPS</b>	<b>OBSERVATION</b>		
	<b>1</b>	<b>2</b>	<b>3</b>
1. Informed the patient about the procedure.			
2. Had the patient's face look at the light source.			
3. Told the patient to take deep breaths from the mouth.			
4. Took the throat swab out of its tube with his/her dominant hand, making sure not contaminate the cotton tip.			
5. Pressed on patient's tongue with the depressor while he/she is breathing.			
6. Swiped the swab on the right tonsil, left tonsil and pharyngeal mucosa with his/her other hand.			
7. If there is exudate/pseudomembrane on the tonsils, firmly rubbed the edges so that they are partially lifted and obtained samples.			
8. Pulled the swab without touching the oral mucosa or saliva.			
9. Carefully placed the tip of the swab in to the tube.			
10. Sent the sample to the laboratory as soon as possible.			
11. If he/she cannot send the sample immediately, or if the laboratory is too far, used a transport medium (e.g. Stuart)			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### Adult Basic Life Support -2022

**TOOLS:** Gloves

**PARTICIPANT:**

STEP NO	STEPS
1	When you encounter the patient, first make sure you are safe and you are in a safe environment.
2	Wear protective gloves if possible
3	Keeping in mind the risk of neck (cervical spine) injury, have the patient lie down on a hard surface without being shaken
4	Stand on the side of the patient.
5	<p>Check if the patient responds and look for breathing:</p> <p>5.a. Gently tap the patient on the shoulders. Ask loudly, "How are you? Are you OK?" (Do not move patient too much, think of possible cervical injury.)</p> <p>5.b. Open the airway using head tilt-chin lift maneuver and check the breathing using "look-listen and feel" technique in 10 seconds for breathing or abnormal breathing (ie, only gasping)</p>
6	<p>If the patient is unresponsive, and not breathing or breathing abnormally (ie. gasping), considere cardiac arrest.</p> <ul style="list-style-type: none"> <li>• Shoute for help</li> <li>• If possible call 112 from mobile phone, or ask someone to call</li> <li>• If there is no mobile phone, Call 112 first, then returne to the patients side</li> </ul>
7	<p>Inform the employee on duty at 112 about the patient and event:</p> <ul style="list-style-type: none"> <li>• Address of the emergency (street, building, room number etc.)</li> <li>• The phone number from which you are calling.</li> <li>• What happened (heart attack, stroke, accident etc.)</li> <li>• Number of people in need of help.</li> <li>• Current status of patient and any treatments given</li> <li>• Do not hang up until the 112 official has hung up.</li> <li>• Activate speaker function of the phone to follow the dispatchers instructions.</li> </ul>
8	Use automated external defibrillator (AED) if available or send the second rescuer to get one.
<p><b>ASSESSMENT AND MANAGEMENT OF CIRCULATION</b></p> <p><b>(CIRCULATION) (C)</b></p>	

<b>1</b>	Kneel beside the patient.
<b>2</b>	Feel the trachea with your right hand in midline and feel the carotid pulse by sliding your hand laterally about 3 cm (For the health professionals).
<b>3</b>	Check for a pulse and regular breathing simultaneously (no more than 10 seconds).
<b>4</b>	<ul style="list-style-type: none"> <li>• If there is definite pulse and normal breathing monitor the patient and activate EMS</li> <li>• If there is definite pulse without normal breathing give 1 breath every 6 seconds.</li> <li>• If there is no pulse and no breathing start cardiopulmonary resuscitation (CPR)</li> </ul>
<b>5</b>	Start chest compressions while the patient is in supine position.
<b>6</b>	Place the heel of your dominant hand on the center of the patient's chest which is 1/2 lower half of the sternum (your fingers must not touch the rib cage).
<b>7</b>	Place the heel of your other hand on top of the first hand.
<b>8</b>	Keep your arms straight.
<b>9</b>	Transfer your weight to the arms.
<b>10</b>	Press down on the sternum of the patient at least 5 cm.(not more than 6 cm)
<b>11</b>	Allow the chest to completely recoil after each compression.
<b>12</b>	Repeat the compressions at a rate of 100-120/minute and give 30 chest compressions hardly and fastly
<b>ASSESSMENT AND MANAGEMENT OF AIRWAY</b>	
<b>(AIRWAY) (A)</b>	
<b>1</b>	Open the airway without losing time.
<b>2</b>	In patients who have not had any trauma, apply the "Head Tilt – Chin Lift" maneuver to elevate the tongue, which may be obstructing the airway: <ul style="list-style-type: none"> <li>• By putting one hand on the patient's forehead and the other on the bony protrusion of the lower jaw, push patient's head backwards and the jaw forwards.</li> </ul>
<b>3</b>	For patients with trauma, use the "Jaw Thrust" maneuver(Only for health professionals): <ul style="list-style-type: none"> <li>• Kneel by the patient's head</li> <li>• Put each hand on one corner of the lower jaw and push upwards and forwards .</li> </ul>
<b>4</b>	Maintain this position and proceed to Breathing.
<b>ASSESSMENT AND MANAGEMENT OF BREATHING</b>	
<b>(BREATHING) (B)</b>	
<b>1</b>	Deliver two effective rescue breaths to the patient.
<b>2</b>	To give a breath, maintain the patient's position to keep the airway patent and close nostrils with the thumb and 2nd finger of one hand.
<b>3</b>	Take a deep breath and give the breath to the patient slowly for at least 1 second through his/her mouth. (the chest wall should be elevated)
<b>4</b>	An alternative way is to close the patient's mouth by supporting the lower jaw with one hand and giving the breath through his/her nose for at least 1 second.
<b>5</b>	Check the exhalation of the air that you delivered.
<b>CONTROL</b>	
<b>1</b>	Continue with chest compressions and rescue breaths in a ratio of 30: 2 for 5 cycles.
<b>2</b>	Check the vital signs of the patient after 5 cycles of CPR (2 minute).
<b>3</b>	Change the CPR providers over about every 2 minutes.
<b>4</b>	Continue CPR if vital signs are absent. As soon as the AED arrive, deliver shock for ventricular fibrillation.

<b>5</b>	Place the patient in a recovery position if the patient's vital signs are regained.
<b>AUTOMATED EXTERNAL DEFIBRILLATOR (AED)</b>	
<b>1</b>	Continue CPR until AED arrive
<b>2</b>	As soon as AED arrive switch on the AED and attach the electrode pads on the victim's chest as shown on the pads. If you are two, have one continue CPR
<b>3</b>	Ensure that nobody is touching the victim while the AED is analysing the rhythm.
<b>4</b>	If a shock is indicated ensure that nobody is touching and push the shock button.
<b>5</b>	After delivering shock, immediately start CPR without pulse control (30 chest compressions/ 2 rescue breaths) Continue as directed by the voice/visual prompts.
<b>6</b>	If no shock is indicated continue CPR.
<b>RECOVERY POSITION</b>	
<b>1</b>	If the patient has a pulse and is breathing but has impaired consciousness, lay him/her on his/her back. (Keep in mind the possibility of neck injury)
<b>2</b>	Stand on right side of patient.
<b>3</b>	Place the right arm of the patient at 90° to his body, elbow bent with the hand palm-up.
<b>4</b>	Bring the patient's left arm across the chest, and hold the back of the hand against the patient's cheek nearest to you.
<b>5</b>	Bend the patient's left leg at the knee 90
<b>6</b>	Holding the patient by the shoulder with your left hand and by the hip with your right hand, turn him/her towards yourself
<b>7</b>	The patient's left knee and elbow should be in contact with the ground.
<b>8</b>	Asses ABC.
<b>9</b>	If the patient will be in recovery position for more than 30 minutes, turn him/her to the opposite side by first laying him/her on the back. Turn the patients opposite side every 30 minutes
<b>10</b>	The patient should wait in recovery position until the ambulance arrives.
<b>11</b>	If there are no signs of circulation or respiration, turn the patient on his/her back and initiate CPR.



# GAZİ UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### Adult Basic Life Support -2022

#### EVALUATION CRITERIAS:

**A - Competent:** Correct application of the examination steps in their proper sequence

**B -Sufficient:** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C – Needs to be improved:** Incorrect application of the examination step sor not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

**By the end of this evaluation, participants should have**

STEP NUMBER		PRACTICE		
		1	2	3
1	Ensured that the patient, the bystanders and the scene are safe			
2	Wore protective gloves if possible.			
3	Support the patient to the ground ( on a firm surface) without being shaken(because of the possibility of neck (cervical) injury)			
4	Kneeled beside the patient			
5	Checked for a response and looked for breathing.  5a. Tapped the patient on the shoulder and shouted at the patient "How are you? / Are you all right?" (Did not move the patient in an excessive manner because of the possibility of neck injury (cervical trauma)).  5b. Looked for breathing or no normal breathing (ie, only gasping)(opened the airway using "head tilt-chin lift" maneuver and checked the breathing using look-listen and feel techniques)			
6	Presumed cardiac arrest for patients who are unresponsive and not breathing normally  <ul style="list-style-type: none"><li>• Shouted for help</li><li>• Called 112 from mobile phone</li><li>• Called 112 and returned to the patients side if there is no mobile phone</li></ul>			
7	While phoning 112, he/she gave appropriate information to the dispatcher			



	<ul style="list-style-type: none"> <li>• Location of the incident (Street, building, room number, etc.).</li> <li>• Gave number of his/her phone.</li> <li>• The events of the incident (heart attack, stroke, traffic accident or etc.)</li> <li>• Number of the patients who need help.</li> <li>• Condition of the patients</li> <li>• Type of aid provided</li> </ul> <p>Did not hang up the phone and activated speaker function of the phone to follow the dispatchers instructions.</p>			
<b>8</b>	Used automated external defibrillator (AED) if available or sent the second rescuer to get one.			
<b>ASSESSMENT AND MANAGEMENT OF CIRCULATION (CIRCULATION) (C)</b>				
<b>1</b>	Kneeled beside the patient.			
<b>2</b>	Felt the trachea with his/her right hand in midline and felt the carotid pulse by sliding his/her hand laterally about 3 cm.			
<b>3</b>	Checked for a pulse and regular breathing simultaneously (no more than 10 seconds).			
<b>4</b>	<ul style="list-style-type: none"> <li>• If there was definite pulse and normal breathing monitored the patient and activated EMS</li> <li>• If there was definite pulse without normal breathing gave 1 breath every 6 seconds.</li> <li>• If there was no pulse and no breathing started cardiopulmonary resuscitation(CPR)</li> </ul>			
<b>5</b>	If there was not a definite pulse, started chest compressions while the patient is in supine position.			
<b>6</b>	Placed the heel of his/her dominant hand on the center of the patient's chest (which is 1/2 lower half of the sternum).  (His/her fingers did not touch the rib cage).			
<b>7</b>	Placed the heel of his/her other hand on top of the first hand.			
<b>8</b>	Kept his/her arms straight.			
<b>9</b>	Transferred his/her weight to the arms.			
<b>10</b>	Pressed down on the sternum of the patient at least 5 cm.(not more than 6 cm)			
<b>11</b>	Allowed the chest to completely recoil after each compression.			
<b>12</b>	Repeated the compressions at a rate of 100-120/minute and gave 30 chest compressions hardly and fastly			
<b>ASSESSMENT AND MANAGEMENT OF AIRWAY (AIRWAY) (A)</b>				
<b>1</b>	Opened the airway without losing time.			
<b>2</b>	Used <b>Head Tilt-Chin Lift</b> maneuver for the patients without evidence of trauma.			
<b>3</b>	Used <b>Jaw Thrust</b> maneuver for the patients with suspected cervical spine injury or the patient had a trauma.			
<b>4</b>	While maintaining the position of the patient, passed on the breathing step.			

