

STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION) NEURO-SURGERY

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: (Specialty applicable):

Unit	Number of Beds	Unit	Number of beds
Unit-I		Unit-IV	
Unit-II		Unit-V	
Unit-III		Unit-VI	

j. Details of PG inspections of the department in last five years:

Date of Inspection	Purpose of Inspection <i>(LoP for starting a course/permission for increase of seats/ Recognition of course/ Recognition of increased seats /Renewal of Recognition/Surprise /Random Inspection/ Compliance</i>	Type of Inspection (Physical/ Virtual)	Outcome <i>(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)</i>	No of seats Increased	No of seats Decreased	Order issued on the basis of inspection <i>(Attach copy of all the order issued by NMC/M</i>

Signature of Dean

Signature of Assessor

	<i>Verification inspection/other)</i>					<i>CI) as Annexure</i>

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 M ²
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

Signature of Dean

Signature of Assessor

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:

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

Signature of Dean

Signature of Assessor

g. Departmental Research:

Research Projects Done in past 3 years.	
List of Research projects in progress.	

h. Equipment:

Name of the Equipment	Available/ Not available	Functional Status	Important specification in brief
Operation instruments for Spinal Surgery			
Operating Microscope			
Cranial Endoscopy Set			
Skull Base Endoscopy Set			
Brain Surgery			
Micro Instruments			
Gamma Knife			
Ultrasonic Aspirator			
Spinal Endoscopy Set			
Electric drill			
Stereotactic System			
Spinal Retractor System			
Nerve Monitoring System			
Diathermy unit			
C-arm			
Neuro Radiology equipments			
Ultrasonography machine for Carotid Doppler			
Others			

C. SERVICES:

i. Intensive care service provided by the department:

Type	Number of total beds	List of Major Equipments and their Numbers	Bed occupancy on the day of inspection	Average bed occupancy for the last year

Signature of Dean

Signature of Assessor

ii. Specialty clinics being run by the department and number of patients in each clinic:

S.No.	Name of the Clinic	Days on which held	Timings	Average No. of cases attended	Name of Clinic In-charge
1	Functional Neuro Surgery				
2	Pediatric Neuro Surgery				
3	Spine Clinic				
4	Vascular Neuro Surgery				
5	Skull Base Surgery				
6.	Trauma/Miscellaneous				
7.	Epilepsy Neuro Surgery				
8.	Peripheral Nerve Clinic				
9.	Others				

iii. Services provided by the Department:

S.No.	Electrophysiology Labs	Yes/No	Weekly Workload/ Details
(a)	(i) EEG		
	(ii) VEEG		
	(iii)PSG		
	(iv)NCV		
	(v)Evoked potentials		
	(vi) Needle EMG		
	(vii)Others		
(b)	Plasmapheresis		
(c)	Interventional Neuro Surgery		
(d)	Rehabilitation		
(e)	Counseling		
(f)	Others		

D. CLINICAL MATERIAL AND INVESTIGATIVE WORKLOAD OF THE DEPARTMENT OF NEURO-SURGERY:

Parameter	On the day of assessment	Previous day data	Year 1	Year 2	Year 3 (last year)
1	2	3	4	5	6
Total numbers of Out-Patients					
Out-Patients attendance (write Average daily Out-Patients attendance in column 4,5,6) *					
Total numbers of new Out-Patients					
New Out Patients attendance					

Signature of Dean

Signature of Assessor

(write average in column 4,5,6) * 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
Total Major surgeries in the department					
Total Minor surgeries in the department					
Histopathology Workload					
Total number of V.P. Shunt					
Total number of Lumbar puncture					
Total number of External Ventricular drainage					
Total number of EEG					
Total carotid Doppler studies					
Total DSA					
X-rays per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
Ultrasonography per day (OPD + IPD). (write average of all working days in column 4, 5 and 6)					
CT scan per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
MRI per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
Cytopathology Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
OPD Cytopathology Workload per day.(write average of all working days in column 4, 5 and 6)					
Haematology workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
OPD Haematology workload per day.(write average of all working days in column 4, 5 and 6)					
Biochemistry Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
OPD Biochemistry Workload per day.(write average of all working days in column 4, 5 and 6)					

Signature of Dean

Signature of Assessor

Microbiology Workload per day (OPD + IPD).(write average of all working days in column 4, 5 and 6)					
OPD Microbiology Workload per day.(write average of all working days in column 4, 5 and 6)					
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.

E. MAJOR SURGERY WORKLOAD:

Name of the Major Surgery	On the day of Assessment	Previous day data	Year 1	Year 2	Year 3 (last Year)
Decompressive Craniotomy					
Burr hole and Hematoma Evacuation					
Craniotomy and Hematoma Evacuation					
Spinal Instrumentation- Cervical and Lumbar					
Transnasal Surgery					
Craniotomy and Tumor Decompression					
Posterior Fossa Tumors					
Minimal Invasive Spine Surgery					
Cerebro- Vascular Neurosurgery					

Signature of Dean

Signature of Assessor

F. 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

* - 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

G. ACADEMIC ACTIVITIES:

S. No.	Details	Number in the last Year	Remarks Adequate/ Inadequate
1.	Clinico- Pathological conference		
2.	Theory classes taken		
3.	Clinical Seminars		
4.	Journal Clubs		
5.	Case presentations		

Signature of Dean

Signature of Assessor

6.	Group discussions		
7.	Guest lectures		
8.	Death Audit Meetings		
9.	Physician conference/ Continuing Medical Education (CME) organized.		
10.	Symposium		

Note: For theory classes, 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:

--

H. 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).

I. 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****J. Please enumerate the deficiencies and write measures are being taken to rectify those deficiencies:****Date:****Signature of Dean with Seal****Signature of HoD with Seal**

Signature of Dean

Signature of Assessor

K.**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/come 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