**STANDARD ASSESSMENT FORM- B**

(DEPARTMENTAL INFORMATION)

**PLASTIC & RECONSTRUCTIVE SURGERY**

|  |
| --- |
| *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**:

1. Date of LoP when PG course was first Permitted: \_\_\_\_\_\_\_\_\_\_
2. Number of years since start of PG course: \_\_\_\_\_\_\_\_\_
3. Name of the Head of Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Number of PG Admissions (Seats): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Number of Increase of Admissions (Seats) applied for: \_\_\_\_\_\_\_\_\_
6. Total number of Units: \_\_\_\_\_\_\_\_\_\_
7. Number of beds in the Department: \_\_\_\_\_\_\_\_\_\_\_\_
8. Total number of ICU beds/ High Dependency Unit (HDU) beds in the department:\_\_\_\_
9. Number of Units with beds in each unit: (Specialty applicable):

|  |  |  |  |
| --- | --- | --- | --- |
| **Unit** | **Number of Beds** | **Unit** | **Number of beds** |
| Unit-I |  | Unit-IV |  |
| Unit-II |  | Unit-V |  |
| Unit-III |  | Unit-VI |  |

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 Inspection/ Compliance Verification inspection/other)* | **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 of Recognition done/denied /other)* | **No of seats Increased** | **No of seats**  **Decreased** | **Order issued on the basis of inspection**  *(Attach copy of all the order issued 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 M2** |
| **Room 1** |  |
| **Room 2** |  |
|  |  |

Waiting area: \_\_\_\_\_\_ M2

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: \_\_\_\_\_\_\_\_\_\_

**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 Specifications in brief** |
| Burn Bathtub |  |  |  |
| Laser |  |  |  |
| Forehead & facelift Instruments |  |  |  |
| set of mastoplasty instruments |  |  |  |
| Breast Retractors |  |  |  |
| Dermatome |  |  |  |
| Silicone implants |  |  |  |
| Electric Saw and Drill |  |  |  |
| Faciomaxillary instrument set orthognathic set |  |  |  |
| Rhinoplasty instruments |  |  |  |
| Skin Graft Mesher |  |  |  |
| Operating microscope |  |  |  |
| Microsurgery instruments |  |  |  |
| Nerve stimulator |  |  |  |
| Hand held Doppler |  |  |  |
| Liposuction machine and fat grafting set |  |  |  |
| Other |  |  |  |

**C. SERVICES:**

**i. Intensive care Service provided by the Department: (Acute Burn care/ Burn ICU)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type** | **Number of total beds** | **List of Major Equipments and their Numbers** | **Bed occupancy on the day of inspection** | **Average bed occupancy for the last year** |
|  |  |  |  |  |
|  |  |  |  |  |

**ii. Speciality clinic run by department:**

|  |  |  |
| --- | --- | --- |
| **Services Provided by the Department** | **Yes/No** | **Weekly Workload/ Details** |
| hand surgery |  |  |
| Microvascular |  |  |
| Maxillofacial surgery |  |  |
| Liposuction |  |  |
| Breast angmentation Surgeries |  |  |
| Rhinoplasty |  |  |
| Laser Scar Removal |  |  |
| Cheek Surgeries |  |  |
| Lip Surgeries |  |  |
| Cranio facial surgeries |  |  |
| Burn Surgeries |  |  |
| Hand Surgeries |  |  |
| Other |  |  |

