**Application form for Accreditation of ‘Level III teaching’ &**

**And ‘Reaccreditation of teaching’ Units**

* **Application for**

 *(Please* ***Note: Choose and keep either Yes / No, by carefully strikethrough inappropriate response below e.g. ~~No~~.)***

|  |  |
| --- | --- |
|  Accreditation : Yes / No  | Re- accreditation: Yes / No  |
|  For One Year (Diploma) : Yes / No For Both Diploma & Fellowship : Yes / No  | For Two Year (Fellowship) : Yes / No   |

* **(I) General Information**

|  |  |  |
| --- | --- | --- |
| 1  | Name of the institute   |  |
| 2  | Address   |  for Correspondence  |  |
| 3  | a. b. c.  | Telephones (land lines, mobile) fax, e mail of the PICU In Charge:  | a. …. b.. c…  |
| 4  | a. b. c.  | Year in which hospital established: Year in which Department of Pediatrics established: Year in which PICU established:  | a... b.. c…  |
| 5  | Status of Hospital: such as private / govt : state, central / voluntary organization / any other (write one in the next column)   |    |
| 6  | Is the hospital recognized by MCI or State Medical Council? For general pediatrics For Pediatric Critical Care   |   |
| 8  | Is the hospital recognized by National Boards for Gen. Pediatrics? |   |
| 9  | Is the hospital recognized by National Boards for any other Specialty or super-specialty? If yes, enumerate:  | a. b. c. d.  |
| 9  | Is the hospital recognized by National Boards for adult Critical Care Fellowship programme?  |   |
| 10  | Is the hospital recognized by National Boards for Neonatology Fellowship?  |   |
| 11  | Is the unit recognized by National Board for Pediatric Critical Care Fellowship?  |   |
| 12  | Is the unit recognized by any other body for Pediatric Critical Care Fellowship?  |   |

* 1. **Medical Personnel (Hospital / Pediatrics / PICU )**

|  |  |
| --- | --- |
| A  | Name of Present Director/ Medical Superintendent of Institution   |
| B  | Name of Head / In-charge of Department of Pediatrics   |
| C  | No. of Consultants in Pediatric ICU: Full Time (spends at least 6 hours in PICU): Part Time: Please provide proof of this information as an Annexure **(Annexure II C** will be a letter from the Hospital management certifying the date of joining and duration of association of the Consultant Pediatric Intensivists mentioned in this space, with their designation, stating whether full time or part time)  |
| D  | Information about Head / Director/ In-charge of PICU: Name: Dr. ………………….. 1. Qualifications
2. Postgraduate experience in Pediatrics
3. Duration of directorship of PICU
4. Details of PIC training **(Annexure II D4 )**
5. Years spent in PIC (at least 4 years)
6. Percentage of daily time spent in PICU –

a) Administrative: b) Patient care in PICU: c) Neonatology  d) Gen Pediatrics : IP OPD : Please provide proof of this information as an Annexure (**Annexure II D** will be a letter from the Hospital management certifying the duration of association of the Head / Director/ In-charge of PICU with the hospital and his/her designation. Also whether full time or part time)  |
| E  | Number of other trained intensivists in the unit:  |
| F  | CV of other trained intensivists **(Annexure II F)** All the information about each intensivist (similar to the above row, namely D)   |
| G  | Details of Consultant call schedule (including Director) – --Fulltime in-house,  -- Daytime in-house,  --On call only (Full time),  --On call only (night)  |
| H  | No. of Residents in the Department of Pediatrics **(Annexure II H**: mention names and qualifications **)** a) Allopathic b) Non-allopathic No of residents posted exclusively for PICU  a) Senior registrar (post MD/DNB) b) PG student (2nd/3rd yr) c) Junior PG student (1st year)  |
| I  | PICU shifts (how many hours each shift?):  |
| J  | Do the Director and Consultants in the PICU have any other affiliation to any other institution, part time/ full time/honorary/ in any other capacity? If so please give details. **(Annexure II J)**  |
| K  | Is the Director/Consultant of the PICU heading or guiding any other Fellowship program of any other specialty in the same or any other institution. If so, please list all such affiliations along with details. **( Annexure II K )**  |

