**Application form for Accreditation as a Level 3 NON teaching PICU**

**Please complete this form *ONLY* by typing**

**(I) General Information**

|  |  |  |
| --- | --- | --- |
| 1 | Name of the institute   |  |
| 2 | Address   |  for Correspondence  |  |
| 3 | a. b. c.  | Name of contact person Phone #E-mail |
| 4 |  Year in | which PICU established  |  |
| 5 | Is the hospital recognized by the National Board for Gen. Pediatrics? |   |
| 6 | Is the Hospital recognized by the National Board for any other programs? If yes, enumerate | a.b.c.d. |
| 7 | Is the unit recognized by any other body for Pediatric Critical Care Fellowship?  |   |
| 8 | Is the hospital recognized by the National Neonatology Forum (NNF) and/or IAP for Neonatology training |  |

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

|  |  |
| --- | --- |
| A | No. of Consultants in Pediatric ICU: Full Time (spends at least 6 hours/day in PICU): Part Time:  |
| B | Name of Head / Director/ In-charge of PICU: 1. Accredited Teacher by IAP – ICC College of Pediatric Critical Care: Yes/No
2. Percentage of daily time spent in various Departments:

a) Administrative: b) Patient care in PICU: c) Neonatology:  d) Gen Pediatrics: IP e) OPD: **Annexure I A –** CV of Director (Compulsory) |
| C | Names of other Intensivists in the PICU (*excluding Director*) – please indicate whether Full-time (FT) or Part-time (PT)

|  |  |  |
| --- | --- | --- |
| Name | FT/PT | Accredited Teacher by IAP-ICC College Council Yes/No |
| 1. |  |  |
| 2. |  |  |
| 3.  |  |  |
| 4. |  |  |

Use additional paper if necessaryPlease attach CV of each additional Intensivist (**Annexure I B)** (Mandatory) |
| D | Total No. of **Junior doctors** in the PICU: a) Allopathic b) non-allopathic Training level of Junior doctors in the PICU (indicate *number* in each category): a) Post MD/DNB Senior Registrar or Fellow b) Pediatric PGsc) SHO (post MBBS) |
| E | Are Junior Doctors’ PICU night duties combines with either General Pediatrics or NICU?  |

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

|  |  |
| --- | --- |
| A | Total Number of nurses in the unit  |
| B | Nurse patient ratio * Ventilated children
* Non-ventilated children
 |
| C | Dedicated infection control nurse available Yes/No * Name
 |
| D | Other paramedical staff: (indicate Y/ N)* ICU technician
* Physiotherapist
* Respiratory therapist

 |

**(IV) Infrastructure**

|  |  |
| --- | --- |
| A | 1. Number of beds in PICU (at least 8):
2. Is a separate High Dependency Unit (HDU / Step-down ICU) available?
3. If yes, number of beds in HDU:

 1. Total beds (PICU + HDU):
 |
| B | 1. Isolation area available (indicate yes / no):
2. Number of Isolation rooms:
3. Type of Isolation rooms (indicate number next to each category:
	1. Single room with common air-conditioning
	2. Single room with separate air-conditioning
	3. Protective Environment (PE – “positive pressure room”)
	4. Airborne Infection Isolation Room (AII - “negative pressure room”)
 |
| C | Others: (indicate Yes / No): * Dirty Utility room:
* Accessible hand wash facility:
* Parents counselling room:
* Storage space:
* Fire Exit:
 |
| D | Power supply back up (indicate generator / UPS / Inverter): |

**(V)** **Equipment**

|  |  |  |
| --- | --- | --- |
| **Equipment** | **Available (Y/N)** | **Total Number** |
|
| Multichannel monitor  |   |   |
| Pulse Oximeter  |   |   |
| End tidal CO2 monitor  |   |   |
| ECG monitoring |   |   |
| NIBP monitoring  |   |   |
| Invasive pressure monitoring |   |   |
| Continuous EEG monitoring |   |   |
| Intracranial pressure monitoring |   |   |
| Oxygen analyser  |   |   |
| Volumetric pumps  |   |   |
| Syringe pumps  |   |   |
| Suction apparatus-central  |   |   |
| Extra portable suction machines  |   |   |
| Overhead warmers/Bear Huggers  |   |   |
| Any other equipment (specify) |   |   |

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

**(VI) 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 within Hospital: Yes/No**  |
| Haematology (+ Coagulation screen) |   |
| Biochemistry  |   |
| Microbiology  |   |
| ABG machine (Location: PICU / Central lab / another place)  |   |
| Medical gas supply (strike out whichever is not applicable)Oxygen: Central / Gas cylindersCompressed air source: Central / portable compressor  |