**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF PLASTIC & RECONSTRUCTIVE SURGERY:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **On the day of assessment** | **Previous day data** | **Year 1** | **Year 2** | **Year 3 (last year)** |
| 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 |  |  |  |  |  |
| Bed occupancy |  |  | X | X | X |
| Bed occupancy for the whole year above 75%. | X | X | Yes/No | Yes/No | Yes/No |
| Total Major surgeries in the department |  |  |  |  |  |
| Total Minor surgeries in the department |  |  |  |  |  |
| Histopathology Workload |  |  |  |  |  |
| X-rays per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| Ultrasonography per day (OPD + IPD). (write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| CT scan per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| MRI per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| Cytopathology Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| OPD Cytopathology Workload per day.(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| Haematology workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| OPD Haematology workload per day.(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| Biochemistry Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| OPD Biochemistry Workload per day.(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| Microbiology Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6) |  |  |  |  |  |
| OPD Microbiology Workload per day.(write average of all working days in column 4, 5 and 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. SURGERY WORKLOAD**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameters** | **On the day of Inspection** | **Previous day** | **Year 1** | **Year 2** | **Year3**  **(Last year)** |
| Breast Reconstruction | | | | | |
| Breast Reconstruction with breast implants |  |  |  |  |  |
| Breast reconstruction with Flap Surgery |  |  |  |  |  |
| Facial Reconstructive procedures | | | | | |
| Rhinoplasty |  |  |  |  |  |
| Lip surgery |  |  |  |  |  |
| Ear Surgery |  |  |  |  |  |
| Cheek surgery |  |  |  |  |  |
| Face lift |  |  |  |  |  |
|  | | | | | |
| Lipo Transfer |  |  |  |  |  |
| Post Burn reconstructive surgeries |  |  |  |  |  |
| Hand Surgery |  |  |  |  |  |
| Replantation Surgeries (Micro surgery) |  |  |  |  |  |
| Endoscopic Plastic Surgery |  |  |  |  |  |
| Flap transfer Micro vascular |  |  |  |  |  |
| Flap transfer Non Microvascular |  |  |  |  |  |
| Facio Maxillay and Reconstructive Orthognathic Surgery |  |  |  |  |  |
| Flap transfer |  |  |  |  |  |
| Skin grafting |  |  |  |  |  |
| Acute burn care |  |  |  |  |  |
| Trauma |  |  |  |  |  |
| Tendon transfer |  |  |  |  |  |
| Nerve Repair (Brachial plexus nerve repair) and peripheral nerve reconstruction ) |  |  |  |  |  |
| Hair transplant |  |  |  |  |  |
| Scar Revision Surgeries |  |  |  |  |  |
| Onco Reconstructive Surgeries |  |  |  |  |  |
| Hand Surgery |  |  |  |  |  |
| Facio Maxillay and Reconstructive Orthognathic Surgery |  |  |  |  |  |
| Dermato surgery |  |  |  |  |  |

**F. 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** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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\* - 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.

**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** |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  |  |  |  |  |

**G. ACADEMIC ACTIVITIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.**  **No.** | **Details** | **Number in the last**  **Year** | **Remarks**  **Adequate/ Inadequate** |
| 1. | Clinico- Pathological conference |  |  |
| 2. | Theory classes taken |  |  |
| 3. | Clinical Seminars |  |  |
| 4. | Journal Clubs |  |  |
| 5. | Case presentations |  |  |
| 6. | Group discussions |  |  |
| 7. | Guest lectures |  |  |
| 8. | Death Audit Meetings |  |  |
| 9. | Physician conference/ Continuing Medical Education (CME) organized. |  |  |
| 10. | Symposium |  |  |

*Note:* *For theory classes, 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:**

|  |
| --- |
|  |

**H. EXAMINATION:**

**i. Periodic Evaluation methods (FORMATIVE ASSESSMENT):**

(Details in the space below)

**ii. Detail of the Last Summative Examination:**

1. **List of External Examiners:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Designation** | **College/ Institute** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **List of Internal Examiners:**

|  |  |
| --- | --- |
| **Name** | **Designation** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. **List of Students:**

|  |  |
| --- | --- |
| **Name** | **Result**  **(Pass/ Fail)** |
|  |  |
|  |  |
|  |  |

**d. Details of the Examination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**I. 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**

**J. Please enumerate the deficiencies and write measures are being taken to rectify those deficiencies:**

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

**K. 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.* |