**STANDARD ASSESSMENT FORM- B**

 (DEPARTMENTAL INFORMATION)

**PAEDIATRICS**

|  |
| --- |
| *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:

|  |  |  |  |
| --- | --- | --- | --- |
|  **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. 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 metre) |  |
| Ventilation | Adequate/Not Adequate |
| Infrastructure and facilities |  |
| Dressing /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 completed in past 3 years |  |
| List the Research projects in progress in research lab |  |

**h. Equipment:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of the Equipment** | **Must/ Desirable** | **Number Available** | **Functional Status** | **Important specification in Brief** | **Adequate****(Yes/No)** |
| ABG Equipment |  |  |  |  |  |
| Phototherapy Units (CFL & LED) |  |  |  |  |  |
| Parenteral nutrition Equipment |  |  |  |  |  |
| Neonatal ventilator with high frequency ventilation |  |  |  |  |  |
| Neonatal ventilator without high frequency ventilation |  |  |  |  |  |
| Inhaled NO machine |  |  |  |  |  |
| Therapeutic hypothermia machine |  |  |  |  |  |
| EEG machine |  |  |  |  |  |
| Oxygen blenders |  |  |  |  |  |
| T piece resuscitator |  |  |  |  |  |
| OAE/BERA machine |  |  |  |  |  |
| Laminar Flow in ICU |  |  |  |  |  |
| CPAP machine |  |  |  |  |  |
| Multipara Monitors |  |  |  |  |  |
| Echo – color Doppler |  |  |  |  |  |
| Resuscitation kit |  |  |  |  |  |
| Radiant warmer |  |  |  |  |  |
| Pulse Oximeters |  |  |  |  |  |
| ECG machine |  |  |  |  |  |
| Crash cart trollies |  |  |  |  |  |
| Computerized PFT equipment |  |  |  |  |  |
| Syringe pump |  |  |  |  |  |
| USG |  |  |  |  |  |
| Defibrillator |  |  |  |  |  |
| Transport Incubator |  |  |  |  |  |
| Computerized weighing scale |  |  |  |  |  |
| HHHFNC |  |  |  |  |  |
| Any other equipment |  |  |  |  |  |

**C. SERVICES:**

**i. Intensive care facilities:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type** | **Available/ Not Available** | **Number of total beds** | **Major Equipment with specifications** | **Bed occupancy on the day of inspection** | **Average bed occupancy for the last year** |
| Neonatal ICU- NICU  |  |  |  |  |  |
| Paediatrics ICU- PICU  |  |  |  |  |  |
| **Any other ICU** |  |  |  |  |  |

**ii. Specialty clinics run by the department of Paediatrics with number of patients in each:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of the Clinic** | **Weekday/s** | **Timings** | **Number of cases (average)** | **Name of Clinic In-charge** |
| Paediatric Cardiology |  |  |  |  |
| Paediatric Nephrology |  |  |  |  |
| Paediatric Endocrine |  |  |  |  |
| Paediatric Haematology |  |  |  |  |
| Diarrhea (Gastro)  |  |  |  |  |
| Paediatric Neurology |  |  |  |  |
| Neonatology* 1. High risk
	2. Well baby
 |  |  |  |  |
| Immunization |  |  |  |  |
| Paediatric Asthma  |  |  |  |  |
| Thalassemia |  |  |  |  |
| Paediatric Rheumatology |  |  |  |  |
| Infectious Disease |  |  |  |  |
| Development and Early Intervention Clinic (DEIC) |  |  |  |  |
| Nutritional Rehabilitation Clinic (NRC) |  |  |  |  |
| Any other clinic |  |  |  |  |

**iii. Services provided by the Department of Paediatrics:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service / facility** | **Available/not available**  | **Adequate/not Adequate.**  | **If not adequate, mention specific deficiencies/reasons** |
| **Neonatal services:** |  |  |  |
|  NICU |  |  |  |
|  Neonatal ventilation |  |  |  |
|  Exchange transfusion |  |  |  |
|  Phototherapy |  |  |  |
| Parenteral nutrition |  |  |  |
| **Endoscopy**  |  |  |  |
| **Dialysis** |  |  |  |
|  Haemodialysis |  |  |  |
|  Peritoneal Dialysis |  |  |  |
|  CRRT |  |  |  |
| Central and Arterial Lines |  |  |  |
| **Paediatric Ventilation** |  |  |  |
| **Thalassemia day care center** |  |  |  |
| **Physiotherapy section** |  |  |  |
| **Child counselling services** |  |  |  |
| **ART Centre** |  |  |  |
| **Delivery room services** |  |  |  |
| **Investigative facilities** |  |  |  |
| Bronchoscopy |  |  |  |
| PFT |  |  |  |
| ABG |  |  |  |
| **Any other** |  |  |  |

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

|  |  |
| --- | --- |
| **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)  |  |  |  |  |  |
| **Deliveries including LSCS per week****(average of all weeks of the year)** |  |  |  |  |  |
| 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 yea

 *\*\** The details of deaths sent by hospital to the Registrar of Births/Deaths

**# Procedures performed**

|  |  |  |  |
| --- | --- | --- | --- |
| **Procedures** | **On the Day of Assessment** | **Data of Previous Month** |  **(Last Year)** |
|  |  |  |  |
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**E. STAFF**:

**i. Unit-wise faculty and Senior Residents 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. | 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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **List of Internal Examiners:**

|  |  |
| --- | --- |
| **Name** | **Designation** |
|  |  |
|  |  |
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|  |  |
|  |  |

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.* |