<b>ASSESSMENT AND MANAGEMENT OF BREATHING (BREATHING) (B)</b>				
<b>1</b>	Delivered two effective rescue breaths to the patient.			
<b>2</b>	Pinched the patient's nose using the index finger and thumb of his/her left hand.			
<b>3</b>	Took a normal (regular) breath (not a deep one) and blew into the patient's mouth slowly taking about 1 second (watched the patient's chest to rise).			
<b>4</b>	In the second way, took a normal breath and gave into the patient's nose taking about 1 second by closing the patient's jaw with his/her right hand. (gave one rescue breath every 6 seconds, 10 breaths/minute)			
<b>5</b>	Checked the exhalation of the air that he/she has delivered.			
<b>CONTROL</b>				
<b>1</b>	Continued with chest compressions and rescue breaths in a ratio of 30: 2 for 5 cycles.			
<b>2</b>	Checked the vital signs of the patient after 5 cycles of CPR (2 minute).			
<b>3</b>	Changed CPR providers over about every 2 minutes.			
<b>4</b>	Continued CPR if vital signs were absent. As soon as the AED arrived delivered shock for ventricular fibrillation.			
<b>5</b>	Placed the patient in a recovery position if the patient's vital signs have been regained.			
<b>AUTOMATED EXTERNAL DEFIBRILLATOR (AED)</b>				
<b>1</b>	Continued CPR until AED arrived			
<b>2</b>	As soon as AED arrived switched on the AED and attached the electrode pads on the victims chest as shown on the pads.			
<b>3</b>	Ensured that nobody is touching the victim while the AED is analysing the rhythm.			
<b>4</b>	If a shock is indicated ensured that nobody is touching and pushed the shock button.			
<b>5</b>	After delivering shock without pulse control immediately started CPR (30 chest compressions/ 2 rescue breaths) Continued as directed by the voice/visual prompts.			
<b>6</b>	If no shock is indicated continued CPR.			
<b>RECOVERY POSITION</b>				
<b>1</b>	Placed the patient who had spontaneous circulation and breathing but abnormal level of consciousness in a position which the patient's back was on the ground (He/she was careful in terms of neck trauma).			
<b>2</b>	Kneeled to the right side of the patient.			
<b>3</b>	Placed the right arm of the patient at 90° to his body, elbow bent with the hand palm-up.			
<b>4</b>	Brought the left arm across the chest, and held the back of the hand against the patient's cheek nearest to him/her.			
<b>5</b>	Grasped the left leg just above the knee and pulled it up, keeping the foot on the ground.			
<b>6</b>	Pulled the patient's shoulder with his/her left hand and hip with right hand and rolled the patient towards him/her.			
<b>7</b>	Adjusted the patient's left elbow and left knee that they might touch the ground.			
<b>8</b>	Made sure that airway, breathing and the circulation of the patient were still secured.			

9	Told that he/she have to turn the patient to the opposite side to relieve the pressure of the lower arm if the patient has to be kept in the recovery position <b>for more than 30 minutes</b> . Turned the patients opposite side every 30 minutes.			
10	Told that he/she have to wait in this position until the ambulance arrived.			
11	Told that he/she have to begin cardiopulmonary resuscitation and must reposition the patient if the patient has no breathing and circulation again.			

# PHASE 2



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### STARTING AN INTRAVENOUS LINE

**TOOLS:** Gloves, tourniquet, i.v. cannula, cotton ball soaked with disinfectant solution, adhesive bandage for fixation

**PARTICIPANT:**

STEP NO	STEPS
1	Wash and dry your hands. Put on your gloves.
2	Tie the tourniquet 10-15 cm above the elbow.
3	Clean the area you will insert the i.v. line with tampon soaked in antiseptic solution in a circular motion or starting from the top wiping downwards.
4	Pull down the skin right below the area you will be using with the thumb of your passive hand.
5	With the needle slant facing upwards, insert the cannula 0,5-1 cm below the vein with a 30-45 degree angle, staying parallel to the vein.
6	After penetrating skin, advance the cannula parallel to the skin for 3-5 mm and enter the vein with a 15 degree angle.
7	Advance the cannula for 2-3 mm inside the vein and pull the needle slightly to see if there is blood in the "flash back" chamber.
8	If there is blood in the chamber, you have entered the vein; if not, repeat the procedure starting from step 5.
9	While pulling the needle towards yourself, advance the polyurethane cannula into the vein.
10	Remove the tourniquet.
11	After the i.v. cannula has been placed, fix it with adhesive bandage.
12	If fluids are to be given, connect the serum set to the cannula; if not, close the cap of the cannula. (When tip of the cannula is open, do not forget to compress the vein with your thumb to stop blood flow)
13	Do not forget to write the date on the adhesive bandage.
14	Throw away waste into appropriate waste bags. Remove your gloves and wash your hands.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### STARTING AN INTRAVENOUS LINE

**EVALUATION CRITERIAS:**

Using the grading system below, repeat the skill until all steps will be completed correctly, appropriately and without a pause.

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

<b>PARTICIPANT:</b>	<b>NO:</b>
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<b>COACH:</b>	<b>SIGNATURE:</b>	<b>DATE:</b>
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	STEPS	OBSERVATION		
		1	2	3
<b>1</b>	Washed and dried the hands. Put on the gloves.			
<b>2</b>	Tied the tourniquet 10-15 cm above the elbow.			
<b>3</b>	Cleaned the area that would be inserted the i.v. line with tampon soaked in antiseptic solution in a circular motion or starting from the top wiping downwards.			
<b>4</b>	Pulled down the skin right below the area that would be using with the thumb of the passive hand.			
<b>5</b>	With the needle slant facing upwards, inserted the cannula 0,5-1 cm below the vein with a 30-45 degree angle, staying parallel to the vein.			
<b>6</b>	After penetrating skin, advanced the cannula parallel to the skin for 3-5 mm and entered the vein with a 15 degree angle.			
<b>7</b>	Advanced the cannula for 2-3 mm inside the vein and pulled the needle slightly to see if there was blood in the "flash back" chamber.			
<b>9</b>	Entered the vein if there was blood in the chamber; if not, repeated the procedure starting from step 5.			
<b>10</b>	While pulling the needle towards oneself, advanced the polyurethane cannula into the vein.			
<b>11</b>	Removed the tourniquet.			
<b>12</b>	After the i.v. cannula had been placed, fixed it with adhesive bandage.			
<b>13</b>	If fluids were to be given, connected the serum set to the cannula; if not, closed the cap of the cannula. (When tip of the cannula was open, did not forget to compress the vein with the thumb to stop blood flow)			

14	Did not forget to write the date on the adhesive bandage.			
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## GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

### LEARNING GUIDE

### DRESSING WOUNDS IN SKIN INJURIES

**TOOLS:** Intramuscular injection simulator, forearm mannikin for suturing, saline, wound dressing set, antiseptic solution, adhesive bandage

**PARTICIPANT:**

**Note:** In this exercise, we will start from step 12 and learn how to dress a wound.

STEP NO	STEPS
1	Prepare the supplies.
2	Wash your hands.
3	Put on gloves.
4	Cut off the tube of the saline bag that is used to attach serum set with scissors. If you are using a bottle of saline, remove its cap.
5	Compress the remaining tube from the outside with two fingers.
6	Turn bag of saline upside down.
7	Direct the tip of the bag that you are pressing on towards the wound.
8	Hold the tip 5 cm away from the wound without them coming into contact.
9	Loosen your grip on the tube and let some saline flow onto wound.
10	Clean wound thoroughly by irrigating it completely with the saline.
11	Continue cleaning wound until saline bag is empty.
12	Check autoclave band on dressing set.
13	If there are black diagonal lines on autoclave band, open set from the outside, making sure not to touch the inside.
14	Put on sterile gloves.
15	Pick up clamp with your right hand and hold it with the distal phalanges of your 3rd and 4th fingers.
16	Pick up tissue forceps with your left hand and hold it as you would a pen.
17	Grasp gauze with forceps.
18	Fold gauze inside dressing set using the clamp and tissue forceps.
19	Continue holding the gauze with the forceps and grasp the gauze by the intersection of the folds with the clamp in your right hand.
20	Lock clamp and hold it so that the folds of the gauze face upwards.

<b>21</b>	Ask your assistant to pour antiseptic solution on the gauze without contaminating it.
<b>22</b>	End the procedure when the gauze is thoroughly soaked.
<b>23</b>	Wipe the surroundings of the wound with circular motions without touching the inside.
<b>24</b>	Clean edges of wound with circular motions from center to periphery.
<b>25</b>	Throw away gauze.
<b>26</b>	Pick up another gauze with tissue forceps and unfold with the help of clamp.
<b>27</b>	Drape gauze onto wound.
<b>28</b>	Drape one more gauze in the same way.
<b>29</b>	Cut a piece of adhesive bandage that is 50% longer than the gauze and appropriately wide.
<b>30</b>	Stick one half of the gauze onto skin with the adhesive bandage you prepared.
<b>31</b>	Stick other half of gauze with another piece of bandage with the same size.
<b>32</b>	Throw away waste in appropriate waste bins.
<b>33</b>	Wash your hands.
<b>34</b>	Inform the patient.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### DRESSING WOUNDS IN SKIN INJURIES

**EVALUATION CRITERIAS:**

- A - Competent:** Correct application of the examination steps in their proper sequence
- B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help
- C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

<b>PARTICIPANT:</b>	<b>NO:</b>
---------------------	------------

<b>COACH:</b>	<b>SIGNATURE:</b>	<b>DATE:</b>
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	STEPS	OBSERVATION		
		1	2	3
<b>1</b>	Prepared the supplies.			
<b>2</b>	Washed his/her hands.			
<b>3</b>	Put on gloves.			
<b>4</b>	Cut off the tube of the saline bag that was used to attach serum set with scissors. If a bottle of saline was using, removed its cap.			
<b>5</b>	Compressed the remaining tube from the outside with two fingers.			
<b>6</b>	Turned bag of saline upside down.			
<b>7</b>	Directed the tip of the bag that was pressing on towards the wound.			
<b>8</b>	Held the tip 5 cm away from the wound without them coming into contact.			
<b>9</b>	Loosen grip on the tube and let some saline flow onto wound.			
<b>10</b>	Cleaned wound thoroughly by irrigating it completely with the saline.			
<b>11</b>	Continued cleaning wound until saline bag was empty.			
<b>12</b>	Checked autoclave band on dressing set.			
<b>13</b>	If there were black diagonal lines on autoclave band, opened set from the outside, making sure not to touch the inside.			
<b>14</b>	Put on sterile gloves.			
<b>15</b>	Picked up clamp with right hand and hold it with the distal phalanges of 3rd and 4th fingers.			
<b>16</b>	Picked up tissue forceps with left hand and held it as a pen.			
<b>17</b>	Grasped gauze with forceps.			
<b>18</b>	Folded gauze inside dressing set using the clamp and tissue forceps.			

<b>19</b>	Continued holding the gauze with the forceps and grasped the gauze by the intersection of the folds with the clamp in right hand.			
<b>20</b>	Locked clamp and hold it so that the folds of the gauze face upwards.			
<b>21</b>	Asked to pour antiseptic solution on the gauze without contaminating it.			
<b>22</b>	Ended the procedure when the gauze was thoroughly soaked.			
<b>23</b>	Wiped the surroundings of the wound with circular motions without touching the inside.			
<b>24</b>	Cleaned edges of wound with circular motions from center to periphery.			
<b>25</b>	Threw away gauze.			
<b>26</b>	Picked up gauze with tissue forceps and unfolded with the help of clamp.			
<b>27</b>	Draped gauze onto wound.			
<b>28</b>	Draped one more gauze in the same way.			
<b>29</b>	Cut a piece of adhesive bandage that is %50 longer than the gauze and appropriately wide.			
<b>30</b>	Stacked one half of the gauze onto skin with the adhesive bandage you prepared.			
<b>31</b>	Stacked other half of gauze with another piece of bandage with the same size.			
<b>32</b>	Threw away waste in appropriate waste bins.			
<b>33</b>	Washed hands.			
<b>34</b>	Informed the patient.			



## GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

### LEARNING GUIDE

### INSERTING FEMALE URINARY CATHETER

**TOOLS:** Female urethral catheter mannikin, urethral (Foley) catheter, syringe, saline, antiseptic solution, sterile gel, tampon, gloves

**PARTICIPANT:**

STEP NO	STEPS
1	Wash and dry your hands.
2	Prepare supplies.
3	Take the patient to the appropriate position (bend her legs at the knees and open them to the sides).
4	Put on sterile gloves.
5	Wipe between the perineum and labia majora from front to back with gauze moistened with antiseptic solution. Wipe at least 3 times.
6	Apply sterile gel or vaseline on a gauze and wipe the tip of the Foley catheter with it.
7	Separate the labia majora with the 1st and 2nd fingers of the passive hand while holding the tip of the catheter with the dominant hand.
8	Locate the orifice of the urethra and slowly advance the catheter into it while keeping the catheter parallel to the long axis of the body.
9	Observe the urine output from the end of the catheter where the urine flow is expected.
10	Advance the catheter at least 4 cm further after the urine stream begins.
11	Attach urine bag.
12	Injecte sufficient amount of saline into the balloon of the cathater with a syringe.
13	Slowly pull the catheter to feel the balloon settle at the neck of the bladder; then push the catheter back in 1-2 cm.
14	Hang the urine bag below the level of the bladder.
15	Gather your supplies.
16	Dispose of all waste and gloves safely in the relevant waste bins.
17	Wash your hands.
	<b>REMOVING URINARY CATHATER</b>
1	Take the patient to the appropriate position.
2	Wash and dry your hands.
3	Put on disposable non-sterile gloves.

<b>4</b>	Withdraw all previously given fluid by attaching the syringe to the end of the catheter connected to the balloon.
<b>5</b>	Pull the catheter out of the meatus carefully.
<b>6</b>	Dispose of the catheter and other material in the relevant waste bins.
<b>7</b>	Remove the gloves and dispose of them in the relevant waste bin.
<b>8</b>	Wash your hands.



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### INSERTING FEMALE URINARY CATHETER

**EVALUATION CRITERIA:**

Using the grading system below, repeat the skill until all steps will be completed correctly, appropriately and without a pause.

**A – Competent:** Correct application of the examination steps in their proper sequence

**B – Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C – Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

<b>PARTICIPANT:</b>	<b>NO:</b>
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<b>COACH:</b>	<b>SIGNATURE:</b>	<b>DATE:</b>
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NO	STEPS	OBSERVATION		
		1	2	3
1	Washed and dried the hands.			
2	Prepared supplies.			
3	Took the patient to the appropriate position (bend her legs at the knees and open them to the sides).			
4	Put on sterile gloves.			
5	Cleaned the area between the perineum and labia majora with gauze soaked in antiseptic solution from front to back. Wiped at least 3 times.			
6	Applied sterile gel or aseline on a gauze and wipe the tip of the Foley catheter with it.			
7	Separated the labia majora with the 1 <sup>st</sup> and 2 <sup>nd</sup> fingers of the passive hand while holding the tip of the catheter with the dominant hand.			
8	Located the orifice of the urethra and slowly advanced the catheter into it while keeping the catheter parallel to the long axis of the body.			
9	Observed the urine output from the end of the catheter where the urine flow is expected.			
10	Advanced the catheter at least 4 cm further after the urine stream begins.			
11	Attached an urine bag.			
12	Injected an appropriate amount of saline into balloon with a syringe.			
13	Slowly pulled the catheter to feel the balloon settle at the neck of the bladder; then pushed the catheter back in 1-2 cm.			
14	Hanged the urine bag below the level of the bladder.			
15	Gathered the supplies.			
16	Disposed of all waste and gloves safely in the relevant waste bins.			

<b>17</b>	Washed the hands.			
	<b>REMOVING URINE CATHATER</b>			
<b>1</b>	Took the patient to the appropriate position.			
<b>2</b>	Washed and dried the hands.			
<b>3</b>	Put on disposable non-sterile gloves.			
<b>4</b>	Withdrew all previously given fluid by attaching the syringe to the end of the catheter connected to the balloon.			
<b>5</b>	Pulled the catheter out of the meatus carefully.			
<b>6</b>	Disposed of the catheter and other material in the relevant waste bins.			
<b>7</b>	Removed the gloves and dispose of them in the relevant waste bin.			
<b>8</b>	Washed the hands.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### INSERTING MALE URINARY CATHETER

**TOOLS:** Male urethral catheter mannikin, urethral (Foley) catheter, syringe, saline, antiseptic solution, sterile gel, tampon, gloves

**PARTICIPANT:**

STEP NO	STEPS
1	Wash and dry your hands.
2	Prepare supplies.
3	Put on sterile gloves.
4	Clean the penis starting from the external urethral meatus in a circular motion with gauze soaked in antiseptic solution. Repeat at least 3 times.
5	Apply sterile gel or vaseline on a gauze and wipe the tip of the catheter with it.
6	Hold the penis with your passive hand while holding the tip of the catheter with your dominant hand and slowly advance the catheter into urethra. Make sure the catheter is parallel to the long axis of the penis.
7	When the tip of the catheter has reached the perineum, lower the penis downward to make it parallel to the long axis of the body Continue to advance the catheter upward, parallel to the long axis of the body.
8	Look for urine coming out of the other end of the catheter
9	After the urine stream begins, advance the catheter at least 4 cm further.
10	Attach the urine bag.
11	Inject the required amount of saline to the way to the balloon with your syringe.
12	Slowly pull the catheter to feel the balloon settle at the neck of the bladder; then push the catheter back in 1-2 cm.
13	Hang the urine bag below the level of the bladder.
14	Gather your supplies.
15	Throw away waste into appropriate waste bags.
16	Wash your hands.
<b>REMOVING URINARY CATHATER</b>	
1	Wash and dry your hands.
2	Put on disposable non-sterile gloves.
3	Withdraw all previously given fluid by attaching the syringe to the end of the catheter connected to the balloon.
4	Pull the catheter out of the meatus carefully.
5	Dispose of the catheter and other material in the relevant waste bins.

<b>6</b>	Remove the gloves and dispose of them in the relevant waste bin.
<b>7</b>	Wash your hands.





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### INSERTING MALE URINARY CATHETER

**EVALUATION CRITERIAS:**

Using the grading system below, repeat the skill until all steps will be completed correctly, appropriately and without a pause.

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	OBSERVATION		
		1	2	3
<b>1</b>	Washed and dried the hands.			
<b>2</b>	Prepared supplies.			
<b>3</b>	Put on sterile gloves.			
<b>4</b>	Cleaned the penis starting from the external urethral meatus in a circular motion with gauze soaked in antiseptic solution. Repeated at least 3 times.			
<b>5</b>	Applied sterile gel or vaseline on a gauze and wiped the tip of the catheter with it.			
<b>6</b>	Held the penis with the passive hand while holding the tip of the catheter with the dominant hand and slowly advanced the catheter into urethra. Made sure the catheter was parallel to the long axis of the penis.			
<b>7</b>	When the tip of the catheter reached the perineum, lowered the penis downward to make it parallel to the long axis of the body Continued to advance the catheter upward, parallel to the long axis of the body.			
<b>8</b>	Looked for urine coming out of the other end of the catheter			
<b>9</b>	After the urine stream begins, advanced the catheter at least 4 cm further.			
<b>10</b>	Attached urine bag.			
<b>11</b>	Injected the required amount of saline to the way to the balloon with your syringe.			
<b>12</b>	Slowly pulled the catheter to feel the balloon settle at the neck of the bladder; then pushed the catheter back in 1-2 cm.			
<b>13</b>	Hanged the urine bag below the level of the bladder.			
<b>14</b>	Gathered the supplies.			

<b>15</b>	Threw away waste into appropriate waste bags.			
<b>16</b>	Washed the hands.			
	<b>REMOVING URINARY CATHATER</b>			
<b>1</b>	Washed and dried the hands.			
<b>2</b>	Put on disposable non-sterile gloves.			
<b>3</b>	Withdrew all previously given fluid by attaching the syringe to the end of the catheter connected to the balloon.			
<b>4</b>	Pulled the catheter out of the meatus carefully.			
<b>5</b>	Disposed of the catheter and other material in the relevant waste bins.			
<b>6</b>	Removed the gloves and disposed of them in the relevant waste bin.			
<b>7</b>	Washed the hands.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### INSERTING A NASOGASTRIC CATHETER

**TOOLS:** Nasogastric tube insertion model, nasogastric catheter, syringe, liquid vaseline, gloves, drainage bag.

**PARTICIPANT:**

STEP NO	STEPS
1	Address the patient by name and introduce yourself.
2	Briefly explain the procedure to the patient.
3	Get the patient's consent.
4	Prepare all the necessary materials. Wash and dry your hands. Put on your examination gloves.
5	Position the patient in an upright sitting position, if not possible, give the left lateral position.
6	<b>Measurement:</b> Bring the end of the nasogastric catheter to be inserted in line with the patient's nostrils. With your other hand, extend the catheter up to the earlobe. While holding the part at earlobe level, let go of the part at the tip of the nose. With your free hand, insert the catheter near the neck, in front of the chest wall, towards the abdomen, in the midline. Grasp the portion of the catheter that comes to the lower end of the xiphoid. The distance between the nose-earlobe-xiphoid lower end is the distance required to reach the stomach from the nose.
7	Wipe the measured length of the catheter with a liquid vaseline or other lubricant.
8	Advance the catheter through one nostril of the patient, first parallel to the nostril, then backwards and downwards with calm, soft movements. If there is any resistance, no power is applied; the process is restarted from the other nostril.
9	Ask the patient to tilt his head slightly and swallow when he feels the catheter in his throat. Flexion of the neck causes closure of the trachea and opening of the esophagus, making it easier for the tube to enter the esophagus.
10	If there is no problem, advance the catheter slowly to the pre-marked location.
11	When the marked place is level with the nostrils, hold the catheter to a person.
12	Attach an appropriate syringe to the tip of the catheter and check to see if gastric fluid is drawn.
13	If the liquid does not come out, draw 5 ml of air into syringe.
14	Place your stethoscope on the patient's epigastrium and listen. While you are listening, slowly inject the air in the syringe. If you hear the sound of air passing through liquid, you have reached the stomach.

	Aspirate the stomach again to empty the air you have injected.
<b>15</b>	Fixate the catheter with adhesive bandage, making sure not to compress the nasal septum and wings.
<b>16</b>	Attach an appropriate extension to the end of the catheter, and attach this to a drainage bag placed below the level of the patient so that the fluid flows freely.
<b>17</b>	Throw all waste into appropriate waste bags and wash your hands.



