STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

NEONATOLOGY

1. *Kindly read the instructions mentioned in the **Form 'A'**.*
2. *Write **N/A** where it is **Not Applicable**. Write **'Not Available'**, if the facility is **Not Available**.*

A. GENERAL:

a. Date of LoP when PG course was first Permitted: _____

b. Number of years since start of PG course: _____

c. Name of the Head of Department: _____

d. Number of PG Admissions (Seats): _____

e. Number of Increase of Admissions (Seats) applied for: _____

f. Total number of Units: _____

g. Number of beds in the Department: _____

h. Total number of ICU beds/ High Dependency Unit (HDU) beds in the department: _____

i. Number of Units with beds in each unit: (Specialty applicable):

Unit	Number of Beds	Unit	Number of beds
Unit-I		Unit-V	
Unit-II		Unit-VI	
Unit-III		Unit-VII	
Unit-IV		Unit-VIII	

j. Details of PG inspections of the department in last five years:

Date of Inspection	**Purpose of Inspection** *(LoP for starting a course/permission for increase of seats/ Recognition of course/ Recognition of increased seats /Renewal of Recognition/Surprise /Random*	**Type of Inspection (Physical/ Virtual)**	**Outcome** *(LOP received/denied. Permission for increase of seats received/denied. Recognition of course done/denied. Recognition of increased seats done/denied /Renewal*	**No of seats Increased**	**No of seats Decreased**	**Order issued on the basis of inspection** *(Attach copy of all the order issued*

	Inspection/ Compliance Verification inspection/other)		*of Recognition done/denied /other)*			*by NMC/MCI) as* ***Annexure***

k. Any other Course/observer ship (PDCC, PDF, DNB, M.Sc., PhD, FNB, etc.) permitted/ not permitted by MCI/NMC is being run by the department? If so, the details thereof:

Name of Qualification (course)	**Permitted/not Permitted by MCI/NMC**	**Number of Seats**
	Yes/No	
	Yes/No	

B. INFRASTRUCTURE OF THE DEPARTMENT:

a. OPD

No of rooms: _____

Area of each OPD room (add rows)

	Area in M^2
Room 1	
Room 2	

Waiting area: _____ M^2

Space and arrangements: **Adequate/ Not Adequate.**

If not adequate, give reasons/details/comments: _____

b. Wards

No. of wards: _____

Parameters	**Details**
Distance between two cots (in meter)	
Ventilation	Adequate/Not Adequate
Infrastructure and facilities	
Dressing and procedure room	

c. Department office details:

Department Office	
Department office	Available/not available

Staff (Steno /Clerk)	Available/not available
Computer and related office equipment	Available/not available
Storage space for files	Available/not available

Office Space for Teaching Faculty/residents	
Faculty	Available/not available
Head of the Department	Available/not available
Professors	Available/not available
Associate Professors	Available/not available
Assistant Professor	Available/not available
Senior residents rest room	Available/not available
PG rest room	Available/not available

d. Seminar room

Space and facility: Adequate/ Not Adequate

Internet facility:

Audiovisual equipment details:

e. List of Department specific laboratories with important Equipment:

Name of Laboratory	**Size in square meter**	**List of important equipment available with total numbers**	**Adequate/ Inadequate**

f. Library facility pertaining to the Department/Speciality (Combined Departmental and Central Library data):

Particulars	**Details**
Number of Books	
Total books purchased in the last three years (attach list as Annexure	
Total Indian Journals available	
Total Foreign Journals available	

Internet Facility: Yes/No
Central Library Timing: _____
Central Reading Room Timing: _____

Signature of Dean Signature of Assessor

Journal details

Name of Journal	Indian/foreign	Online/offline	Available up to

g. Departmental Research:

Research Projects Done in past 3 years.	
List of Research projects in progress.	

h. Equipment

Name of the Equipment	Available/ Not available	Functional Status	Important specification in brief
Multipara Monitors			
Echo – color Doppler			
Resuscitation kit			
Phototherapy Units (CFL & LED)			
Radiant warmer			
Pulse Oximeters			
Neonatal ventilator including high frequency ventilation			
ECG machine			
CPAP machine			
Crash cart trollies			
Computerized PFT equipment			
ABG Equipment			
Syringe pump			
USG			
Defibrillator			
Transport Incubator			
Stadiometer/weighing scale			

Name of the Equipment	Available/ Not available	Functional Status	Important specification in brief
Laminar Flow in ICU			
HHHFNC			
EEG Machine			
Phototherapy Equipment			
Parenteral nutrition Equipment			
Inhaled NO machine			
Therapeutic hypothermia machine			
Neonatal bronchoscopy			
Oxygen blenders			
T piece resuscitator			
OAE/AABR machine			
Any other equipment			

C. SERVICES:

i. Intensive care service provided by the department

Type	Number of total beds	List of Major Equipment	Bed occupancy on the day of inspection	Average bed occupancy for the last year
Neonatal ICU- NICU				
Level-I				
Level-II				
Level-III				
Level-IV				

ii. Specialty clinics being run by the department and number of patients in each clinic

Name of the Clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge
Neuro development Clinic				
Well Baby OPD				
Neonatal &Fetal surgery				