* 1. **Nurses / Ancillary staff:**

|  |  |
| --- | --- |
| A  | Name of the head nurse • Qualification: * Total experience:
* Experience in PICU:
 |
| B  | Total Number of nurses in the unit (Names, qualification, years of experience) **(Annexure III B A letter issued by the Head of HR or Nursing Department certifying number of nurses and their names and qualifications and date of joining the work in PICU. All nurses working in PICU must be at least GNM nurses. Auxiliary Nurse Midwives (ANM) are not allowed to work in the critical care areas except as helpers to GNM nurses)**  |
| C  | Total number of nurses per shift* Morning shift:
* Afternoon shift:
* Night shift:
 |
| D  | Nurse patient ratio * Ventilated children
* Non-ventilated children
 |
| E  | Dedicated infection control nurse available Yes/No • CV **(Include in Annexure III E)**  |
| E  | Other paramedical staff: (indicate Y/ N, hours per day)* ICU technician:
* Physiotherapist / Respiratory therapist:
* Biomedical Engineer:
 |
| I  | Helpers : a) Ward boys per shift: b) Sweepers per shift:  |

**(IV) Academics:**

|  |  |
| --- | --- |
| A  | Conference room available near PICU (indicate Yes / No) :  |
|   |   |
| B  | Library in hospital: * No. of working hours on working day \_ \_ and on a holiday \_ \_
* Names of books/ journals (hard copy) / online journals **(Annexure IV B)**
* Departmental library in PICU (indicate Yes/ No):
 |
| C  | Publications by PICU in indexed journal and non-indexed journals separately **(Annexure IV C)**  |
| D  | PG training facilities in pediatrics & other (names) specialties **(Annexure IV D)**  |
| E  | PICU teaching schedule **(Annexure IV E)**  |
| F  | Have you formed a local critical care group in your city? (indicate Y/N): 1. Frequency of meetings (Furnish the details of meetings held in last 1 year) **(Annexure IV F)**  |
| G  | Details and proof of CME, Workshop, National or International conferences attended by Intensivists of Unit **(Annexure IV G)**  |
| H  | Name and details of conferences/CME/Workshops organized /will be organized by the hospital, particularly PICU **(Annexure 1V H)**  |

**(V) Infrastructure**

|  |  |
| --- | --- |
| A  | 1. Total no. of beds in PICU (at least 8):
2. Total No. of beds in PICU with ventilation facility :
3. Total No of bed in PICU without ventilation facility:
4. If step-down unit / high dependency is not the part of PICU indicate no of beds available in this unit:
 |
| B  | Isolations area (indicate yes / no) :  |
| C  | Total floor area of PICU (sq. ft): * Floor area per bed (PICU):
* Inter-bed distance (PICU):

Floor area of step-down ward if separate (sq. ft):  |
| D  | Others: (indicate Yes / No): * Dirty Utility room:
* Accessible hand wash facility:
* Parents counselling room (indicate Yes/ No):
* Storage space:
* Safe exit in case of fire:
 |
| E  | Power supply back up (indicate generator / UPS / Inverter): |

(VI) **Equipment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Equipment**  | **Available (Y/N)**  | **Total Number**  | **Availability** |  |  |
| **All beds**  | **>50%**  | **< 50%**  |
| Multichannel monitor  |   |   |   |   |   |
| Pulse Oximeter  |   |   |   |   |   |
| End tidal CO2 monitor  |   |   |   |   |   |
| ECG monitoring  |   |   |   |   |   |
| NIBP monitoring  |   |   |   |   |   |
| Invasive pressure monitoring  |   |   |   |   |   |
| Continuous EEG monitoring  |   |   |   |   |   |
| Intracranial pressure monitoring  |   |   |   |   |   |
| Oxygen analyzer  |   |   |   |   |   |
| Volumetric pumps  |   |   |   |   |   |
| Syringe pumps  |   |   |   |   |   |
| Suction apparatus-central  |   |   |   |   |   |
| No. of extra suction machines  |   |   |   |   |   |
| Overhead warmers/Bear Huggers  |   |   |   |   |   |
| Any other  |   |   |   |   |   |

