STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

ANAESTHESIOLOGY

*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. 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*	**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/M*

	Verification inspection/other)					*CI) 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 M^2
Room 1	
Room 2	

Waiting area: _____ M^2

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		**Bed occupancy**

	Number of beds	**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, SpO_2, IBP-1, IBP-2, $ETCO_2$, 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**	**Available/Not Available**	**Functional Status**	**Remarks**
ICU Beds: Mechanically or electronically operated along with air mattress				
ICU Ventilators integrated with humidifier (1 for 3 HDU beds)				
Multiparameter (5 parameter) monitor: ECG, NIBP, SpO_2, 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				
2) 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

* - 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**

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.*