Combined clinic				
High risk Neonatal clinic				
Retinopathy of Prematurity clinic				
Others				

iii. Services provided by the Department

Parameters	**Yes/No**	**If Yes – Weekly Workload**
Neonatal Ventilation		
Exchange transfusion		
Phototherapy		
Parenteral nutrition		
high risk infants follow up with Rehabilitation		
Counseling		
Others		

D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF NEONATOLOGY:

Parameters	**On the day of inspection**	**Previous day data**	**Year 1**	**Year 2**	**Year 3**
1	**2**	**3**	**4**	**5**	**6**
Total numbers of Out-Patients					
Out-Patients attendance (write **Average daily Out-Patients attendance** in column 4,5,6) *					
Total numbers of new Out-Patients					
New Out Patients attendance (write average in column 4,5,6) * for Average daily New Out-Patients attendance					
Total Admissions for Year					
Bed occupancy			X	X	X

Bed occupancy for the whole year above 75 % (prepare a data table)	X	X	Yes/ No	Yes/ No	Yes/ No
ABG workload					
X-rays per day (OPD + IPD) (write average of all working days in column 4,5,6)					
Ultrasonography per day (OPD + IPD) (write average of all working days in column 4,5,6)					
CT scan per day (OPD + IPD) (write average of all working days in column 4,5,6)					
Cytopathology Workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Cytopathology Workload per day (write average of all working days in column 4,5,6)					
Haematology workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Haematology workload per day (write average of all working days in column 4,5,6)					
Biochemistry Workload per day (OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Biochemistry Workload per day (write average of all working days in column 4,5,6)					
Microbiology Workload per day					

(OPD + IPD) (write average of all working days in column 4,5,6)					
OPD Microbiology Workload per day (write average of all working days in column 4,5,6)					
Total Deaths **					
Total Blood Units Consumed including Components					

* **Average daily Out-Patients attendance** is calculated as below.
Total OPD patients of the department in the year divided by total OPD days of the department in a year

***The details of deaths* sent by hospital to the Registrar of Births/Deaths

E. STAFF:

i. Unit-wise faculty and Senior Resident details:

Unit no: _____

Sr. No.	Designation	Name	Joining date	Relieved/ Retired/working	Relieving Date/ Retirement Date	Attendance in days for the year/part of the year * with percentage of total working days** [days (%)]	Phone No.	E-mail	Signature

* - Year will be previous Calendar Year (from 1st January to 31st December)

** - Those who have joined mid-way should count the percentage of the working days accordingly.

Signature of Dean

Signature of Assessor

ii. Total eligible faculties and Senior Residents (fulfilling the TEQ requirement, attendance requirement and other requirements prescribed by NMC from time-to-time) available in the department:

Designation	**Number**	**Name**	**Total number of Admission (Seats)**	**Adequate / Not Adequate for number of Admission**
Professor				
Associate Professor				
Assistant Professor				
Senior Resident				

iii. P.G students presently studying in the Department:

Name	**Joining date**	**Phone No**	**E-mail**

iv. PG students who completed their course in the last year:

Name	**Joining date**	**Relieving Date**	**Phone no**	**E-mail**

F. ACADEMIC ACTIVITIES:

S. No.	**Details**	**Number in the last Year**	**Remarks Adequate/ Inadequate**
1.	Clinico- Pathological conference		
2.	Clinical Seminars		
3.	Journal Clubs		
4.	Case presentations		
5.	Group discussions		
6.	Guest lectures		
7.	*Death Audit Meetings*		

8.	Physician conference/ Continuing Medical Education (CME) organized.		
9.	Symposium		

Note: *For seminars, Journal Clubs, Case presentations, Guest Lectures the details of dates, subjects, name & designations of teachers and attendance sheets to be maintained by the institution and to be produced on request by the Assessors/PGMEB.*

Publications from the department during the past 3 years:

G. EXAMINATION:

i. Periodic Evaluation methods (FORMATIVE ASSESSMENT):
(Details in the space below)

ii. Detail of the Last Summative Examination:

a. List of External Examiners:

Name	Designation	College/ Institute

b. List of Internal Examiners:

Name	Designation

c. List of Students:

Name	Result (Pass/ Fail)

d. Details of the Examination: _____

Insert video clip (5 minutes) and photographs (ten).

H. MISCELLANEOUS:

i. Details of data being submitted to government authorities, if any:

ii. Participation in National Programs.
(If yes, provide details)

iii. Any Other Information

I. Please enumerate the deficiencies and write measures which are being taken to rectify those deficiencies:

Date: **Signature of Dean with Seal** **Signature of HoD with Seal**

Signature of Dean Signature of Assessor

J. REMARKS OF THE ASSESSOR

1. *Please **DO NOT** repeat information already provided elsewhere in this form.*
2. *Please **DO NOT** make any recommendation regarding grant of permission/recognition.*
3. *Please **PROVIDE DETAILS** of deficiencies and irregularities like fake/ dummy faculty, fake/dummy patients, fabrication/falsification of data of clinical material, etc. if any that you have noticed/came across, during the assessment. Please attach the table of list of the patients (IP no., diagnosis and comments) available on the day of the assessment/inspection.*
4. *Please comment on the infrastructure, variety of clinical material for the all-round training of the students.*