**STANDARD ASSESSMENT FORM- B**

(DEPARTMENTAL INFORMATION)

**GERIATRIC MEDICINE**

|  |
| --- |
| *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-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 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 based on 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: Available/Not Available

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 Lab:**

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

**h. Equipment:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of the Equipment** | **Must/Preferable** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** | **Adequate**  **Yes/No** |
| Multipara Monitors |  |  |  |  |  |
| Upper GI endoscope |  |  |  |  |  |
| lower GI endoscope(colonoscope) |  |  |  |  |  |
| Dialysis machines |  |  |  |  |  |
| Ultrasonography with color Doppler and curvilinear probe, Linear probe, and Phased array probe(cardiac) |  |  |  |  |  |
| Resuscitation kit |  |  |  |  |  |
| Pulse Oximeters |  |  |  |  |  |
| ECG |  |  |  |  |  |
| Holter |  |  |  |  |  |
| Crash cart |  |  |  |  |  |
| Computerized PFT equipment |  |  |  |  |  |
| Syringe pump |  |  |  |  |  |
| Bronchoscope |  |  |  |  |  |
| TMT |  |  |  |  |  |
| Defibrillator |  |  |  |  |  |
| Other routine use equipment |  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **i. Intensive care facilities under Geriatric Medicine:**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Type** | **Available/ not Available** | **Number of total beds** | **List of Major Equipment and their Numbers** | **Bed occupancy on the day of inspection** | **Average bed occupancy for the last year** | | Medical ICU - MICU |  |  |  |  |  | | Intensive Coronary Care Unit-ICCU |  |  |  |  |  | | Any other ICU (add rows) |  |  |  |  |  | |  |  |  |  |  |  |   **j. Dialysis:**  i. Number of Beds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ii. Number of hemodialysis machines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **On the day of assessment** | **Year 1** | **Year 2** | **Year 3**  **(last year)** | | Total hemodialysis |  |  |  |  | | Total peritoneal dialysis |  |  |  |  | |

**C. SERVICES:**

**i. Specialty clinics run by the Department of Geriatric Medicine with number of patients in each:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Clinic** | **Weekday/s** | **Timings** | **Number of cases (Avg)** | **Name of Clinic In-charge** |
| Cardiovascular |  |  |  |  |
| Nephrology |  |  |  |  |
| Endocrine |  |  |  |  |
| Haematology |  |  |  |  |
| Gastroenterology |  |  |  |  |
| Neurology |  |  |  |  |
| Memory Clinic |  |  |  |  |
| Any other clinic |  |  |  |  |

**ii. Services provided by the Department of Geriatric Medicine:**

|  |  |
| --- | --- |
| **Service / facility** | **Yes / No – Remarks if any** |
| 1. **Cardiology services (ICCU)**    * 1. ECG      2. TMT      3. Echo (with color Doppler)      4. Holter |  |
| 1. **Bronchoscopy** |  |
| 1. **Endoscopy & Colonoscopy** |  |
| 1. **Dialysis** |  |
| 1. **Physiotherapy Section.** |  |
| 1. **Investigative facilities**    * 1. Nerve conduction,      2. EMG etc. |  |
| 1. **Other special facilities** |  |

***(NOTE: These facilities are an integral part of* Geriatric Medicine *and should be available in the department even if independent Super Specialty departments exist in the institution)***

**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF GERIATRIC MEDICINE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Parameter** | **Numbers** | | | | |
| **On the day of assessment** | **Previous day data** | **Year 1** | **Year 2** | **Year 3 (last year)** |
| 1 | 2 | - | 3 | 4 | 5 |
| Total numbers of Out-Patients |  |  |  |  |  |
| Out-Patients attendance (write **Average daily Out-Patients attendance** in column 3,4,5) \* |  |  |  |  |  |
| Total numbers of new Out-Patients |  |  |  |  |  |
| New Out Patients attendance  (write average in column 3,4,5) \* 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 |
| Procedures performed (see table below) # |  |  |  |  |  |
| ECG per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| X-rays per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Ultrasonography per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| CT scan per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| MRI per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Cytopathology Workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Cytopathology Workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Haematology workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Haematology workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Biochemistry Workload per day (OPD + IPD). (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Biochemistry Workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| Microbiology Workload per day (OPD + IPD)... (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| OPD Microbiology Workload per day. (write average of all working days in column 3, 4 and 5) |  |  |  |  |  |
| 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

**#** Major procedures performed

|  |  |  |
| --- | --- | --- |
| **Procedures** | **On the day of Assessment** | **(Last Year)** |
| Central line placement |  |  |
| Upper GI endoscopy |  |  |
| Lower GI endoscopy |  |  |
| Non-invasive ventilations |  |  |
| Pleural tapping/chest tube insertion |  |  |
| Cardioversion/defibrillation |  |  |
| Endotracheal intubation with direct laryngoscopy |  |  |
| Endotracheal intubation with video laryngoscopy |  |  |
| Transcutaneous Pacing |  |  |
| Lumber puncture |  |  |
| Ascites tapping |  |  |
| Bone marrow aspiration biopsy |  |  |

**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.* |