IAP NEONATOLOGY CHAPTER NEONATOLOGY FELLOWSHIP PROGRAM

Inspection Report for Accreditation and Re- Accreditation (For internal circulation only)

Purpose of Inspection :New Center / Re inspection / Inspection for increase in seats

Date of Inspection –

Place of Inspection -

No of the Evaluators :

1. **Name –**

   Phone no –

   E mail -

   Address -

   Signature –

2. **Name –**

   Phone no –

   E mail –

   Address –

   Signatures

I)General Information

1	**Name of the institute**	
2	**Address**	
3	**Phone and Fax**	
4	**E mail**	
5.	**Registration no of Hospital**	
6	**Year in which Hospital Established**	
7	**Year in which Level III NICU Established**	
8.	**Is Hospital/Institute recognized by MCI**	
9.	**Is Hospital recognized by National Board for DNB**	
9	**Is Hospital recognized for any other fellowship program, if yes please mention all** **Name of fellowship :** **No: of seats**	

II)Faculty Details: -

	Faculty 1	Verified by (evaluator)
Name		
Qualification **DM (Neonatology)** **MD (Ped)**		
Year of Passing		
University/ College		
Date of Joining in Present Institute		
Experience Post Qualification		
Papers Published in Indexed Journals		
IAP Membership No **Neonatology Chapter Membership No**		

	Faculty 2	Verified by (evaluator)
Name		
Qualification **DM (Neonatology)** **MD (Ped)**		
Year of Passing		
University/ College		
Date of Joining in Present Institute		
Experience Post Qualification		
Papers Published in Indexed Journals		
IAP Membership No **Neonatology Chapter Membership No**		

	Faculty 3	Verified by (evaluator)
Name		
Qualification **DM (Neonatology)** **MD (Ped)**		
Year of Passing		
University/ College		
Date of Joining in Present Institute		
Experience Post Qualification		
Papers Published in Indexed Journals		
IAP Membership No **Neonatology Chapter Membership No**		

	Faculty 4	Verified by (evaluator)
Name		
Qualification **DM (Neonatology)** **MD (Ped)**		
Year of Passing		
University/ College		
Date of Joining in Present Institute		
Experience Post Qualification		
Papers Published in Indexed Journals		
IAP Membership No **Neonatology Chapter Membership No**		

Total No of Faculties (Full time only) –

All Faculties IAP and Neonatology Chapter Members – Yes /No

Senior Residents – Total No -

Details

S. No	Name	Qualification	Working Since	Verified by
1.				
2.				
3.				
4.				

Junior Residents (Minimum MBBS qualification) – Total No –

Details -

S. No	Name	Qualification	Working Since	Verified by
1.				
2.				
3.				
4.				

Any other Pediatric Subspecialty- Yes/No (If yes , mention details in the table below)

S. No	Name	Qualification	Working Since
1.			
2.			
3.			
4.			

III)Nursing Staff/Paramedical Staff

			Verified by
1	**Name of NICU Sister In Charge**		
2	**Total No of staff nurses in the unit**		
3	**No of staff nurses per shift**		
4	**Nurse : patient ratio**		
5	**Helpers per shift**		
6	**Sweepers per shift**		

IV)Academics

		Yes/No	Capacity/No	Verified by
1	**Conference room**			
2	**Library**			
3	**Journals (Mention names)**			
4	**Conferences/ CME organized**			
5	**Any other teaching facilities**			
6	**Others**			

V)Infrastructure

1. **Neonatology Area**

	Area (in Sq feet)	No of Beds	Level of Cleanliness and asepsis (good/average/poor)	Verified by
Level III				
Level II				
Level I				
Total Patient area (Level III+II+I)				
Feeding Area				
Hand Washing Basins				
Counselling area				
Care by Parents Rooms				
Postnatal Ward				
Any other				

2. **Labor room resuscitation area –**

Equipment	Yes/No	Working	Verified by
Warmer			
Resuscitation equipment- Ambu Bag/T piece, Laryngoscope, ET etc)			
Pulse oximeter			
Blender			

3. NICU Equipment

i) Beds

S. No	No.	Imported/ Indian	Brand Name	Working	Verified by
Open Care / Warmer					
Incubators					
Cots					
Total					

ii)Ventilatos/CPAP

- **Centralized Oxygen – Yes/No**
- **Centralized Compressed air – Yes /No**
- **Centralized Suction – Yes/No**

