**STANDARD ASSESSMENT FORM- B**

 (DEPARTMENTAL INFORMATION)

**IMMUNOHAEMATOLOGY & BLOOD TRANSFUSION**

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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. Total number of Laboratories Units: \_\_\_\_\_\_\_\_\_\_\_\_\_
8. Number of beds (including beds / couches for whole blood donation, Apheresis donation and therapeutic procedures) in the Department: \_\_\_\_\_\_\_\_\_\_\_\_
9. 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 |  |

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 by MCI/NMC** | **Number of Admissions per year** |
|  | Yes/No |  |
|  | Yes/No |  |

**B. INFRASTRUCTURE OF THE DEPARTMENT:**

**a. Blood donation area**

 No. of rooms: \_\_\_\_\_\_\_\_\_\_

i.Details of each room:

|  |  |  |  |
| --- | --- | --- | --- |
| **Particulars** | **Area in M2** | **Adequate/ Not Adequate** | **List of required equipment in brief** |
| Counsellors Room  |  |  |  |
| Medical Examination Room for Doctors  |  |  |  |
| Blood Donation Room  |  |  |  |
| Refreshment and Post- Donation Counselling Room  |  |  |  |

ii. Waiting area: \_\_\_\_\_\_ M2

iii. Space and arrangements: Adequate/ not adequate.

 If not adequate, give reasons/details/comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**b. Apheresis area**

i. No of rooms: \_\_\_\_\_\_\_\_\_\_

ii. Required Area in M2: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

iii. Equipment:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of the Equipment** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** |
| Apheresis Machine  |  |  |  |
| Donor Couch  |  |  |  |
| Emergency Tray  |  |  |  |

iv. Waiting area: \_\_\_\_\_\_ M2

v. Space and Arrangements: Adequate/ not adequate.

 If not adequate, give reasons/details/comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**c. Therapeutic area**

i. No of rooms: \_\_\_\_\_\_\_\_\_\_

ii. Area in M2

iii. Equipment

|  |  |  |  |
| --- | --- | --- | --- |
| **Equipment** | **Numbers Available** | **Functional Status** | **Important Specifications in brief** |
| PRP Centrifuge  |  |  |  |
| ROTEM Machine  |  |  |  |

iv. Waiting area: \_\_\_\_\_\_ M2

v. Space and arrangements: Adequate/ not adequate.

 If not adequate, give reasons/details/comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**d. Wards**

 No of wards: \_\_\_\_\_\_\_\_\_\_\_

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

**e. Laboratories**

 No of laboratories: \_\_\_\_\_\_\_\_\_\_\_

 **Area of each laboratory (add rows):**

|  |  |  |
| --- | --- | --- |
| **Name of Laboratory / Designation** | **Area in M2** | **List of important equipment in brief** |
| Cross-match Room  |  |  |
| Quality Control  |  |  |
| Advanced Immuno Heamatology Lab  |  |  |
| Point of Care Testing Lab  |  |  |
| TTD Room  |  |  |
| Coagulation Lab  |  |  |

**f. 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 |

**g. Seminar Room:**

Space and facility: Adequate/ Not Adequate

 Internet facility: Available/Not Available

 Audiovisual equipment details:

**h. List of department specific laboratories with important equipment:**

|  |  |  |
| --- | --- | --- |
| **Name of Laboratory** | **Size in square meter** | **List of important equipment available** |
| **Donor area** |  |  |
| Apheresis Area |  |  |
| TTI Lab. |  |  |
| Component Lab |  |  |
| Immuno-haematology Lab |  |  |
| Quality Control Lab |  |  |
| Cross-match Lab |  |  |
| Other |  |  |

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

**j. Departmental Research Lab:**

|  |  |
| --- | --- |
| Space |  |
| Equipment |  |
| Research Projects completed in past 3 years |  |
| List the Research projects in progress in research lab |  |

**k. Equipment:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of the Equipment** | **Must/ Preferable** | **Numbers Available** | **Functional Status**  | **Important Specifications in brief** | **Adequate****Yes/No** |
|  |  |  |  |  |  |
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**C. SERVICES:**

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Clinic** | **Weekday/s** | **Timings** | **Number of cases (Avg)** | **Name of Clinic In-charge** |
|  |  |  |  |  |
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**ii. Services provided by the department of IHBT:**

|  |  |
| --- | --- |
| **Service / Facility** | **Yes / No – Remarks if any** |
| Donor Apheresis |  |
| Therapeutic Apheresis |  |
| Therapeutic Phlebotomy |  |
| Autologous donation |  |
| Stem Cell Apheresis |  |
| Point of Care Coagulation Test  |  |
| Autologous PRP |  |
| Resolution of Complex Immuno-haematological Problems  |  |
| Support in all transplant surgeries pre and post op and intra op  |  |
| Transplant immunology lab  |  |
| Others |  |

**iii. Any Intensive care service provided by the department of IHBT:**

(List in the space provided below)

**D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF IMMUNOHEAMATOLOGY & BLOOD TRANSFUSION**

|  |  |
| --- | --- |
| **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 Whole blood donation |  |  |  |  |  |
| Whole Blood Donation(write **Average daily whole blood donation** in column 3,4,5)\* |  |  |  |  |  |
| Total numbers of Apheresis donations |  |  |  |  |  |
| Apheresis donation(write average in column 3,4,5)\* for Average daily Apheresis donation |  |  |  |  |  |
| Total Donations (Whole blood and Apheresis)for Year |  |  |  |  |  |
| Total donor reactions(Write average of donor reactions of all 365 days in column 3,4,5) for **Percentage of donor reactions** |  |  |  |  |  |
| Therapeutic Phlebotomy per day (write average of all working days in column 3, 4 and 5). |  |  |  |  |  |
| Therapeutic Apheresis per day (write average of all working days in column 3, 4 and 5). |  |  |  |  |  |
| Autologous Donation per day (write average of all working days in column 3, 4 and 5). |  |  |  |  |  |
| Stem Cell Collection (write average of all working days in column 3, 4 and 5). |  |  |  |  |  |
| Total Blood Units Consumed including Components  |  |  |  |  |  |

\***Average daily Whole Blood Donation** is calculated as below.

Total whole blood donations collected by the department in the year divided by total working days of the department in a year.

**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 |  |  |
| AssistantProfessor |  |  |
| 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. | 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.* |