|  |  |  |
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|   |  | **European** **Board of** **Anaesthesiology** |
| **Questionnaire for departments of Anaesthesia****seeking Accreditation as Teaching Hospital by the ESAIC and the EBA** |
| To be completed by the Head of department or the authorised deputy. |
| Please fill in all required fields (in blue) and send to ataic@esaic.org with electronic attachments (If attachments are to heavy to be sent by email, please send a CD to the ESAIC Secretariat). |
| Use the TAB-key to move forward to the next field – Shift-TAB to move backwards. |
| **1. BASIC DATA** |
| [Name of Hospital](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Krankenhaus%20/%20H%C3%B4pital%20/%20Hospital) |       |
| [**Department**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Abteilung%20/%20D%C3%A9partement%20/%20Departamento) |       |
| [**Street + number**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Strasse%20und%20nummer%20/%20Rue%20et%20num%C3%A9ro%20/%20Calle%20y%20numero) |       |
| [**Postal code**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Postcode%20/%20Code%20postal%20/%20Codigo%20postal) |       |
| [**City**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Stadt%20/%20Ville%20/%20Ciudad) |       |
| [**Country**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Land%20/%20Pays%20/%20Pais) |       |
| Website |       |
| **Head of Department details** |
| **Surname** |       |
| [**First** **Name**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Vornamen%20/%20Pr%C3%A9nom%20/%20Nombre) |       |
| **Telephone + country/area code** |       |
| **Telephone + country/area code** |       |
| **Mobile telephone** |       |
| E-mail address |       @      |
| **Director of the training programme details** |
| **Surname** |       |
| [**First** **Name**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Vornamen%20/%20Pr%C3%A9nom%20/%20Nombre) |       |
| **Telephone + country/area code** |       |
| **Telephone + country/area code** |       |
| **Mobile telephone** |       |
| E-mail address |       @      |
| Comments on structure, organisation, composition and location of the institution (department) |       |
| Person to contact (if different) |       |
| E-mail address |       @      |
| **Other hospital(s) in which training takes place under the responsibility of the parent institution (department)** |
| 1. [Name of Hospital](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Krankenhaus%20/%20H%C3%B4pital%20/%20Hospital) | **N° of beds** | **N° of Specialties (including intensive Care)** |
|       |       |       |
| 2. [Name of Hospital](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Krankenhaus%20/%20H%C3%B4pital%20/%20Hospital) | **N° of beds** | **N° of Specialties (including intensive Care)** |
|       |       |       |
| **Other hospital(s) in which training takes place under separate responsibility** |
| 1. [Name of Hospital](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Krankenhaus%20/%20H%C3%B4pital%20/%20Hospital) | **N° of beds** | **N° of Specialties (including intensive Care)** |
|       |       |       |
| 2. [Name of Hospital](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Krankenhaus%20/%20H%C3%B4pital%20/%20Hospital) | **N° of beds** | **N° of Specialties (including intensive Care)** |
|       |       |       |
| **Special commitments** |
| **Exchanges with other institutions (please specify)** |       |
| **Others** |
| **Written “aims, goals and objectives” for the general activity of the department** | [ ]  yes [ ]  no (If yes, please attach a copy) |
| **Annual report** | [ ]  yes [ ]  no (If yes, please attach a copy) |
| **Written “aims, goals and objectives” for the educational activity**  | [ ]  yes [ ]  no (If yes, please attach a copy) |
| **2. MEDICAL PERSONNEL** |
|  | **Numbers** |
| **Head(s) of department** |       |
| **Staff members** |       |
| **Other qualified anaesthesiologists** |       |
| **Anaesthesiologists in training 1-2 years** |       |
| **Anaesthesiologists in training 2-4 years** |       |
| **Anaesthesiologists in training >4 years** |       |
| **Nationals (by citizenship)** |       |
| **Non-nationals** |       |
| **Faculty proficient in English** |       |
| **Trainee proficient in English** |       |