	No.	Imported / Indian	Brand Name	Graphics	Working	Verified by
HFO						
Ventilators - Conventional						
CPAP						
HHHFNC						
Total						

iii) Monitoring Devices

S. No	No.	Imported/ Indian	Brand Name	Working	Verified by
Multipara Monitos (ECG+Pulse Ox + NIBP+IBP+Temp)					
Multipara Monitos (ECG+Pulse Ox + NIBP+IBP)					
Multipara Monitos (ECG+Pulse Ox + NIBP)					
NIBP alone					
Pulse Oximeter alone					
Any Other					
Total					

iv) Infusion Pumps

	No.	Imported/ Indian	Brand Name	Working	Verified by
Syringe Pumps					
Drip Pumps					
Total					

v) Phototherapy Equipment

S. No	No.	Imported/ Indian	Brand Name	Working	Verified by
Conventional					
CFL					
LED					
Bili Blanket					
Total					

vi) Neonatal Transport Equipment

Equipment	Yes	No
Transport ambulance		
Transport Incubator		
Transport Ventilator		

vii) Brain Cooling device – Yes/ No

S. No	No.	Imported/ Indian	Brand Name	Working	Verified by
Cooling device					

viii) Laboratory / Investigation Support

S. No	No.	Yes/No	Working	Verified by
Basic Lab work up				
Hemoglucometer				
Blood Culture Facility				
CSF examination facility				
ABG facility				
Portable X rays				
Portable USG				
Portable ECHO				

(Till here Can be filled by Center)

VI)Patient workload

i) Obstetrics workload (Last 5 years data)

	Year 2017	Year 2016	Year 2015	Year 2014	Year 2013	Verified by
No of Deliveries						
LSCS						
Normal Deliveries						
Total						

i) NICU/ Nursery Admissions(Last 5 years data)

	Year 2017	Year 2016	Year 2015	Year 2014	Year 2013	Verified by
NICU Admissions						
Nursery/Level I/ Level II admissions						
Total						
Inborn						
Outborn						
Total						

ii) Ventilation/CPAP data (Last 5 year data)

	Year 2017	Year 2016	Year 2015	Year 2014	Year 2013	Verified by
Ventilation						
CPAP						
HHHFNC						
Total						

VII)Facilities –

Procedure	Yes	No	Verified by
Lumbar Puncture			
Umbilical Lines			
Central Lines (PICC)			
Endotracheal Intubation			
Intercostal Dainage			
Peritoneal Dialysis			
Kangaroo Mother Care			
Breast Feeding Training			

VII)Subspecialty/ Other related specialty Support Facilities

	Yes/No	Name of Consultant and Qualification	Full Time/Visiting	Verified by
ROP Screening				
ROP Treatment				
Auditory evaluation BERA/OEA				
Pediatric Surgery				
Pediatric Cardiology				
Physiotherapy/Occupational Therapy				

High Risk Follow up				
Pediatric Cardiology				
Breast Feeding Training				

IX) Neonatal Unit Policies

Policy	**Yes/No**	**Verified by**
Asepsis Protocol		
Antibiotic Policy		
Treatment Protocols		

Proposed Fellowship CoordinatorDetails

Name –

Phoneno –

Email –

1.
2.

PostalAddress

Hospital –

Residence -

Evaluator's Overall Impression based on the above form and Comments (If any)

1.

Signature

2.

Signature

Fellowship Center / Coordinator Undertaking

I/we …….. / …….

On behalf of our hospital/institute, I/we undertake the following…..

1. I/we have provided correct details to the "Office of the IAP Neonatology Chapter" and the evaluators for the purpose of accreditation for Neonatology Fellowship Program.
2. If any of the faculty leave institute/hospital for any reasons or if there is any major infrastructure or location change of the said center, I will inform the office of IAP Neonatology Chapter for the same. The chapter has full authorization to reinspect/derecognize my/our center.
3. If there is any change of faculties/location or major infrastructural change of center/ unit, new fellowship candidates shall not be admitted until the chapter officially allow the concerned unit/center to do so.
4. I/we will abide by the rules and regulation of the Fellowship program as decided by the Neonatology Chapter and Central IAP. Any change of rules or regulation in the program shall be applicable to our unit as decided by Neonatology Chapter/IAP central body from time to time.
5. The admission of the fellowship candidates for the fellowship program shall be done in accordance with the guidelines laid by the IAP Neonatology Chapter. Any deviation from the rules shall lead to cancellation of admission process.
6. I/ we understand, that Neonatology Fellowship Program and Fellowship position is a FULL TIME POSITION. The candidates admitted in the program has to work full time in the concerned unit/hospital/Institute. Part time/visiting or working at any other place except the enrolled center will be considered as the violation of fellowship program rules and in this situation center may get derecognized for the present as well as future fellowship admissions.
7. If any of fellowship candidate leave the program or shift to some other center or program, I/we will inform the Office of Neonatology Chapter immediately.

Fellowship Program Coordinator	**Hospital Director / Med Supdt**
Name	**Name**
Signature	**Signature**
Place	**Place**
Date	**Date**

CONFIDENTIAL ***(To be filled by Office bearer only)***

IAP Neonatology Chapter Office and Fellowship Committee Meeting Decision Regarding Accreditation of Neonatology Fellowship Program

(Please keep in record)

Institute/ Hospital –

Name -

Address -

Fellowship Coordinator –

Name –

E mail -

Phone No –

Address –

Evaluators Recommendations – (Detail Report Attched)

1. **Name -**

   Recommended **Yes /No**

2. **Name -**

   Recommended **Yes/No**

Neonatology Chapter Office and Fellowship Committee Opinion–

Approved – Yes / No

Approved from Date -

No of Seats -

Comments if any-

Nameand Signatures

Chairperson -

Secretary -

Treasurer -

Date –

Place -