STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

RESPIRATORY 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:

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. Total number of ICU beds/ High Dependency Unit (HDU) beds 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 Recognition/Surprise*	**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 based on inspection** *(Attach copy of all the order issued by NMC/ MCI*

Signature of Dean Signature of Assessor

	/Random Inspection/ Compliance Verification inspection/other)		*of Recognition done/ denied /other)*			*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 M^2
Room 1	
Room 2	

Waiting area: ______ M^2

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	
Isolation ward details	
MDR ward details	
Negative pressure facility	Available/not available
Counselling room	Available/not available
Dressing and procedure room	

Signature of Dean Signature of Assessor

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/ procedure room with important Equipment:

Name of Laboratory/ procedure room	Size in square meter	List of important equipment available with total numbers

f. Library facility pertaining to the Department/Speciality (Combined Departmental and Central Library data):

Particulars	Details

Signature of Dean   Signature of Assessor

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. Departmental Museum:

Space	
Total number of Specimens	
Total number of Chart/ Diagrams	

i. Intensive care facilities if any with department of Respiratory Medicine:

Type	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

Signature of Dean Signature of Assessor

Respiratory Intensive Care Unit (RICU):				
Any other ICU (add rows)				

j. Equipment:

Name of the Equipment	Must/ Prefe rable	Number s Availab le	Functi onal Status	Important Specifications in brief	Adequate (Yes/No)
Multipara Monitors					
Pulse Oximeters					
ECG					
Resuscitation kit					
MDR treatment facilities					
Nebulizers					
Ventilators / non invasive ventilation					
Computerized PFT equipment/ / PEFR					
Crash cart					
DLCO					
Syringe pump					
Fibreoptic Bronchoscope					
Other routine use equipment					
Defibrillator					
USG					
Any other equipment					

Signature of Dean Signature of Assessor

C. SERVICES:

a. Specialty clinics run by the department of Respiratory Medicine with number of patients in each:

Name of the Clinic	Weekday/s	Timings	Number of cases (Avg)	Name of Clinic In-charge
Pulmonary Rehabilitation				
Asthma / COPD				
Bronchoscopy / interventional				

b. Services provided by the department:

i. Bronchoscopy
ii. Thoracoscopy
iii. Thoracocentesis
iv. Intercostal Drainage
v. Physiotherapy Section. / Pulmonary Rehabilitation
vi. PFT test and DLCO.
vii. Blood Gas Analysis
viii. Other intervention procedures if any –
ix. RICU Services
x. Aerosol Therapy
xi. Treatment for MDR Tuberculosis
xii. FNAC from Pleura and Lung
xiii. Any other

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

Parameter	Numbers				
	On the day of assessment	Previous day data	Year 1	Year 2	Year 3 (last year)
1	2	-	3	4	5

Signature of Dean Signature of Assessor

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.

\# **List of procedures**

Procedures	**On the day of Assessment**	**(Last Year)**

Signature of Dean

Signature of Assessor

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

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		

Signature of Dean   Signature of Assessor

7.	Death Audit Meetings		
8.	Chest radiology		
9.	Physician conference/ Continuing Medical Education (CME) organized.		
10.	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

Signature of Dean   Signature of Assessor

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