★ Indicate the equipment taken on loan from other sources (specify source)

**(VII) Diagnostic Facilities**

|  |  |
| --- | --- |
|   | **Availability (Yes / No )** |
| Bedside X- ray machine  |   |
| Bedside ultrasonography / echocardiography  |   |
| Bedside GI endoscopy  |   |
| Bedside flexible bronchoscopy  |   |
| Bedside EEG  |   |
| Whole body CT scan available in same hospital\* |   |
| Whole body MRI scan available in same hospital\*  |   |
|   |   |
| **Lab Facilities**  |
|   | Availability: 24 Hrs / < 24 Hrs  |
| Hematology (+ Coagulation screen) |   |
| Biochemistry  |   |
| Microbiology  |   |
| ABG machine (Location: PICU / Central lab / other place)  |   |
| Medical gas supply Oxygen : Central / Gas cylinders NO: Yes / No  |

\*Indicate facilities outsourced (enumerate below and mention the distance from the hospital)

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(VIII) Therapeutic facilities**

|  |  |  |
| --- | --- | --- |
| **Facilities** | **Available (Yes/ No)** | **Total Numbers** |
| Mechanical ventilation (Exclusively for PICU) Specify the name of manufacturer / model **(Annexure VIII)**  |   |   |
| Ventilators with graphics facility  |   |   |
| Non-invasive ventilator  |   |   |
| Defibrillator in PICU (24 hours)  |   |   |
| Temporary pacing in ICU  |   |   |
| Renal replacement ( PD, HD, CVVH ) Specify if bedside facility available  |   |   |
| CRASH CART (in PICU)  |   |   |
| Difficult Airway management equipment  |   |   |
| 24 Hrs pharmacy  |   |   |
| Blood bank facility (on site/ outsourced) 24 hours <24 hours  |   |   |
| All blood components available 24 hours <24 hrs  |   |   |
| Cardiac cath. lab  |   |   |

**(IX) Table indicating availability of Support Services:**

|  |  |  |  |
| --- | --- | --- | --- |
|   |  | **In hospital**  | **Outsourced**  |
| •  | Pediatric surgeon  |   |   |
| •  | Neurosurgeon  |   |   |
| •  | Ped Cardiologist  |   |   |
| •  | Ped Orthopedic surgeon  |   |   |
| •  | CTV surgeon  |   |   |
| •  | Ped Neurologist  |   |   |
| •  | Ped Nephrologist  |   |   |
| •  | Ped Gastroenterologist  |   |   |
| •  | Radiologist  |   |   |
| •  | Psychiatrist/ Psychologist  |   |   |
| •  | Dietician  |   |   |
| •  | Physiotherapy  |   |   |
| •  | Occupational therapist  |   |   |
| •  | Social worker  |   |   |
| •  | Hematology lab  |   |   |
| •  | Biochemistry lab  |   |   |
| •  | Microbiology  |   |   |
| •  | Pathology  |   |   |
| •  | Central sterilization unit  |   |   |

* **(X) Policies and Protocols (Annexure X)**

**(XI) Table showing beds capacity of the entire hospital and pediatric facility:**

|  |  |  |
| --- | --- | --- |
|   | **No of beds**  | **No of admissions per year**  |
| Entire Hospital  |   |   |
| Pediatric General Ward (> 30 days)  |   |   |
| Pediatric Special Rooms  |   |   |
| Neonatal ICU (0-30 days)  |   |   |
| PICU  |   |   |
| Pediatric Cardiac ICU  |   |   |
| Adult ICU  |   |   |
| Any other ICU  |   |   |

* **(XII) Table showing: admissions, ventilations, procedures, mortality data**

|  |  |
| --- | --- |
| **PICU admission categorization in one year** |  |
| CNS:  | Infection:  | Hemat-Onco:  |
| RS:  | Trauma:  | Miscellaneous:  |
| CVS  | Post-surgery:  |   |
| Liver / GI  | Toxicology:  |   |
| Post Cardiac Surgery:  |   |   |
| **Ventilation data:** * No. of patients ventilated in a year :
* No. of INVASIVE ventilations per year:
* Invasive Ventilator days (number invasively ventilated patients x days ventilated)
 |  |
| **Invasive lines data:** * No. of central line inserted in a year
* No. of arterial line inserted in a year
 |  |
| No. of peritoneal dialysis/HD/CRRT in a year   |  |
| No. of **deaths** in a year/per 100 ventilated patients   |  |