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### INSERTING A NASOGASTRIC CATHETER

**EVALUATION CRITERIAS:**

- A - Competent:** Correct application of the examination steps in their proper sequence
- B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help
- C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

<b>PARTICIPANT:</b>	<b>NO:</b>
---------------------	------------

<b>COACH:</b>	<b>SIGNATURE:</b>	<b>DATE:</b>
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STEP NO	STEPS	OBSERVATION		
		1	2	3
1	Addressed the patient by name and introduced herself/himself.			
2	The procedure was briefly explained to the patient.			
3	Patient's consent was taken.			
4	All of the necessary materials were prepared. Hands were washed. After drying hands, the examination gloves were put on.			
5.	The patient was positioned in an upright sitting position, if not possible, positioned the left lateral position.			
6	The measurements were made.			
7	The measured length of the catheter was wiped with a liquid vaseline or other lubricant.			
8	The catheter was slowly advanced through one nostril.			
9	The patient was told to swallow when he/she felt the catheter in their throats.			
10	The catheter was slowly pushed up to the measured length.			
11	When the marked length was at the level of the nostrils, someone was told to hold the catheter in place.			
12	An appropriate syringe was attached to the tip of the catheter and it was checked whether the gastric fluid was drawn.			
13	If no fluid was drawn, 5 ml of air was drawn into syringe.			
14	Stethoscope was placed on the patient's epigastrium and was listened. While listening, the air was slowly injected in the syringe. Then syringe was reused as an aspirator in order to empty the air.			
15	The catheter was fixated with adhesive bandage without making any compress to the nasal septum and wings.			
16	An appropriate extension was attached to the end of the catheter, and			

	this part was attached to a drainage bag below the level of the patient in order to free flow.			
<b>17</b>	All wastes were thrown into an appropriate waste bags and hands were washed.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

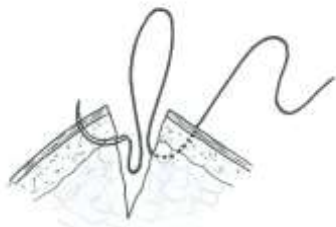
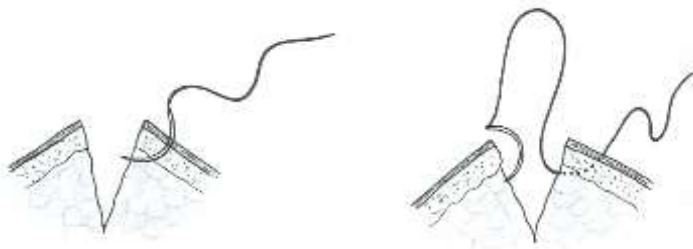
### SUTURING

**TOOLS:** Suturing set, wound suturing cushion, wound suturing cushion holder, suturing supplies, needle holder, tissue forceps, scissors, gloves

**PARTICIPANT:**

STEP NO	STEPS
1	Prepare supplies. Wash and dry your hands. <i>(Skip this step in exercise.)</i> Put on sterile gloves. <i>(Skip this step in exercise.)</i> Clean wound with antiseptic solution. <i>(Skip this step in exercise.)</i>
2	Hold needle by posterior 1/3rd with the last 2 mm of the needle holder.
3	Determine the point you will insert the needle, which should be 2-4 mm away from the cut edge of the wound, and insert needle into skin with a 90 degree angle to it. When the needle reaches the dermis, advance the needle with the help of its curvature towards the inside of the wound.
4	Hold the tip of the needle with the tissue forceps and release the needle from the needle holder. Grasp the needle from its posterior end with the needle holder and pull the needle away from the wound with a circular motion of the wrist, again with the help of the curvature of the needle. Hold the free end of the needle with the tissue forceps and grasp the needle with the needle holder once again as you did in step 2.
5	Insert the needle into the other cut edge of the wound with a 90 degree angle to the subcutaneous tissue, making sure that your entry point is at the same depth as the other edge. Using the curvature of the needle, advance the needle until it exits the skin with a 90 degree angle, making sure the distance of the exit point from the edge is the same as the opposite cut edge. Place both tips of tissue forceps on both sides of exit point. Push skin down while continuing to advance the needle Grasp needle with tissue forceps. Release the needle from the needle holder.
6	Grasp the needle end that has exited the skin with the needle holder. Pull the needle out of the skin with a motion from the wrist using the curvature of the needle. Pull the suture until 2-3 cm are left at the point you began suturing. Release needle from needle holder. Place down your tissue forceps.
7	Hold the suture by the long end with the needle attached to it with your free hand and wrap it around the tip of the needle holder 2 times. Grasp the short free end on the opposite side of the wound and pull the long and short ends to opposite sides, making a crossing motion with your hands. Pull the knot that has formed away from the wound, so that it settles on the point you first entered with the needle. Pull the knot tight until the cut edges come together and slightly heap up on the sides (eversion). Release the free end of the suture from the needle holder.

<b>8</b>	Wrap the suture around the needle holder once in the opposite direction. Grasp the free end of the suture with the needle holder and pull the ends away from each other in the opposite directions as the step before.
<b>9</b>	Repeat these steps until you have 3 or 4 knots.
<b>10</b>	Cut off the ends of the suture with the scissors so 5-7 mm remain.
<b>11</b>	Throw away used supplies into appropriate bins. Wash your hands.



Penset  
Tissue forceps



Portegü  
Needle holder





# GAZİ ÜNİVERSİTESİ TIP FAKÜLTESİ KLİNİK BECERİ EĞİTİMİ

## EVALUATION GUIDE

### SUTURING

#### DEĞERLENDİRME KRİTERLERİ:

Aşağıdaki puanlama sistemini kullanarak, tüm basamaklar doğru, sıralı ve duraksamadan yapıp, tümünden tam not alana dek beceriyi yineleyiniz.

**A - Ustalaşmış:** Basamağın duraksamadan ve eğiticinin yardımına gereksinim olmadan doğru olarak ve sırasında uygulanması

**B - Yeterli:** Basamağın doğru olarak ve sırasında uygulanması; ancak eğiticinin yardımına gereksinim duyulması

**C - Geliştirilmesi gerekir:** Basamağın hiç uygulanmaması; yanlış uygulanması ya da sırasında uygulanmaması

**KATILIMCI:**

**NO:**

**GÖZLEMCİ:**

**İMZA:**

**TARİH:**

BASAMAK NO	BASAMAKLAR	DENEME		
		1	2	3
1	After washing and drying the hands he put the sterile gloves on and clean the wound with the antiseptic solution.			
2	He hold the needle from its posterior 1/3rd with the 2 mm tip of the needle holder.			
3	He determined the point to insert the needle which should be 2-4 mm away from the cut edge of the wound, and inserted needle into skin with a 90 degree angle to it. When the needle reached the dermis, he advanced the needle with the help of its curvature towards the inside of the wound.			
4	He held the tip of the needle with the tissue forceps and released the needle from the needle holder. He grasped the needle from its posterior end with the needle holder and pulled the needle away from the wound with a circular motion of the wrist, again with the help of the curvature of the needle. He held the free end of the needle with the tissue forceps and grasped the needle with the needle holder once again as he did in step 2.			
5	He inserted the needle into the other cut edge of the wound with a 90 degree angle to the subcutaneous tissue, making sure that his entry point was at the same depth as the other edge. Using the curvature of the needle, he advanced the needle until it exit the skin with a 90 degree angle, making sure the distance of the exit			

	<p>point from the edge was the same as the opposite cut edge.  He placed both tips of tissue forceps on both sides of exit point.  He pushed the skin down while continuing to advance the needle.  He grasped needle with tissue forceps.  He released the needle from the needle holder.</p>			
<b>6</b>	<p>He grasped the needle end that has exited the skin with the needle holder.  He pulled the needle out of the skin with a motion from the wrist using the curvature of the needle.  He pulled the suture until 2-3 cm is left at the point he began suturing.  He released the needle from needle holder.  He placed down his tissue forceps.</p>			



## GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

### LEARNING GUIDE

#### INTRAVENOUS INJECTION SKILL

**AIM:** To acquire the intravenous injection skill

**TOOLS:** Medication, syringe, antiseptic, tampon, gloves, tourniquet, paper towel, medical waste box

**PARTICIPANT:**

STEP NO	STEPS
1	Prepare the materials to be used in a tray and check them before starting the process.
2	Introduce yourself to the patient. Explain the reason for the intravenous injection and the method of application. Get the patient's consent.
3	Place the patient on a stretcher or on the examination table.
4	Have the patient remove her clothes, leaving the lower 1/3 of the arms and forearms open.
5	Wash and dry your hands.
6	Wear disposable non-sterile examination gloves.
7	Examine the antecubital (anterior part of the elbow) or dorsum of the hand and select a sufficiently prominent vein.
8	Prepare your syringe.
9	Support the arm for venous access, keeping the forearm in extension and external rotation, at a 30-degree angle with the trunk.
10	Tie the tourniquet 8-10 cm above the elbow.
11	Wipe the skin on the vein that you will enter with antiseptic solutions by moving from the center to the periphery.
12	Take the syringe in the actively used hand and remove the protective part of the needle.
13	Insert the needle of the syringe into the skin at an angle of 35 degrees, with the sharp end close to the skin.
14	After passing the skin, advance the needle of the syringe 3-5 mm parallel to the skin and enter the vein.
15	Advance the tip of the needle 2-3 mm into the vein.
16	Hold the syringe and needle without moving them.
17	Check if you are in the vein by pulling the plunger part of the syringe backwards slowly. If there is no blood, repeat from step 10.
18	If the vein is entered, untie the tourniquet with your passive hand.



<b>19</b>	Give the drug slowly, controlling the vein.
<b>20</b>	After giving the medicine, pull back the syringe at the same angle and speed while pressing with the dry pad.
<b>21</b>	Keep pressing with the tampon to stop bleeding at the injection site.
<b>22</b>	Adhere the special tape to the injection point.
<b>23</b>	Throw the syringe in the sharp, infected waste box, the used materials and gloves in the medical waste box.
<b>24</b>	Wash and dry your hands.



## GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

### EVALUATION GUIDELINE

#### INTRAVENOUS INJECTION

**EVALUATION CRITERIAS:**

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	<u>OBSERVATION</u>		
		1	2	3
<b>1</b>	Washed and dried hands. Put on gloves.			
<b>2</b>	Removed syringe from its sterile packaging and attached needle onto it.			
<b>3</b>	Taped the ampule to ensure that the medication was in the body part of it. Broke the neck of the ampule pushing on the indicated point with thumb, using a tampon for support.			
<b>4</b>	Removed cap of syringe and drew medication into it.			
<b>5</b>	Held the syringe perpendicular to the ground and lightly tapped it to move bubbles upward. Lightly pushed the piston to remove the air bubbles. Replaced the cap.			
<b>6</b>	Determined the vein to be used. Tied the tourniquet 10-15 cm above the area would be used and made sure did not disrupt the arterial circulation.			
<b>7</b>	Cleaned the area with a tampon soaked in antiseptic solution starting from above and wiping downwards.			
<b>8</b>	After removing the cap of the syringe, stabilized the arm with passive hand and stretched the skin underneath the area injected downwards with thumb.			
<b>9</b>	Held the needle with its slant facing upwards (sharp edge close to skin) and inserted with a 35 degree angle.			

<b>10</b>	After penetrating skin, advanced the needle parallel to skin for 3-5 mm and entered the vein.			
<b>11</b>	Advanced the needle 2-3 mm inside the vein.			
<b>12</b>	Pulled the piston with passive hand and made sure had entered the vein.			
<b>13</b>	If insided the vein, removed tourniquet with passive hand.			
<b>14</b>	Slowly injected medication while observing the vein.			
<b>15</b>	After the injection, pressed on the area with a dry tampon and quickly pulled out the needle, maintaining the same angle.			
<b>16</b>	Continued compressing the area with the tampon to achieve hemostasis.			
<b>17</b>	Applied special bandage on the area.			
<b>18</b>	Threw syringe into appropriate bin and other supplies into medical waste bag. Washed and dried hands.			