**(VII) Therapeutic facilities**

|  |  |  |
| --- | --- | --- |
| **Facilities** | **Available (Yes/ No)** | **Total Numbers** |
| Mechanical ventilators (exclusively for PICU) |   |   |
| High Frequency Oscillatory Ventilator (HFOV)Make / model: |  |  |
| Non-invasive ventilator  |   |   |
| High Flow Nasal Cannula therapy (HFNC)  |   |   |
| Defibrillator in PICU (24 hours)  |   |   |
| Temporary pacing in ICU  |   |   |
| Renal replacement1. PD
2. HD
3. CRRT
 |   |   |
| CRASH CART (in PICU)  |   |   |
| Difficult Airway management equipment  |   |   |
| Blood bank facility (on site / outsourced) |   |   |

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

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **In hospital** | **Outsourced** |
| •  | Pediatric surgeon  |   |   |
| •  | Neurosurgeon  |   |   |
| •  | Ped Cardiologist  |   |   |
| •  | Ped Orthopaedic surgeon  |   |   |
| •  | CTV surgeon  |   |   |
| •  | Ped Neurologist  |   |   |
| •  | Ped Nephrologist  |   |   |
| •  | Ped Gastroenterologist |   |   |
|  | Ped. Pulmonologist |  |  |
| •  | Radiologist  |   |   |
| •  | Psychiatrist/ Psychologist  |   |   |
| •  | Dietician  |   |   |
| •  | Occupational therapist  |   |   |
| •  | Social worker |   |   |
| •  | Central sterilization unit  |   |   |
| •  | Microbiologist |   |   |
| •  | Pathologist |   |   |
|  | Clinical Pharmacist |  |  |

**(IX) Policies and Protocols (Annexure II)**

**(X) Table showing bed capacity of the entire hospital and pediatric facility**

|  |  |  |
| --- | --- | --- |
|  | **No of beds** | **No of admissions per year (specify year)** |
| Entire Hospital  |   |   |
| Pediatric Ward |   |   |
| Neonatal ICU (0-30 days)  |   |   |
| PICU  |   |   |
| HDU (if separate)  |  |  |
| Paediatric Cardiac ICU  |   |   |
| Any other ICU (eg. Transplant, Adult ICU etc.) |   |   |

**(XI) PICU admissions, ventilation, mortality and procedures data**

|  |  |  |  |
| --- | --- | --- | --- |
| **Please provide data for the previous 3 years*****PLEASE COMPLETE ALL DETAILS*** | **Year 1****(Enter year below)** | **Year 2****(Enter year below)** | **Year 3****(Enter year below)** |
| **Admission data** |  |  |  |
| No. of PICU admissions |  |  |  |
| No. of HDU admissions (if separate) |  |  |  |
| Total # of admissions (PICU + HDU) |  |  |  |
| No. of Deaths |  |  |  |
| Crude mortality rate % |  |  |  |
| **Ventilation Data** |
| No. of invasively ventilated patients |  |  |  |
| No. of invasive ventilation days |  |  |  |
| No. of NIV patients (DO NOT INCLUDE HFNC) |  |  |  |
| **Procedure data** |
| No. of Central Venous Catheters inserted |  |  |  |
| No. of Arterial cannulae inserted |  |  |  |
| **Renal Replacement data** |
| PD |  |  |  |
| HD/SLED |  |  |  |
| CRRT |  |  |  |

|  |
| --- |
| ***Declaration******I, Dr. , Director of the Pediatric Critical Care Unit at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** ***Certify that all information is correct to the best of my knowledge.******SIGNATURE DATE*** ***SEAL*** |

**Instructions**

Inspection fee for the **Non Teaching Level 3 Unit Accreditation / Reaccreditation is** **Rs. 20,000**/- to be paid to the IAP Intensive Care Chapter by NEFT *ONLY* – please include NEFT details along with application

Before making any payment, please ensure that the PICU satisfies the current Level 3 Unit Criteria, available at:

<https://www.piccindia.com/assets/pdf/picu-level-criteria.pdf?v=1>

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

The travel and stay (Approximately 4-star kind of facility) of the inspectors should be borne by the institution applying for the accreditation / reaccreditation.

Period of Accreditation is 5 years

**NEFT: IAP INTENSIVE CARE CHAPTER BANK DETAILS**

**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

**Please DO NOT send any hard copies of your application forms or annexures**

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

**Dr. Ebor Jacob,**

**VICE Chancellor, PICC College Council**

Email: eborjacob@gmail.com

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

Dr. SHIVAKUMAR SHAMARAO : drshiv\_2000@yahoo.com

Dr. RACHNA SHARMA : rachna9us@gmail.com

Dr. BALA RAMACHANDRAN : mdpicu@hotmail.com

College VC Office : vc.iapicc.college@piccindia.com

College Secretary’s Office : secretary@piccindia.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 I A** | CV of Head / Director of the PICU |
| 2 | **Annexure I B** | CV of other Pediatric Intensivists |
| 12 | **Annexure II** | PICU Policies and Protocols |