| **3. OTHER PERSONNEL** |
| **Registered nurse anaesthetist** |       |
| **Nurses (Anaesthesia/Intensive Care/Pain)** |       |
| **Assistants/Technicians** |       |
| **Secretaries/clerks/library** |       |
| **Computer staff** |       |
| **Medical technologists** |       |
| **4. ALLOCATION OF MEDICAL PERSONNEL** |
| **During office hours** |
|  | **Qualified Anaesthesiologists** | **Trainee** **Anaesthesiologists** | **Nurses** |
| **Clinical anaesthesia** |       |       |       |
| **Intensive care** |       |       |       |
| **Pain management** |       |       |       |
| **Emergency medicine**  |       |       |       |
| **Research** |       |       |       |
| **Other** |       |       |       |
| **Outside office hours (on call)** |
|  | **Qualified anaesthesiologists** | **Trainee** **anaesthesiologists** | **Nurses** |
| **Clinical anaesthesia** |       |       |       |
| **Intensive care** |       |       |       |
| **Pain management** |       |       |       |
| **Emergency medicine** |       |       |       |
| **Other** |       |       |       |
| **Is there a special team on call for:** |
| **Transplantation surgery** | [ ]  yes [ ]  no |
| **Neonatal surgery** | [ ]  yes [ ]  no |
| **Trauma/Emergency Medicine** | [ ]  yes [ ]  no |
| **Other specialised surgery****Describe:**  | [ ]  yes [ ]  no       |
| **5. CLINICAL EXPERIENCE AVAILABLE** |
| **Anaesthesia** |
| **Techniques** | **Elective cases per annum** | **Emergency cases per annum** |
| **General anaesthesia** |       |       |
| **Epidural anaesthesia excluding obstetrics** |       |       |
| **Epidural anaesthesia in obstetrics** |       |       |
| **Spinal anaesthesia excluding obstetrics** |       |       |
| **Spinal anaesthesia in obstetrics** |       |       |
| **Other regional techniques** |       |       |
| **Monitored anaesthesia care** |       |       |
| **Type of surgery** |
|  | **Minimal trainee’s rotation/ month** | **Approx. n° of cases performed** |
| **General (+urology)** |       |       |
| **Trauma/orthopedic** |       |       |
| **Thoracic** |       |       |
| **Vascular** |       |       |
| **Pediatric** |       |       |
| **Gynecology** |       |       |
| **Obstetrics** |       |       |
| **ENT surgery** |       |       |
| **Eye surgery** |       |       |
| **Day case surgery** |       |       |
| **Diagnostic procedures** |       |       |
| **Dental/oral/maxillo-facial** |       |       |
| **Cardiac surgery** |       |       |
| **Neurosurgery** |       |       |
| **Neonatal surgery** |       |       |
| **Transplant surgery** |       |       |
| **Others****Specify:** |            |            |
| **Preoperative assessment** |
| **Performed** | [ ]  regularly [ ]  occasionally [ ]  rarely [ ]  never |
| **Time of preop. examination**  | [ ]  policlinically [ ]  day before surgery [ ]  same day  |
| **Postoperative assessment** |
| **Performed** | [ ]  regularly [ ]  occasionally [ ]  rarely [ ]  never |
| **Time of preop. examination**  | [ ]  same day [ ]  day after surgery [ ]  later  |
| **6. OPERATING DEPARTMENT FACILITIES** |
| **Facilities** |
| **Number of induction rooms** |       |
| **Number of operating rooms** |       |
| **Number of recovery room beds** |       |
| **Anaesthesia record** | *Please attach sample* |
| **Equipment**  | **Induction room** | **Operating room** | **Recovery rooms** |
| **Anaesthesia machine** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Ventilator** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **ECG** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Blood pressure monitor (non-invasive)****Blood pressure monitor (invasive)** | [ ]  yes [ ]  no [ ]  yes [ ]  no  | [ ]  yes [ ]  no[ ]  yes [ ]  no | [ ]  yes [ ]  no[ ]  yes [ ]  no |
| **Pulse oximeter** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Capnograph** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Vapour concentration monitor** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **NMT-Monitor** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Depth of anaesthesia monitors**  | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Blood warmer** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Infusion pumps** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Warming blankets** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Defibrillators** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Difficult airway equipment** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Others** | [ ]  yes [ ]  no | [ ]  yes [ ]  no | [ ]  yes [ ]  no |