# PHASE 3



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### OBTAINING ANAMNESIS

**Tools:** None

NO	STEPS
1	Greet the patient and find out his/her name. Establish eye contact, use a polite language.
2	Introduce yourself and explain your task/role; "I'm a doctor ... and I will help you with your diagnosis and treatment".
3	Show care and respect, give importance to the patient's physical comfort.
4	Note gender, date of birth, occupation, marital status, number of children (if any), city/town where they live, and whom has provided the anamnesis.
5	Find out the reason for the application with open-ended questions; "Which problem brought you to the hospital", "What is your chief complaint that caused you to apply to the hospital?"
6	Listen to the patient's initial sentences without interrupting.
7	Try to identify all of their complaints and then repeat using the patient's sentences to confirm that you understand their complaints.
8	After listening to the patient's complaints, use close-ended questions for detailing their complaints like; "Does your fever accompany this complaint?" "Did your diarrhea start at the same time as your complaint?"
9	Listen to his/her story about his/her complaint (when it started, is there an increase, has she received treatment/beneficial before? etc.)
10	Question patient's past history; Inquire about chronic diseases such as Hypertension, Diabetes, vaccination history, previous surgeries, regularly used medications, allergy status (drug, food).
11	Inquire about family history (first degree relatives; mother, father, child, second degree relatives).
12	Note patient's regular use of drugs, how many times a day? Route of application? Etc.
13	Obtain their habits; cigarette; how many years/how many packs per day, alcohol consumption, substance abuse.
14	Is there any weight loss/weight gain, how long and how many kilos?
15	Question the presence of weakness, loss of appetite, fever, night sweats.
16	Skin, hair, nails: Changes in characteristics (eg, dryness, dandruff, thickening-thinning, etc.), photosensitivity, malar rash, discoid rash, petechiae-purpura discoloration, itching, rashes, wounds, subcutaneous nodules. hair loss, increase in hair growth, decrease in hair growth, etc. Specify yes/no.
17	Head and Neck System: Headache, history of head trauma, dizziness, imbalance, visual impairment, stinging or pain in the eyes, redness of the eye, increased tearing, double vision, blurred vision, flashes of light in the eye, decreased hearing, tinnitus, ear discharge, nasal itching, runny nose, stuffy nose, epistaxis, post-nasal drip, facial pain, pain in the gums, bleeding gums, dry mouth, voice change, sore inside the mouth, swelling in the neck, pain and tenderness, neck pain on movement, etc. Specify yes/no.
18	Breast: Gland or swelling, pain or tenderness, redness/warmth of the breast skin, nipple discharge, etc. Specify yes/no.

19	Respiratory system: Cough, sputum, wheezing, shortness of breath, etc. Specify yes/no.
20	Cardiac and circulatory system: Paroxysmal nocturnal dyspnea, orthopnea, angina pectoris, palpitations, syncope Presyncope, orthostatic hypotension, edema of the legs, Claudication, foot cramps, varicose veins, history of deep vein thrombosis, etc. Specify yes/no.
21	Digestive system: Appetite, dysphagia, retrosternal burning, nausea, vomiting, abdominal pain, flatulence, hematemesis, hematochezia, melana, defecation habit, stool incontinence, fecal characteristics, jaundice. For abdominal pain; the character (location, severity, character, pattern) of the pain. The course of the pain (onset, frequency, duration, increase). Decreasing / increasing causes (position, food, activity, drugs). Associated signs/symptoms are nausea, vomiting, fever, chills, anorexia, weight loss, cough, shortness of breath, dysuria, Intestinal bowel function changes (diarrhea, constipation, obstipation, hematochezia, melena). etc. Specify yes/no.
22	Urinary system: increased frequency of urination, increased daily urine volume (polyuria), frequent urination at night (nocturia), burning during urination (dysuria), bloody urine (hematuria), urinary incontinence, history of kidney stones, bifurcated urination, or decrease in calibration, etc. Specify yes/no.
25	Musculoskeletal system: Morning stiffness, myalgia, joint pain, night pain, activity-related pain, joint swelling, deformities, increased temperature and/or redness in the joint, limitation of movement, neck-back or low back pain, etc. Specify yes/no.
26	Hematological and Immunological system: Blood type, anemia history, easy bruising (ecchymosis), transfusion reaction history, frequent infection history, allergy history, atopy history, etc. Specify yes/no.
27	Endocrine System: Weight gain, slimming, History of thyroid disease, extreme nervousness, heat or cold intolerance, excessive sweating polydpsia, polyphagia, polyuria, enlargement of glove/shoe size, etc. Specify yes/no.
28	Psychiatric evaluation: Memory changes, impaired concentration, sleep disturbance (insomnia or hypersomnia), fatigue, exhaustion or loss of energy, recurrent suicidal thoughts of death, symptoms of anxiety disorder, restlessness, excessive excitement or worry, etc. Specify yes/no.

# EVALUATION GUIDELINE

## OBTAINING ANAMNESIS

### EVALUATION CRITERIAS:

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**KATILIMCI:**

**NO:**

**GÖZLEMCİ:**

**İMZA:**

**TARİH:**

BASAMAK NO	BASAMAKLAR	DENEME		
		1	2	3
1	Greeted the patient, learned his/her name, communicated appropriately.			
2	Introduced him/herself with the phrase "I'm doctor XXX"			
3	Noted gender, date of birth, occupation, marital status, number of children (if any), city/town where they live, and whom has provided the anamnesis.			
4	Find out the reason for the application with open-ended questions; "Which problem brought you to the hospital", What is your chief complaint that caused you to apply to the hospital?"			
5	Listened to the patient's initial sentences without interrupting.			
6	After listening to the patient's complaints, tried to identify all of their complaints and then repeat using the patient's sentences to confirmed that he/she understood their complaints.			
7	Used close-ended questions for detailing their complaints like; "Does your fever accompany this complaint?" Did your diarrhea start at the same time as your complaint?"			
8	Listen to his/her story about his/her complaint (when it started, is there an increase, has she received treatment/beneficial before? etc.)			
9	Questioned patient's past history; Inquire about chronic diseases such as Hypertension, Diabetes, vaccination history, previous surgeries, regularly used medications, allergy status (drug, food).			
10	Inquired about family history (first degree relatives; mother, father, child, second degree relatives).			
11	Noted patient's regular use of drugs, how many times a day? Route of application? Etc.			
12	Obtained their habits; cigarette; how many years/how many packs per day, alcohol consumption, substance abuse.			
13	Was able to obtain a detailed anamnesis for any of the systems (GIS, cardiac etc)			





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### HEAD AND NECK EXAMINATION

**TOOLS:** otoscope, light source/head light, tongue depressor

**PARTICIPANT:**

STEP NO	STEPS
1.	First complete taking complaints and medical history.
2.	Inform the patient about the examination.
3.	Wash your hands.
4.	The patient sits on the examination chair. The physician stands in front of the patient on the right side.
5.	Observe the patient's face while he/she is motionless and while he/she is speaking. Assess the patient's breaths and presence of stridor. Note any abnormalities of the patient's speech and voice.
6.	Observe the size, shape, position of the head as well as its ratio to the neck and other parts of the body. Inspect the skin of the face, scalp and the hair, and inspect their lesions. Palpate the skull and skin of the head for mass lesions or tenderness.
7.	Assess the symmetry of the eyes, eye movements and presence of nystagmus. Palpate the temporomandibular joint in neutral position and during movement. Palpate the sinus regions (frontal, maxillary).
8.	Assess the external ear canal, mastoid region and auricle. Move the auricle up and down, press on tragus and mastoid bone to find out if there is tenderness.
9.	Assess hearing. The physician closes one of the patients' ears with her/his hand. Whisper (two syllabic words or numbers) or create a sound by rubbing two fingers against each other to the other ear from a distance of 30-60 cm and get gradually closer. Then perform the same procedure to the other ear (8th CN)
10.	Perform otoscopy (examine the adults by pulling the auricle to posterior superior direction and the children to posterior inferior direction). Inspect the external ear canal for structural problems, swelling, discharge, foreign body, erythema, etc. Inspect the tympanic membrane for perforation, color change, swelling, retractions, etc.
11.	Examine the nose. Examine the inner structure of the nose, nasal septum, conchae and the air passage by using a light source.
12.	Examine the oral cavity and the pharynx by using a light source. Inspect the lips, tongue,

	teeth, gums, floor of mouth, hard and soft palate and other oral mucosal sites. Examine the oropharynx by using a light source and a tongue depressor.
<b>13.</b>	Watch the symmetry of the neck. Inspect the neck for enlarged lymph nodes, other mass lesions, scar tissues, and skin lesions in both neutral position and head extension. Then palpate the neck and thyroid.
<b>14.</b>	Wash your hands.
<b>15.</b>	Note the findings.
<b>16.</b>	Inform the patient.



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### HEAD AND NECK EXAMINATION

**EVALUATION CRITERIAS:**

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**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

STEP NO	STEPS	<u>OBSERVATION</u>		
		1	2	3
	<b>Head and Neck Examination</b>			
<b>1.</b>	Completed taking complaints and medical history.			
<b>2.</b>	Informed the patient about the examination.			
<b>3.</b>	Washed her/his hands.			
<b>4.</b>	Stood in front of and to the right of the patient while he/she is sitting in the examination chair.			
<b>5.</b>	Observed the patient's face while he/she is motionless and while he/she is speaking. Assessed the patient's breaths and presence of stridor. Noted any abnormalities of the patient's speech and voice.			
<b>6.</b>	Observed the size, shape, position of the head as well as its ratio to the neck and other parts of the body. Inspected the skin of the face, scalp and the hair, and inspected their lesions. Palpated the skull and skin of the head for mass lesions or tenderness.			
<b>7.</b>	Assessed the symmetry of the eyes, eye movements and presence of nystagmus. Palpated the temporomandibular joint in neutral position and during movement. Palpated the sinus regions (frontal, maxillary).			
<b>8.</b>	Assessed the external ear canal, mastoid region and auricle. Moved the auricle up and down, pressed on tragus and mastoid bone to find out if there is tenderness.			
<b>9.</b>	Assessed hearing. Closed one of the patients's ears with her/his hand. Whispered (two syllabic words or numbers) or created a sound by rubbing two fingers against each other to the other ear from a distance of 30-60 cm and get gradually closer. Then performed the same procedure to the other ear (8th CN)			
<b>10.</b>	Performed otoscopy (examined the adults by pulling the auricle to posterior superior direction and the children to posterior inferior direction). Inspected the external ear canal for structural problems, swelling, discharge, foreign body, erythema, etc. Inspected the tympanic membrane for perforation, color change, swelling, retractions, etc.			

<b>11.</b>	Examined the nose. Examined the inner structure of the nose, nasal septum, conchae and the air passage by using a light source.			
<b>12.</b>	Examined the oral cavity and the pharynx by using a light source. Inspected the lips, tongue, teeth, gums, floor of mouth, hard and soft palate and other oral mucosal sites. Examined the oropharynx by using a light source and a tongue depressor.			
<b>13.</b>	Watched the symmetry of the neck. Inspect the neck for enlarged lymph nodes, other mass lesions, scar tissues, and skin lesions in both neutral position and head extension. Then palpated the neck and thyroid.			
<b>14.</b>	Washed her/his hands.			
<b>15.</b>	Recorded the findings.			
<b>16.</b>	Informed the patient.			



