STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

IMMUNOHAEMATOLOGY & BLOOD TRANSFUSION

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. Total number of Laboratories Units: _____________

h. Number of beds (including beds / couches for whole blood donation, Apheresis donation and therapeutic procedures) in the Department: ____________

i. 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*	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*	No of seats Increased	No of seats Decreased	Order issued on the basis of inspection *(Attach copy of all the order issued by*

	Recognition/Surprise /Random Inspection/ Compliance Verification inspection/other)		*of Recognition done/denied /other)*			*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 M^2**	**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: ______ M^2

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 M^2: ________________

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iii. Equipment:

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

iv. Waiting area: ______ M^2

v. Space and Arrangements: Adequate/ not adequate.
If not adequate, give reasons/details/comments: ________________________

c. Therapeutic area

i. No of rooms: __________

ii. Area in M^2

iii. Equipment

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

iv. Waiting area: ______ M^2

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 M^2	List of important equipment in brief

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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		

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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

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

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 assessm ent	**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).					

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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.

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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

Signature of Dean

Signature of Assessor

* - 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.	Audit Meetings		
8.	Physician conference/ Continuing		

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	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

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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:

Signature of Dean   Signature of Assessor

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**

Signature of Dean Signature of Assessor

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.*

Signature of Dean   Signature of Assessor