| **Recovery rooms** |
| **N° of physicians regularly present** |       |
| **N° of patients per nurse** |       |
| **7. INTENSIVE CARE** |
| **Under the responsibility of the department of anaesthesia** | [ ]  yes [ ]  no |
| **N° of beds** | **Adults** | **Children** |
| ***Surgical*** |       |       |
| ***Non -surgical*** |       |       |
| ***Total*** |       |       |
| **N° of admissions per year** |       |       |
| **Average duration of stay** |       (days) |       (days) |
| **% of ventilated patients** |       |       |
| **Staff** |
| ***Anaesthesiologists*** |       |
| ***Trainee anaesthesiologists*** |       |
| ***Intensivists (full-time)*** |       |
| ***Surgeons*** |       |
| ***Other doctors*** |       |
| ***Nurses per bed*** |       |
| **Severity scores in use*****Which one?*** | [ ]  yes [ ]  no      |
| **Regular ward rounds: N°/week** |       |
| **Structured teaching hours: N°/week** |       |
| **8. EMERGENCY MEDICINE** |
| **Cases per year** |       |
| **Types of patient** |       |
| **In-hospital emergency transportation** | [ ]  yes [ ]  no |
| ***Cases per year*** |       |
| ***Types of patient*** |       |
| **Pre-hospital emergency** | [ ]  yes [ ]  no |
| ***Cases per year*** |       |
| ***Types of patient*** |       |
| **In-hospital emergency / resuscitation team** | [ ]  yes [ ]  no |
| **Special training in CPR / emergencies** | [ ]  yes [ ]  no |
| **9. PAIN MANAGEMENT** |
| **Acute Pain** |
| **Acute pain team** | [ ]  yes [ ]  no |
| **Types of patient** | [ ]  postoperative [ ]  posttraumatic [ ]  cancer [ ]  others |
| **Types of treatment*****Regional analgesia******Systemic analgesia*** | [ ]  epidural block [ ]  spinal block [ ]  peripheral block [ ]  other **Specify:**      [ ]  PCA [ ]  Infusion [ ]  other **Specify:**       |
| **Chronic Pain** |
| **Chronic pain service*****Under the responsibility of dep. of anaesth.*** | [ ]  yes [ ]  no[ ]  yes [ ]  no |
| **Organisation**  | [ ]  pain clinic [ ]  others |
| **Service in palliative medicine** | [ ]  yes [ ]  no |
| **10. DEPARTMENT** |
|  | **Excellent** | **Appropriate** | **Needs improvement** |
| **Accommodation** | [ ]  | [ ]  | [ ]  |
| **Secretariat** | [ ]  | [ ]  | [ ]  |
| **Laboratories** | [ ]  | [ ]  | [ ]  |
| **Library/Internet** | [ ]  | [ ]  | [ ]  |
| **11. MEDICAL AUDIT** |
| **Systematic Reporting of incidents/Complications** | [ ]  yes [ ]  no |
| **Critical incident conferences** | [ ]  yes [ ]  no |
| **Crisis Resource Management training** | [ ]  yes [ ]  no |
| **Morbidity/ mortality conferences** | [ ]  yes [ ]  no |
| **Systematic reporting of complaints from patients and relatives** | [ ]  yes [ ]  no |
| **Departmental meetings (apart from above)** | [ ]  yes [ ]  no |
| **Introductory programs for the use of anaesthesia and monitoring equipment (driver licences)** | [ ]  yes [ ]  no |
| **Written personalised teaching programs****Contracts tutor/student** | [ ]  yes [ ]  no |
| **Trainee records/logbooks** | [ ]  yes [ ]  no |
|  |
| **12. OTHER EDUCATIONAL ACTIVITIES** |
|       |
| **13. RESEARCH ACTIVITIES**  |
|       |
| *Please attach list of publications for the past two years* |
| **14. COMMENTS** |
|       |
| **15. ESAIC/EBA VISIT** |
| **Dates proposed for the visit (at least 3)** |       or       or       or            or       or       or       |
| **National Visitor proposed with the agreement of the national society** |
| **Surname** |       |
| [**First** **Name**](file:///C%3A/Users/iwona/Local%20Settings/Temporary%20Internet%20Files/Content.IE5/ONBV6GHT/Vornamen%20/%20Pr%C3%A9nom%20/%20Nombre) |       |
| **Telephone + country/area code** |       |
| **Telephone + country/area code** |       |
| **Mobile telephone** |       |
| E-mail address |       @      |
| [ ]  *I hereby accept the regulations of the Accreditation of Training in Anaesthesiology and Intensive Care programme and I agree to take in charge the food and accommodation costs of the 3 Visitors on the most reasonable basis.* Name:      Date:       |