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### RESPIRATORY SYSTEM EXAMINATION

**TOOLS:** Stethoscope

**PARTICIPANT:**

STEP NO	STEPS
1	Wash your hands.
2	Inform the patient and/or his/her relatives about the examination.
3	The patient should be examined in a warm(non-cold), well-lit environment, as undressed as possible (with only underwear on if possible).
	EVALUATION BY INSPECTION
4	Evaluate the overall picture and anatomical structure of the chest wall.
5	Evaluate the skin and soft tissues of the chest wall.
6	Determine if both lungs partake equally in breathing.
7	Evaluate respiratory rate, type, and depth.
8	Evaluate the partaking of accessory respiratory muscles in breathing.
	EVALUATION BY PALPATION
9	Evaluate whether the trachea is in the midline.
10	Palpate the skin and subcutaneous tissues in the chest wall.
11	Evaluate thoracic expansion using your thumbs and the palmar sides of your hands.
12	Evaluate thoracic vibration using the palmar sides of your hands.
	EVALUATION BY PERCUSSION
13	Percuss the distal joint of the middle finger of your hand(being percussed) with the tip of the middle/index finger of the other hand(percussing).
14	While percussing, move your hand by the wrist and make short and perpendicular strokes to the distal joint being percussed.
15	Perform percussion comparing both hemithoraces.
16	Percuss the anterior and posterior aspects of the chest wall separately.
17	Put your finger being percussed on the intercostal area on the anterior chest wall and on the interscapular area on the posterior chest wall.
18	Perform anterior chest wall percussion starting just below the clavicle while the patient is in the supine position.
19	While percussing the posterior chest wall (on dorsum), percuss the apex first, then the interscapular area.
20	After the interscapular area, percuss the intercostal areas in the lower part of the scapula on dorsum.
21	Evaluate the presence of pathological sound during percussion.

	EVALUATION BY OSCULTATION
<b>22</b>	The room where auscultation is performed should be as quiet as possible.
<b>23</b>	Perform auscultation with the patient in supine or erect sitting position.
<b>24</b>	The stethoscope should be placed firmly on the chest wall.
<b>25</b>	Listen to both lungs individually from the front and back.
<b>26</b>	Perform the auscultation from top to bottom and symmetrically.
<b>27</b>	Evaluate both inspiration and expiration during auscultation.
<b>28</b>	Evaluate the presence of pathological sound during auscultation.
<b>29</b>	Wash your hands.
<b>30</b>	Inform the patient about the examination findings.



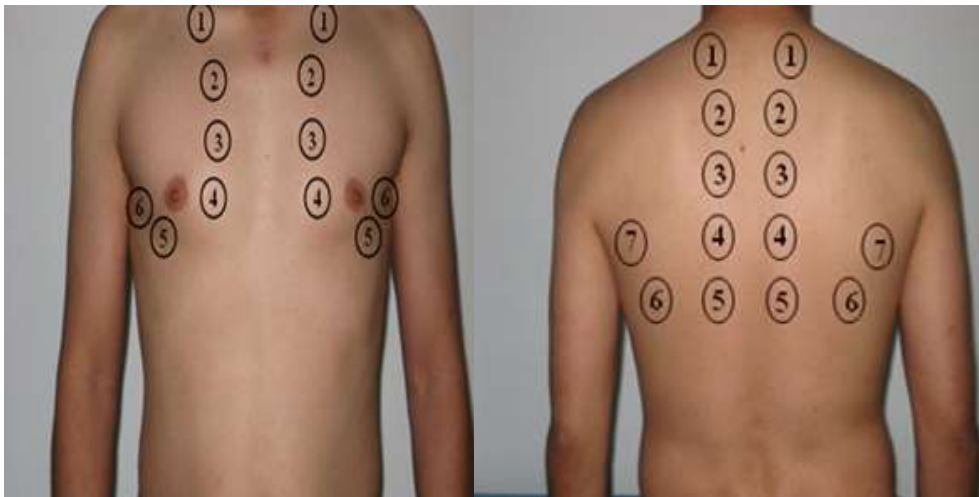
Evaluation of thoracic expansion



Evaluation of thoracic vibration



Percussion of the chest wall anterior and posterior



Auscultation scheme



# GAZI UNIVERSITY FACULTY OF MEDICINE

## EVALUATION GUIDELINE

### RESPIRATORY SYSTEM EXAMINATION

**EVALUATION CRITERIAS:**

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**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	<u>OBSERVATION</u>
1	Hands were washed.	
2	The patient and/or his/her relatives were informed about the examination.	
3	The overall picture and anatomical structure of the chest wall were evaluated.	
4	The skin and soft tissues of the chest wall were evaluated.	
5	It was evaluated if both lungs partake equally in breathing.	
6	Respiratory rate, type, and depth were evaluated.	
7	It was evaluated if the accessory respiratory muscles partake in breathing.	
8	It was evaluated whether the trachea is in the midline.	
9	The skin and subcutaneous tissues in the chest wall were palpated.	
10	Thoracic expansion was evaluated by using the thumbs and the palmar sides of the hands.	
11	Thoracic vibration was evaluated by using the palmar sides of your hands.	
12	The anterior aspect of the chest wall was percussed by comparing	
13	The posterior aspect of the chest wall was percussed starting from the apex by comparing.	
14	The presence of pathological sound was evaluated during percussion.	
15	The stethoscope was firmly placed on the chest Wall during auscultation.	
16	Lungs were auscultated symmetrically from the anterior side.	
17	Lungs were auscultated symmetrically from the posterior side.	
18	Inspiration and expiration were both evaluated during auscultation.	
19	The presence of pathological sound were evaluated by auscultation.	
20	Washed and dried his/her hands.	
21	Informed the patient about the examination findings.	





# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## LEARNING GUIDE

### EXAMINATION OF HEART SOUNDS

**TOOLS:** Stethoscope, heart and breath sound simulator

**PARTICIPANT:**

In this application, we will gain the skill of listening to heart sounds with auscultation used during cardiac examination, which is one of the most important components of cardiovascular evaluation.

It is necessary to know the components that make up the physiological heart sounds that occur during the cardiac cycle. The heart has two functions which occurs sequentially; systole (contraction of the ventricles) and diastole (filling of the ventricles). Just before systole, the closing sound (S1) of the mitral and tricuspid valves is heard. After the end of systole, the sound of closing the aortic and pulmonary valves before diastole (S2) is heard. Other sounds heard between these two sounds are called additional sounds and murmurs. Murmurs from S1 to S2 are called systolic murmurs, and murmurs heard from S2 to S1 are called diastolic murmurs. It is important to record the duration, character, intensity of the murmurs.

During cardiac examination, besides auscultation, inspection and palpation methods are used. The use of percussion in cardiac examination is quite limited.

During the inspection, findings that may be important for cardiovascular examination should be examined and noted. For this purpose, cyanosis, pallor, sweating, xanthelasma, chest deformity, scar tissue from previous cardiac surgery, peripheral findings (clubbing, splinter hemorrhage, amputation, etc.)

Pulses should be checked bilaterally with palpation. Apart from this, hepatomegaly, pretibial edema, and ascites examination should be performed, especially in patients with heart failure.

STEP NO	STEPS
1	In order to be able to hear heart sounds comfortably, first turn off the doors and windows of the examination room and the sounds of devices that make noise (computer, smart phone, etc.).
2	Before starting the procedure, disinfect your hands and inform the patient about the procedure.
3	Ask patient to take his/her clothes(top) off.
4	First, inspect the patient in a sitting position. (Chest deformity, surgical scar, cyanosis, pallor, do accessory respiratory muscles participate in breathing, dyspnea, etc.)
5	Ask patient to lay down.
6	Check if there is jugular venous distention. (Make sure that the head is at a 45° angle)
7	Examine the peripheral pulses (palpate the bilateral carotid, lower and upper extremity pulse zones)
8	Confirm that the conductive part of the stethoscope is on the diaphragm side before auscultation with the patient in the supine position.

<b>9</b>	Record whether the heart sounds are rhythmic, and if there are additional sounds or murmurs with S1 and S2.
<b>10</b>	Auscultate for the focus of the aorta from the second intercostal space to the right sternal border.
<b>11</b>	Auscultate for the pulmonary focus from the second intercostal space to the left of the sternum.
<b>12</b>	Auscultate for the tricuspid focus at the 5th intercostal space on the left side of the xiphoid.
<b>13</b>	Auscultate for the mitral focus (apex) at the intersection of the midclavicular line and the 5th intercostal space.
<b>14</b>	Auscultate for the mesocardiac focus to the left of the sternum between the mitral focus and the aortic focus.
<b>15</b>	Listen for heart sounds just to the left of the xiphoid after giving the patient a full exhalation in a sitting position so that you can hear the pericardial smear (if you suspect pericarditis).
<b>16</b>	Tell the patient to get dressed.
<b>17</b>	Note down your examination findings.
<b>18</b>	Inform the patient.



# GAZI UNIVERSITY FACULTY OF MEDICINE

## EVALUATION GUIDELINE

### EXAMINATION OF HEART SOUNDS

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**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	OBSERVATION		
<b>1</b>	Shut down the doors, windows and sound of noisy devices.			
<b>2</b>	Disinfect his/her hands and informed the patient.			
<b>3</b>	Asked patient to take his/her clothes(top) off.			
<b>4</b>	Inspected the patient in a sitting position. Noted the relevant details.			
<b>5</b>	Asked patient to lay down.			
<b>6</b>	Checked if there is jugular venous distention. (Made sure that the head is at a 45 <sup>0</sup> angle)			
<b>7</b>	Examined the peripheral pulses (palpate the bilateral carotid, lower and upper extremity pulse zones)			
<b>8</b>	Confirmed that the conductive part of the stethoscope is on the diaphragm side before auscultation with the patient in the supine position.			
<b>9</b>	Recorded whether the heart sounds are rhythmic, and if there are additional sounds or murmurs with S1 and S2.			
<b>10</b>	Auscultated for the focus of the aorta from the second intercostal space to the right sternal border.			
<b>11</b>	Auscultated for the pulmonary focus from the second intercostal space to the left of the sternum.			
<b>12</b>	Auscultated for the tricuspid focus at the 5th intercostal space on the left side of the xiphoid.			
<b>13</b>	Auscultated for the mitral focus (apex) at the intersection of the midclavicular line and the 5th intercostal space.			
<b>14</b>	Auscultated for the mesocardiac focus to the left of the sternum between the mitral focus and the aortic focus.			
<b>15</b>	Listened for heart sounds just to the left of the xiphoid after giving the patient a full exhalation in a sitting position so that you can hear the pericardial smear (if you suspect pericarditis).			
<b>16</b>	Told the patient to get dressed.			

<b>17</b>	Noted down your examination findings.			
<b>18</b>	Informed the patient.			



# GAZI UNIVERSITY FACULTY OF MEDICINE

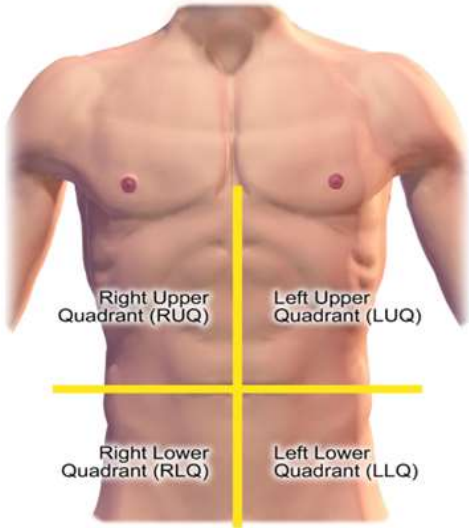
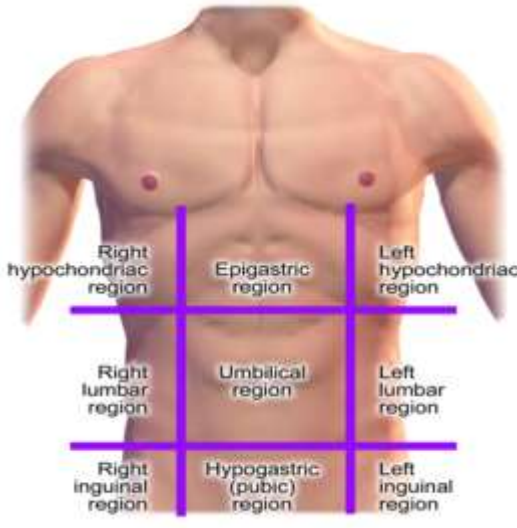
## Clinical Skills Training

