

STANDARD ASSESSMENT FORM- B

(DEPARTMENTAL INFORMATION)

TRAUMATOLOGY AND 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</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</i>	No of seats Increase	No of seats Decreased	Order issued on the basis of inspection <i>(Attach copy of all the</i>

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	<i>Recognition/Surprise /Random Inspection/ Compliance Verification inspection/other)</i>		<i>increased seats done/denied /Renewal of Recognition done/denied /other)</i>			<i>order issued by NMC/MCI) 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

Signature of Dean

Signature of Assessor

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:

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

Signature of Dean

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Central Library Timing: _____

Central Reading Room Timing: _____

Journal details

Name of Journal	Indian/foreign	Online/offline	Available up to

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 Specifications in brief
Upper GI Endoscope set			
Lower GI Endoscope set			
Laparoscopy equipment set (write total no of functioning sets available with the Department).			
Ultrasonic Dissector/ Coagulator			
Vessel Sealing Equipment.			
Ultrasonography machine with Doppler facility linear, convex and cardiac probe and puncture guide			
Laparoscopy Trainers			
Any other equipments			

C. SERVICES:**i. Services provided by the Department of Traumatology and Surgery:**

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Service / facility	Yes / No – Remarks if any
a)	
b)	
c)	

ii. ICU

Type	Available/ not Available	Number of total beds	Major Equipment list	Bed occupancy on the day of inspection	Average daily bed occupancy for the last year
Surgical ICU (under care of Traumatology and Surgery)					

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

Parameter	Numbers				
	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 (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

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Total Major surgeries in the department					
Total Minor surgeries in the department					
Histopathology Workload per day (average of all working days)					
X-rays per day (OPD + IPD). (write average of all working days in column 4,5,6)					
Ultrasonography per day (OPD + IPD). (write average of all working days in column 4,5,6)					
CT scan per day (OPD + IPD). (write average of all working days in column 4,5,6)					
MRI per day (OPD + IPD). (write average of all working days in column 4,5,6)					
Cytopathology Workload per day (OPD + IPD). (write average of all working days in column 4,5,6)					
OPD Cytopathology Workload per day. (write average of all working days in column 4,5,6)					
Haematology workload per day (OPD + IPD). (write average of all working days in column 4,5,6)					
OPD Haematology workload per day. (write average of all working days in column 4,5,6)					
Biochemistry Workload per day (OPD + IPD). (write average of all working days in column 4,5,6)					
OPD Biochemistry Workload per day. (write average of all working days in column 4,5,6)					
Microbiology Workload per day (OPD + IPD). (write average of all working days in column 4,5,6)					
OPD Microbiology Workload per day. (write average of all working days in column 4,5,6)					
Total Deaths. **					
Total Blood Units Consumed including Components.					

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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		

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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:

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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