**STANDARD ASSESSMENT FORM- B**

(DEPARTMENTAL INFORMATION)

**ANAESTHESIOLOGY**

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| *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. Number of Units with beds in each unit:

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

i. 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*** |
|  |  |  |  |  |  |  |

j. 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. 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 |

**c. Seminar room**

Space and facility: Adequate/ Not Adequate

Internet facility: Available/Not Available

Audiovisual equipment details:

**d. 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** |
|  |  | |  |  |
|  |  | |  |  |
|  |  | |  |  |

**e. Departmental Research Lab:**

|  |  |
| --- | --- |
| Space |  |
| Equipment |  |
| Research Projects Done in past 3 years |  |
| list Research projects in progress in research lab |  |

**f. Departmental Museum:**

|  |  |
| --- | --- |
| Space |  |
| Total number of Specimens |  |
| Total number of Chart/ Diagrams |  |

**g. Equipment:**

|  |
| --- |
|  |
| **Equipment name** | | **Numbers available** | **Functional status** | **Important Specification in Brief** | **Adequate**  **Yes/No** |
| Operating Tables | |  |  |  |  |
| Anesthesia work station per operating table | |  |  |  |  |
| Multiparameter Monitors (8 parameters) per operating table | |  |  |  |  |
| Laryngoscope (Macintosh) | |  |  |  |  |
| Flexible Bronchoscope  (Size and length) | |  |  |  |  |
| Second generation Supraglottic Airway devices | |  |  |  |  |
| Video-laryngoscope | |  |  |  |  |
| Bougies/Stylets/Airway exchange catheters | |  |  |  |  |
| Resuscitation equipment/Crash cart | |  |  |  |  |
| Defibrillators | |  |  |  |  |
| Ultrasound machine with 3 probes (Linear, curvilinear, and phased array) | |  |  |  |  |
| Patient warming devices | |  |  |  |  |
| Any other equipment (Add rows) | |  |  |  |  |

**h. Intensive care facilities under Anaesthesia department**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of ICU** | **Number of beds** | **Bed occupancy** | | | |
| **Bed occupancy on the day of inspection** | **Average bed occupancy per day for the year 1** | **Average bed occupancy per day for the year 2** | **Average bed occupancy per day for the year 3 (last year)** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**i. Equipment in ICU (Required with each Intensive Care Unit Bed)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **Number** | **Available/Not Available** | **Functional Status** | **Remarks** |
| **ICU Beds:** Mechanically or electronically operated along with air mattress |  |  |  |  |
| **ICU Ventilators integrated with humidifier** |  |  |  |  |
| **Multiparameter (8 parameters) monitor:** ECG, NIBP, SpO2, IBP-1, IBP-2, ETCO2, Temp-1, Temp-2 |  |  |  |  |
| **No. of dedicated outlets**  **(**There should be two oxygen, one medical air and two vacuum outlets per bed) | **NA** |  |  |  |
| **Syringe infusion pumps** (should be at least 3 per ICU bed) |  |  |  |  |
| **Patient warming device** (At least 1 per 2 ICU beds) |  |  |  |  |

**j. Other Equipment required in the ICU Facility**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **Number** | **Available/Not Available** | **Functional Status** | **Remarks** |
| **Ultrasound machine color Doppler and echocardiogram facility** with 3 probes (curvilinear, linear, and phased array) |  |  |  |  |
| **Defibrillator** |  |  |  |  |
| **Patient warming device** (At least 1 per 2 ICU beds) |  |  |  |  |
| **⁠Airway/Crash cart** |  |  |  |  |
| **Oxygen cylinder (B-type)** with **pressure regulator** |  |  |  |  |
| **Patient transport trolley** with **3 parameters monitor** |  |  |  |  |
| **Arterial Blood Gas Analyzer** |  |  |  |  |
| **Flexible Bronchoscope** |  |  |  |  |
| Facility for bedside **Renal Replacement Therapy** |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Nurse patient ratio in ICU** (Min 1:2 required) | **Available Ratio=** |  |  |
| **Doctor patient ratio** (Min 1:6 required) | **Available Ratio=** |  |  |

**k. Equipments required with each High Dependency Unit (HDU)/Step down ICU Bed**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item** | **~~Number per ICU bed~~**  **Number** | **Available/Not Available** | **Functional Status** | **Remarks** |
| **ICU Beds:** Mechanically or electronically operated along with air mattress | **~~NA~~** |  |  |  |
| **ICU Ventilators integrated with humidifier** (1 for 3 HDU beds) |  |  |  |  |
| **Multiparameter (5 parameter) monitor:** ECG, NIBP, SpO2, IBP, Temperature |  |  |  |  |
| **No. of dedicated outlets** (oxygen = 2, medical air = 1, vacuum = 2)  There should be two oxygen, one medical air and two vacuum outlets per bed |  |  |  |  |
| (should be at least 1 per HDU bed) |  |  |  |  |

**l. Other Equipment required in the HDU/Step down ICU Facility**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Item** | **Number** | | | **Available/Not Available** | **Functional Status** | **Remarks** |
| **Defibrillator** |  | | |  |  |  |
| **Patient warming device**  should be at least 1 per 6 HDU beds |  | | |  |  |  |
| **⁠Airway/Crash cart** |  | | |  |  |  |
| **Oxygen cylinder (B-type)** with **pressure regulator** |  | | |  |  |  |
| **Nurse patient ratio in HDU/Step down ICU** (Min 1:3 required) | | **Available Ratio=** |
| **Doctor patient ratio in HDU/Step down ICU** (Min 1:8 required) | | **Available**  **Ratio =** |

**C. SERVICES:**

**i. Specialty clinics run by the department of Anaesthesia with number of patients in each:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Clinic** | **Weekday/s** | **Timings** | **Average number of cases/days** | **Name of Clinic In-charge** |
| 1. Pain clinic |  |  |  |  |
| 1. Pre-anesthetic clinic |  |  |  |

**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF ANAESTHESIOLOGY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Total numbers** | | | | |
| **Number on day of assessment** | **Previous day data** | **Year1** | **Year2** | **Year3 (last year)** |
| Preoperative Assessment (PAC) |  |  |  |  |  |
| Major surgeries |  |  |  |  |  |
| Minor surgeries performed under only local anaesthesia |  |  |  |  |  |
| Anaesthesia procedures/techniques   * General Anaesthesia (GA) * Central neuraxial blocks * Nerve blocks * GA + Regional Block * Monitored Anaesthesia Care under Sedation * Non-operating room anaesthesia (NORA) |  |  |  |  |  |
| Number of Deliveries in institute |  |  |  |  |  |
| Number of patients who received Labour analgesia |  |  |  |  |  |
| Number of Caesarean sections |  |  |  |  |  |
| Number of patients seen in Pain Clinic |  |  |  |  |  |
| Number of Interventional Pain Procedures |  |  |  |  |  |
| Number of Emergency surgeries |  |  |  |  |  |

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

**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:**

1. **List of External Examiners:**

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

**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**

1. **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**

**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.* |