### LEARNING GUIDE

#### ABDOMINAL PHYSICAL EXAMINATION SKILL

**TOOLS:** Stethoscope, gloves

**PARTICIPANT:**

NO	STEPS
1	Introduce yourself to the patient and call them by name.
2	Provide information about the examination to be performed.
3	Wash your hands, clean the stethoscope with alcohol.
4	Make sure the patient is prepared in such a way that you can see the entire abdomen (from the breast level to the knees).
5	Move to the patient's right side by asking him/her to lie on his back and turn his head slightly to the left.
6	Encourage the patient to lie down calmly and relaxed.
7	Begin the examination with inspection.
8	<p>Examine the abdomen by dividing it into 4 quadrants or 9 regions and use these regions to describe your findings.</p> <div style="display: flex; justify-content: space-around; align-items: center;">   </div> <ul style="list-style-type: none"> <li>- 4 quadrants: Right upper and lower quadrants, left upper and lower quadrants</li> <li>- 9 regions: Right hypochondrium, epigastrium, left hypochondrium, right lumbar (colic), umbilical, left lumbar (colic), right inguinal (iliac), hypogastrium (suprapubic), left inguinal (iliac)</li> </ul>
9	<p>In the inspection, pay attention to the following:</p> <ul style="list-style-type: none"> <li>- Abdominal skin (color, edema, striae, scar, rash, localized swelling, caput medusa, spider angioma...)</li> <li>- Participation of the abdominal wall in respiration</li> </ul>

	<ul style="list-style-type: none"> <li>- Abdominal shape, asymmetry, distention, localized swelling</li> <li>- Pulsation</li> <li>- Peristaltic wave</li> <li>- Location and condition of the umbilicus</li> </ul>
<b>10</b>	<p>Continue the examination with auscultation. Listen to the 4 quadrants of the abdomen for at least one minute. Pay attention to the following in auscultation</p> <ul style="list-style-type: none"> <li>- Number of bowel sounds heard per minute (normal expected 4-6/min)</li> <li>- Presence of murmur (unilateral-bilateral, systolic-diastolic-continuous)</li> <li>- Presence of frotman</li> </ul>
<b>11</b>	<p>After auscultation, switch to percussion. For percussion, place the third finger of your passive hand on the abdominal skin, using the tip of the third finger of your other hand, with the movement of the wrist (keeping the elbow fixed), make short strokes on the part of the finger that you placed on the skin between the nail base and the first phalanx joint.</p>
<b>12</b>	<p><u>Ascites examination:</u> Beginning from the xiphoid, evaluate the entire abdomen in a radial and fan-like manner. Identify the places where the dullness is detected.</p> <ul style="list-style-type: none"> <li>- If the opening of the parabola formed by the points you have determined is upwards, first consider acid.</li> <li>- If the opening of the parabola is downwards, consider the causes of mass effect such as globe vesicle, ovarian tumor.</li> <li>- Pay attention to whether the dullness is displaced when you change the patient's position (dullness displaced by position is in favor of acid).</li> <li>- Acid will not be free due to adhesions in tuberculous peritonitis. Do not forget that in these patients, a checkerboard-like dullness may be obtained, which does not change with position.</li> <li>- Be suspicious of peritonitis if percussion is painful.</li> </ul>
<b>13</b>	<p><u>Liver percussion:</u> Percuss on the anterior chest wall along the right midclavicular line, from top to bottom, into the intercostal spaces. Determine the level you have determined to be dullness. Tap up along the abdomen in the same line to determine the lower border of the liver. The region between the two dullness limits will guide the liver size (expected 6-12 cm). For the upper border of the liver, relative dullness is expected to start from the 4th intercostal space, and dullness from the 5th to 6th intercostal space. Consider taking lower as 'ptotic liver' and higher as 'high liver'.</p>
<b>14</b>	<p><u>Spleen percussion:</u> The region between the left anterior axillary line, the vertical line drawn from the xiphoid and the costal arc is called Traube's space and normally tympanic sound is expected from percussion of this area using the intercostal spaces. If you get dullness to percussion over Traube's space, you can express this as 'Traube closed'. Note that dullness to percussion over Traube's space most commonly indicates splenomegaly, rarely tumors of the greater curvature of the stomach, left kidney or left lobe of liver.</p>
<b>15</b>	<p>Proceed to palpation as the final step of the examination. Pay attention to the following in palpation.</p> <ul style="list-style-type: none"> <li>- Keep your hand and forearm in the same plane.</li> <li>- Question the area where the patient's pain is most intense and leave the palpation of it to the last.</li> <li>- In the absence of pain, prefer to continue the examination starting from the left inguinal region and continuing towards the rib arc.</li> </ul>
<b>16</b>	<p><u>Superficial palpation:</u> Gently feel the patient's abdomen with your fingertips. Do not press your hand more than 1 cm on the patient's abdomen. In the meantime, constantly observe the facial expression of the patient. Identify areas of increased pain response, discomfort, or tone.</p>
<b>17</b>	<p><u>Deep palpation:</u> Press the palm and fingers as deeply as possible. Try to have an idea about the physical qualities of the deep formations. Therefore, after pressing, move your hand a few centimeters in the right-left and up-down directions.</p> <ul style="list-style-type: none"> <li>- In patients with very hard abdominal wall or obese patients, do this examination by placing both hands on top of each other. Try to achieve effective palpation by pressing with your upper hand while your lower hand is passive.</li> <li>- Do not forget that in this examination, you especially investigate the presence of pain (tenderness) and mass. If you detect a mass, carefully evaluate the following features: localization, dimensions, depth, shape, consistency, surface condition (smooth, rough), whether it is painful or not, whether it is mobile (mobile, fixed), whether it is pulsatile or not and its movement with respiration.</li> <li>- Defense assessment: Assess the muscle tone in the abdominal wall during palpation. Abdominal wall rigidity is typical in patients with peritonitis with an acute abdomen. Determine if the defense is localized or widespread.</li> <li>- Evaluation of rebound: Perform deep palpation at the point where you detect tenderness on palpation (in this case, the pain is expected to increase). Hold the position of your hand for a few</li> </ul>

	more seconds and then withdraw your hand suddenly. If the patient's pain gets worse with this pulling motion, qualify the rebound finding as positive. Rebound finding is typical in patients with acute abdomen and peritonitis.
<b>18</b>	<p><u>Liver and spleen palpation:</u> With your hand on deep palpation and your fingertips pointing towards the opposite shoulder, slowly move from the inguinal region towards the costal arch. In the meantime, ask the patient to make a deep inspiration and expiration. The mass that hits your hand by moving down on inspiration and moving up on expiration is the liver or spleen. Pay attention to the following in the palpation of the organs.</p> <ul style="list-style-type: none"> <li>- Pain-tenderness (liver tenderness in hepatitis or heart failure)</li> <li>- Pulsation (aortic aneurysm if midline)</li> <li>- Whether it exceeds the costal arc (organomegaly, mass)</li> <li>- Contour features (palpation of the notch indicates spleen)</li> <li>- Relationship with respiration (kidney is fixed while spleen is mobile with respiration)</li> </ul>
<b>19</b>	<p>Finally, evaluate the painful special points in the abdomen.</p> <p><b>Murphy's point:</b> It is the point where the midclavicular line intersects the right rib arc. Tenderness in this localization often indicates gallbladder disease (acute or subacute cholecystitis). Assess tenderness by deep palpation at this point (with the palm of your hand and fingertips facing the shoulder). Keeping the position of your hand, ask the patient to make a deep inspiration. If the patient is holding his breath (inability to complete the inspiration) due to pain, describe this situation as 'murphy positivity'.</p> <p><b>Mc Burney point:</b> It is the 1/3 outer point of the line connecting the umbilicus and the right anterior superior iliac spine. Evaluate this point, which is a guide for acute appendicitis, in terms of tenderness, defense, rebound and mass (plastron).</p>
<b>20</b>	Switch to hernia examination: Inspect potential hernia sites (inguinal, umbilical, incision sites). Evaluate whether there is swelling by palpating these areas, whether the swelling disappears with palpation (reduced-incarcerated), and the width of the fascia defect. Make sure the patient has the valsava maneuver and see if there is a mass under your hand during straining.
<b>21</b>	Have the patient sit on the examination table to assess costovertebral angle tenderness. With your open hand and fingers together, tap the hypothenar area of your hand on the right and left costovertebral angles (12th vertebral level, posterolateral). Assess tenderness by palpating along the ureteral trace.
<b>22</b>	Perform a rectal touch examination. Ask the patient to lie on his side with his back to you and pull the upper leg towards his stomach. After wearing gloves, first inspect the perianal area. Then, using a lubricating gel, touch it with your index finger. Assess prostate consistency, size, tenderness, and local temperature increase in men. Complete the examination by turning your finger 360 degrees clockwise for other pathologies in the anal canal and distal rectum (such as mass, abscess, polyp).
<b>23</b>	Tell the patient to get dressed.
<b>24</b>	Wash your hands and clean your stethoscope with alcohol.
<b>25</b>	Note down your examination findings.
<b>26</b>	Inform the patient.

# GAZI UNIVERSITY FACULTY OF MEDICINE Clinical Skills Training



## EVALUATION GUIDE

### ABDOMINAL PHYSICAL EXAMINATION SKILL

**ASSESSMENT CRITERIA:**

Using the scoring system below, repeat the skill until all steps are done correctly, in order, without hesitation, and you get full marks from all of them.

**A - Professional:** Performing the step correctly and in sequence without hesitation and without the need for the help of the trainer.

**B - Adequate:** Performing the step correctly and in sequence; but the need for the help of the trainer

**C - Needs improvement:** No implementation of the step; incorrectly applied or not applied

**PARTICIPANT:**

**NO:**

**OBSERVER:**

**SIGNATURE:**

**DATE:**

STEPS	TRIAL		
	1	2	3
<b>Abdominal Examination Skill</b>			
1. He/she introduced himself to the patient.			
2. He/she gave information about the examination to be made.			
3. He/she washed his hands, cleaned the stethoscope with alcohol.			
4. He/she ensured that the patient was prepared in such a way that he/she could see the entire abdomen (from the breast level to the knees).			
5. He/she moved to the right side of the patient, asking the patient to lie on his/her back and turn his/her head slightly to the left.			
6. He/she advised the patient to lie down calmly and loosely.			
7. He/she started the examination with inspection.			
8. He/she divided the abdomen into 4 (or 9) regions and examined it. He used these regions to describe the findings.			
9. On inspection. abdominal skin (color, edema, striae, scarring, rash, localized swelling, caput medusa, spider angioma...), involvement of the abdominal wall in respiration, abdominal shape, asymmetry, distension, localized swelling, pulsation, peristaltic wave, the location and condition of the umbilicus were evaluated.			
10. He/she continued the examination with auscultation. He listened to the 4 quadrants of the abdomen for at least a minute. He evaluated the number of bowel sounds heard per minute, the presence of murmur, and the presence of friction.			
11. After auscultation, he/she switched to percussion. He/she placed the third finger of his passive hand on the abdominal skin for percussion. Using the tip of the third finger of the other hand, with the movement of his wrist (keeping his/her elbow fixed), he/she strucked short blows between the nail base and the first phalanx joint of the finger placed on the skin.			