**(XIII) Following to be filled by the unit seeking re- accreditation:**

|  |
| --- |
| Date of initial accreditation of unit : No of years:  |
| Total No. of candidates appeared for * One year - Indian Diploma of Pediatric Critical Care Medicine (IDPCC) :
* Two year - Indian Fellowship of Pediatric Critical Care Medicine (IFPCCM):
 |
| Number of trainees (IDPCCM / IFPCCM) joined during previous 2 years |
| Pass Candidates data: * Total no. of candidates passed in IDPCC :
* Total no. of candidates passed in IDPCC in first attempt:

 * Total no. of candidates passed in IFPCCM :
* Total no. of candidates passed in IFPCCM in first attempt:
* Total number of candidates who appeared for exams during previous three years:
* Number amongst these who passed:
 |
| Change of PICU Director after last accreditation: Yes / NoIf yes: Indicate: Name of the previous director (date of change)    |
| Recognized teachers / Intensivists: * No. of intensivist currently employed in PICU:
* No. of intensivist left unit since last accreditation:
* No. of Pediatric Critical Care Council accredited teachers:

  |
| Infrastructure changes since last accreditation:  ▪ Enumerate changes:   |
| New equipment and monitoring facilities:  • Enumerate …   |
| New medical services or support services added since last accreditation  • Enumerate …  |

|  |
| --- |
| ***Declaration******I, Director of the Pediatric Critical Care Diploma / Fellowship programme at -----------*** ***-----------------------------------------------------------------------------------------------------------*** ***am not Heading a Fellowship programme in any another super-specialty*** ***(E.g. Neonatology/Neurology/Nephrology/Pulmonology). I also undertake that, during*** ***my tenure as a Teacher/Director, I will not take up another such said position.*** ***I hereby take the moral responsibility and stand by the whole information provided and shall provide proof for the same if needed.*** ***SIGNATURE DATE***  |

**I hereby certify that all information is correct to best of my knowledge**

# Name of PICU Director / In-charge

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Date Important Instructions:**

If the unit satisfactorily fulfils prescribed requirements, inspection will be conducted as per the PICC college rules.

Inspection fee for the **New Teaching Unit Accreditation FEE** is Rs. 25,000/- Initial accreditation of a NEW UNIT is for 3 years. Program Director must then submit a Reaccreditation Form and a physical inspection will be conducted. Subsequent accreditation will be for 5 years.

**Reaccreditation Fee**:

Rs. 20,000 to be paid to Chapter. The travel and stay (Approximately 4 star kind of facility) of the inspectors will be borne by the institution applying for the accreditation/ reaccreditation.

An honorarium will be paid to the Inspectors by the IAP-Intensive Care Chapter as follows:

* Out of town Inspector: Rs. 5,000/-
* Local Inspector: Rs. 2,000/-

**Please note:** *This amount will be paid by the IAP Intensive Care Chapter and not by the applying Institution*

Please send the Demand Draft (DD) (by registered mail/courier)

NEFT detail may be sent by email.

Please ensure that correct fee is made payable to “IAP Intensive Care Chapter “

|  |
| --- |
| Mailing address (**for DD ONLY)** **Dr. Praveen Khilnani MD FAAP MCCM (USA)**  **Vice Chancellor IAP College council, IAP intensive care Chapter** American Board Certification in Pediatrics and Pediatric Critical Care Medicine Senior Consultant Pediatric Pulmonology and Critical Care Clinical Director, Madhukar Rainbow Children’s Hospital, FC-29, Plot No. 5, Geetanjali Near Malviya Nagar Metro Station, Gate No.1, New Delhi-110017   |