12. Starting from the xiphoid, He/she evaluated the entire abdomen in a radial and fan-like manner (ascites examination). He/she identified the places where dullness was detected. He/she paid attention to whether the dullness shifted when the patient changed his position.			
13. He/she percussed the intercostal spaces along the right midclavicular line on the anterior chest wall, from top to bottom and set the level that dullness detected. He/she percussed upward on the same line along the abdomen to determine the lower border of the liver. He evaluated liver size.			
14. He/she percussed the Traube triangle and evaluated whether the Trauben was closed.			
15. By keeping his hand and forearm in the same plane, He/she palpated the abdomen. He questioned the area where the patient's pain was most intense and left the palpation of this area for last.			
16. He/she constantly observed the facial expression of the patient while performing superficial palpation. He identified areas of increased pain response, discomfort, and tone.			
17. While performing deep palpation, he/she pressed the palm and fingers as deeply as possible. He investigated the presence of pain (tenderness) and mass. He/she evaluated the defense. He/she evaluated whether the defense was localized or widespread. Evaluated the presence of rebound.			
18. Liver and spleen palpation were performed. He/she evaluated the presence of pain-tenderness, pulsation, organomegaly, and mass. He evaluated the contour of the spleen. He evaluated the relationship between spleen and respiratory movements.			
19. Evaluated the sensitivity at the Murphy point and evaluated Mc Burney point in terms of tenderness, defense, rebound and mass (plastron).			
20. He/she did a hernia examination. He/she examined potential hernia sites (inguinal, umbilical, incision sites). He made the patient do the valsava maneuver and checked whether there was a mass under his hand during the straining.			
21. To assess costovertebral angle sensitivity, he tapped the hypothenar region of his hand to the right and left costovertebral angles with his open hand and fingers together. He evaluated tenderness by palpating along the ureteral trace.			
22. He/she did a rectal touch examination. He/she asked the patient to lie on his side with his back to him and pulling the upper leg towards his stomach. After wearing gloves, he/she first performed an inspection of the perianal region. Then, using a lubricating gel, he/she touched it with his/her index finger and evaluated prostate consistency, size, tenderness, and local temperature increase in a male patient. He/she completed the examination by turning his finger 360 degrees clockwise in terms of other pathologies in the anal canal and distal rectum (such as mass, abscess, polyp).			
23. He/she told the patient to get dressed.			
24. He/she washed his hands and cleaned his stethoscope with alcohol.			
25. He/she noted the findings of the examination.			
26. Informed the patient.			



# GAZİ UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS TRAINING


## LEARNING GUIDE



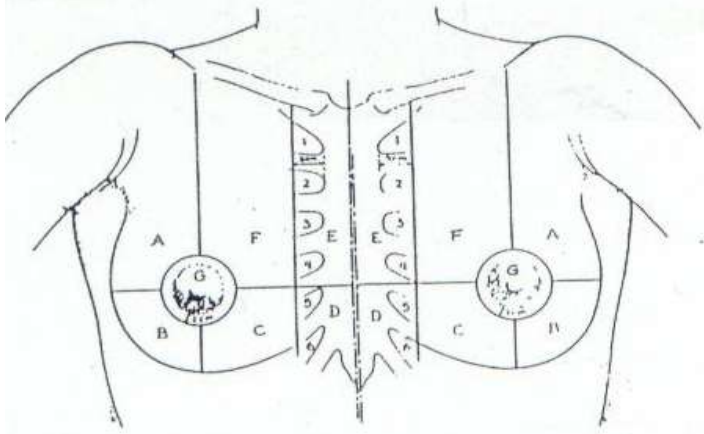
### BREAST AND AXILLA EXAMINATION

**Tools:** Non-sterile examination gloves


**Participant:**

#### BREAST EXAMINATION

STEP NU.	STEPS
1	Introduce yourself to the patient and inform patient about the examination.
2	Wash your hands.
3	Put on gloves.
4	Have the patient sit on examination table bare from the waist up and legs hanging downward. Inspect both of the breasts and nipples by facing the patient.
5	Repeat the inspection with the arms; at the sides, above the head, at the waist and both the arms extended forward parallel to the floor. Observe the following findings in particular; <div style="display: flex; align-items: center; justify-content: space-between; margin-top: 10px;"> <div style="text-align: center;">  </div> <div style="flex-grow: 1;"> <ul style="list-style-type: none"> <li>- Skin appearance, color, thickness, orange peel appearance,</li> <li>- The size and the symmetry of the breasts</li> <li>- Characteristics of the nipples</li> </ul> </div> </div>
6	Ask the patient to lie on their back (supine position).
7	If the complaint is unilateral, start the physical examination on the healthy side.
8	Place a pillow under the shoulder on the side being examined and ask the patient to place her/his hand on that side under their head. Thus, the breast will spread better on the thoracic wall and it will be easier to detect the masses.

	
<p><b>9</b></p>	<p>Palpate the breast tissue with circular movements, starting from the nipple, in a radial fashion or circularly parallel to the nipple by pressing gently with the pulp of the 2nd, 3rd, 4th fingers.</p> 
<p><b>10</b></p>	<p>If you detect a mass, note its size, boundary relationship with the surrounding tissues, mobility, and consistency.  (In order to define clinical findings, the breast is divided into quadrants by two methods. In the first, it is divided into four quadrants by horizontal and vertical lines passing through the nipple, these are upper-outer, upper-inner, lower-outer and lower-inner quadrants. In the other method, it is divided into seven quadrants. In addition to the lines in the previous method, the breast is divided into 6 quadrants with a vertical line passing 2-3 cm lateral to the costochondral joint. The seventh quadrant is the region consisting of the tissue (retroareolar area) that passes 1 cm from the outer line of the areola. The distance of the lesion is defined by its distance from the nipple or areola margin.)</p> 
<p><b>11</b></p>	<p>After the completion of palpation, determine whether there is nipple discharge by pressing the areola clockwise with the fingertip.</p>
<p><b>12</b></p>	<p>Repeat the same steps for the opposite breast.</p>

## AXILLA EXAMINATION

STEP NU.	STEPS
<b>1</b>	Introduce yourself to the patient and inform patient about the examination
<b>2</b>	Wash your hands.
<b>3</b>	Put on gloves.
<b>5</b>	Have the patient sit on examination table bare from the waist up and legs hanging downward.
<b>6</b>	Ask the patient to raise their arms up and observe the skin of the axilla.
<b>7</b>	<p>Ask the patient to lower one side arm down. Lay the patient's bended arm on the elbow level (flexion) parallel to your ipsilateral arm and grasp the patient's elbow from the inside with your hand and raise the bended arm a little (abduction).</p> 
<b>8</b>	Join together all the fingers of your free hand.
<b>9</b>	Keep your fingers pointing to the midpoint of the patient's clavicle and press the patient's involved axilla to palpate the highest point that can be reached.
<b>10</b>	Check the entire axillary fossa for the presence of lymph nodes by pressing your fingers against the chest wall and sliding them up and down.
<b>11</b>	Repeat the same process on the other side.



# GAZİ UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS TRAINING

## ASSESSMENT GUIDE

### BREAST AND AXILLA EXAMINATION SKILL

**ASSESSMENT CRITERIA:**  
Using the scoring system below, repeat the skill until all steps are done; correctly, in order, without hesitation and until you get full marks from all of them.

**A - Professional:** Performing the step correctly and in sequence without hesitation and without the need for the help of the instructor.

**B - Adequate:** Performing the step correctly and in sequence; but in need for the help of the instructor

**C - Needs improvement:** No implementation of the step; applied incorrectly or not applied in correct order.

**STUDENT:** \_\_\_\_\_ **STUDENT ID:** \_\_\_\_\_

**INSTRUCTOR:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

STEP NU.	STEPS	<u>ASSESSMENT</u>
1	He/She introduced himself/herself to the patient and informed the patient about the procedure.	
2	Washed his/her hands.	
3	He/she did put on gloves.	
4	He/she inspected separately with the arms at the sides, the arms above the head, the arms at the waist, and both arms extended parallel to the ground.	
5	He/she gave the correct position to the patient for palpation of the breast.	
6	He/she performed palpation starting from the nipple by circular motions, pressing lightly with the pulp of the fingers.	
7	He/she repeated the examination for the contralateral breast.	
8	He/she gave the correct position to the patient for the palpation of the axilla.	
9	He/she examined the entire axillary fossa by joining all the fingers together for the palpation.	
10	He/she repeated the examination for the contralateral axilla.	

# GAZI UNIVERSITY FACULTY OF MEDICINE

## Clinical Skills Training



### EVALUATION GUIDE

#### SKIN EXAMINATION

NO	STEPS
1	Wash your hands
2	Inform the patient about the skin examination and tell him/her to be comfortable
3	Control whether there is Increased pigmentation in the skin and mucosa Loss of pigmentation, redness, paleness, cyanosis and jaundice
4	Examine whether the skin is dry, sweaty or oily
5	Test the general warmth of the skin with the dorsal side of your hand and test the warmth of the red areas if any
6	Control the surface of the skin whether smooth or not
7	Examine the mobility and turgor of the skin
8	Control the amount, distribution, structure and color of the hair via inspection and palpation
9	Examine the hand and foot nails via inspection and palpation in terms of color, shape and lesion
	FOR THE LESIONS
10	Specify the lesions on the skin
11	Observe the anatomic localization of the lesion and its distribution over the body
12	Define the shape of the lesions
13	Specify the surface characters of the lesion (smooth, filiform, rough, indented, dry, moistened, oily)
14	Control the array of the lesion (linear, in groups, annular, arc-shaped and dermatomal)
15	Examine the consistency (soft, hard) of the lesion via palpation
16	Control whether the lesion is painful on palpation
17	Specify the character of the mass lesion (adherence to the tissues below, mobility, hardness or softness, fine-peduncled or large, etc)
18	Wash your hands
19	Inform the patient about the examination findings



# GAZI UNIVERSITY FACULTY OF MEDICINE CLINICAL SKILLS EDUCATION

## EVALUATION GUIDELINE

### SKIN EXAMINATION

**EVALUATION CRITERIAS:**

Using the grading system below, repeat the skill until all steps will be completed correctly, appropriately and without a pause.

**A - Competent:** Correct application of the examination steps in their proper sequence

**B - Sufficient :** Correct application of the examination steps in their proper sequence with the help of coach or need help

**C - Needs to be developed :** Incorrect application of the examination steps or not application or improper sequence of steps

**PARTICIPANT:**

**NO:**

**COACH:**

**SIGNATURE:**

**DATE:**

	STEPS	OBSERVATION		
		1	2	3
<b>1</b>	Washed and dried the hands.			
<b>2</b>	Informed the patient about the skin examination.			
<b>3</b>	Checked the skin and mucous membranes for increased pigmentation, loss of pigmentation, redness, pallor, cyanosis, and jaundice.			
<b>4</b>	Checked whether the skin is dry, sweaty or oily.			
<b>5</b>	Looked at the general temperature of the skin of the fingers and the temperature of the red areas, if any.			
<b>6</b>	Evaluated the general temperature of the skin and the temperature of the red areas, if any.			
<b>7</b>	Checked whether the skin surface is smooth.			
<b>9</b>	Checked the mobility and turgor of the skin.			
<b>10</b>	Checked the amount, distribution, structure and color of the hairs by inspection and palpation.			
<b>11</b>	Examined fingernails and toenails for color, shape and lesion by inspection and palpation.			
	FOR THE LESIONS			
<b>12</b>	Identified the lesions on the skin.			
<b>13</b>	Looked at the anatomical location of the lesion and its distribution in the body.			
<b>14</b>	Described the shape of the lesions on the skin.			
<b>15</b>	Determined the surface characteristics of the lesion ( smooth, filiform, rough, indented, dry, moistened, oily ).			
<b>16</b>	Controlled the array of the lesion ( linear, in groups, annular, arc-			

	shaped and dermatomal)			
<b>17</b>	Examined the consistency (soft, hard) of the lesion via palpation.			
<b>18</b>	Controlled whether the lesion is painful on palpation.			
<b>19</b>	Specified the character of the mass lesion (adherence to the tissues below, mobility, hardness or softness, fine-pedincled or large, etc)			
<b>20</b>	Washed and dried his/her hands.			
<b>21</b>	Informed the patient about the examination findings.			