**NEFT:**

**IAP INTENSIVE CARE CHAPTER BANK DETAIL**

**Name of beneficiary**: - IAP Intensive Care Chapter

**Name of Bank:** - THE FEDERAL BANK LTD, SATARA

**Name of accounts:** - IAP Intensive Care Chapter

**Type of account:** - Current A/c

**Account No:** - 15840200003657

**IFSC Code**: - FDRL0001584

**Registered Mobile No**: - 09822057577

**Please DO NOT send any hard copies of your application forms or the annexures by courier. Please send only the DD (by registered mail/courier)**

**All the documents (duly filled application form should be signed, then scanned, and converted to PDF format. Similarly, all the required annexures (experience letters, degree certificates etc.) to be scanned and saved in PDF format) are required to be E-Mailed** to:

**Dr. Rajiv Uttam,**

**VICE Chancellor, PICC College Council**

Email: rajivuttam@hotmail.com AND collegepcc2016@gmail.com

**Please make sure a CC of the e-mail is ALSO** sent **to:**

Dr. Praveen Khilnani: drpraveen.k@rainbowhospitals.in

Dr. Bala Ramachandran: mdpicu@hotmail.com

Dr. Rachna Sharma: rachna9us@gmail.com

Dr. Shivakumar Shamarao: drshiv\_2000@yahoo.com

Dr. Arun Bansal: drarunbansal@gmail.com

**Check List of Annexures:**

(Please number and submit the annexure in the following order; leave a blank annexure if not applicable)

|  |  |  |
| --- | --- | --- |
| **Sr** **No**  | **Annexure Number**  | **Guidance about the content of the Annexure**  |
| 1  | Annexure II C  | A letter from the Hospital management certifying the date of joining and duration of association of the consultant pediatric intensivists mentioned in this space, with the hospital and their designation. Also whether full time or part time  |
| 2  | Annexure II D  | A letter from the Hospital management certifying the duration of association of the Head / Director/ In-charge of PICU with the hospital and his/her designation. Also whether full time or part time  |
| 3  | Annexure II D4  | Details of PICU training of each intensivist  |
| 4  | Annexure II F  | CV of other trained intensivists  |
| 5  | Annexure II H  | No. of Residents in the department of pediatrics and their details (qualifications, date of joining etc)  |
| 6  | Annexure II J  | Affiliation of Director PICU/ Intensivist/ Consultants in PICU to any other institute  |
| 7  | Annexure II K  | Affiliation of Director / Intensivist / Consultants PICU to any other Fellowship program  |
| 8  | Annexure III B  | A letter issued by the Head of HR Department certifying to tal number of nurses and their names and qualifications and date of joining the work in PICU.  |
| 9  | Annexure III E  | About Infection Control Nurse. Letter from HR Dept about her/his qualification/experience as infection control nurse and date of joining the hospital.  |
| 10  | Annexure IV B  | Names of books / journals (hard copies)/ online journals  |
| 11  | Annexure IV C  | Publication in national / international journals by PICU team  |
| 12  | Annexure IV D  | Post graduate training facility in pediatric and other specialties  |
| 13  | Annexure IV E  | PICU training schedule  |
| 14  | Annexure IV F  | Details of meeting for local Critical care group in last one year  |
| 15  | Annexure IV G  | CME/workshops/ conferences attended in last one year by intensivist  |
| 16  | Annexure 1V H  | List of conferences/ CME/ workshops organized by hospital particularly PICU  |
| 17  | Annexure VIII  | Name, model number and total number of ventilators  |
| 18  | Annexure X  | Policies and protocols of PICU  |

**Expected Turn-around-time:**

Your application will first undergo

* Phase-1 scrutiny for appropriateness of the documentation, which will be finished in 2 weeks’ time.
* In Phase-2, the PICC College council shall discuss and make the final decision in 2 weeks.
* Once a decision is made, the college council shall discuss with you about the convenient time to carry out an inspection of your unit. As per the mutual agreement, the inspection shall be carried out and the final decision made by the PICC college council shall be informed to you in 2 to 4 weeks’ time from the date of inspection of your unit.
* If you have any query / suggestions, feel free to contact us by e-mail at:

collegepcc2016@gmail.com (cc to mdpicu@hotmail.com)