SUMMER TRAINING AT CALCUTTA MEDICAL RESEARCH INSTITUTE

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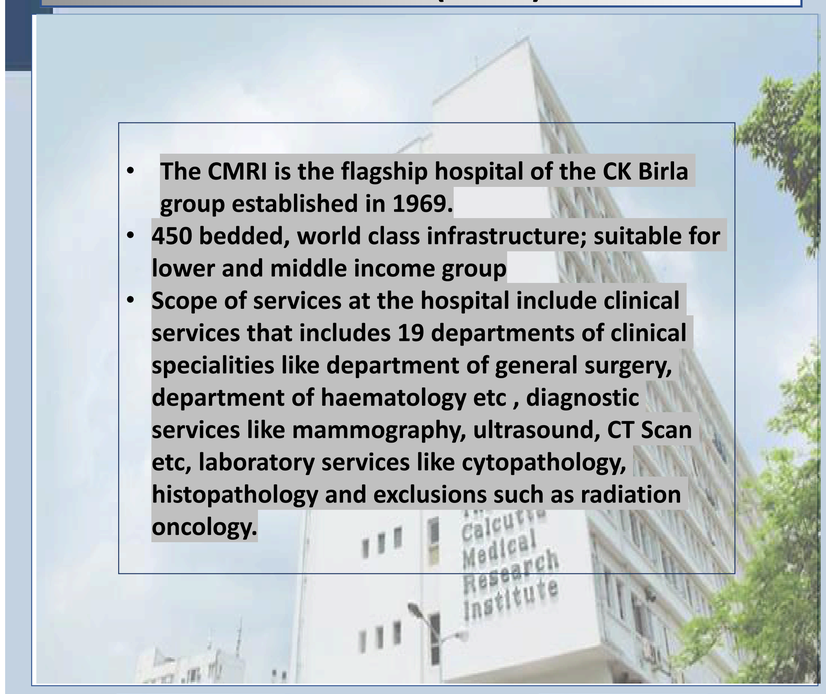
IIHMR UNIVERSITY

About Calcutta Medical Research Institute(CMRI)



- **The CMRI is the flagship hospital of the CK Birla group established in 1969.**
- **450 bedded, world class infrastructure; suitable for lower and middle income group**
- **Scope of services at the hospital include clinical services that includes 19 departments of clinical specialities like department of general surgery, department of haematology etc , diagnostic services like mammography, ultrasound, CT Scan etc, laboratory services like cytopathology, histopathology and exclusions such as radiation oncology.**

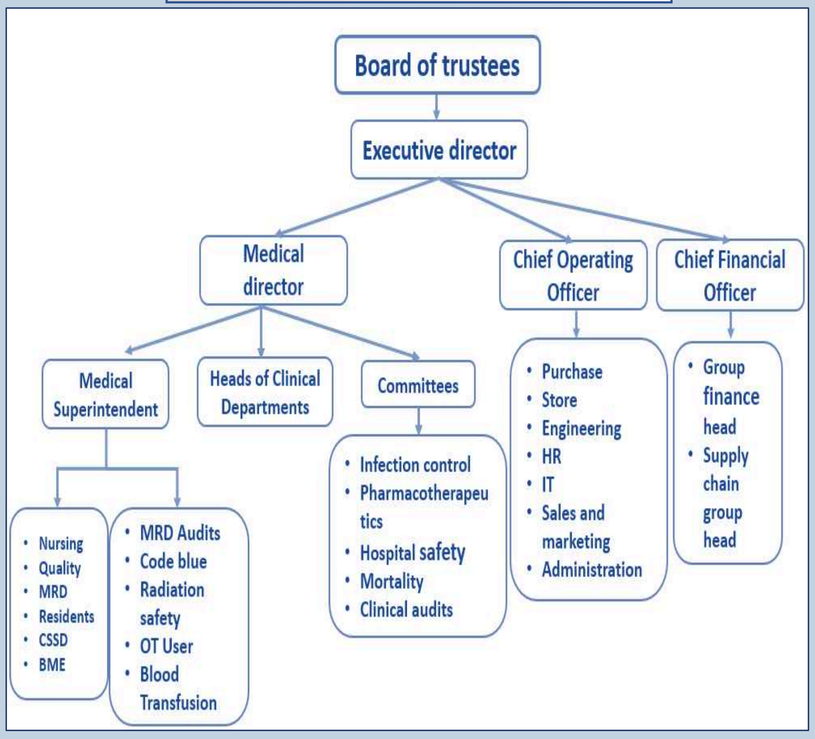
MISSION

"To offer the best standard of medical services with care, commitment, and compassion to all the sections of the society. To create clinical centers of excellence on a strong backbone of academics, research, and evidence-based medicine for best clinical and patient outcome". (-CMRI Bulletin)

VISION

"To be the leading healthcare and research institute in the Eastern India with International standard of service and quality. To provide best and efficient patient service and to achieve clinical excellence". (-CMRI Bulletin)

CMRI Organogram



CMRI Floor Plan

G	Reception, help desk, emergency department, CT Scan, MRI, USG, X-Ray, pharmacy, cardiology test room, public relations office, security office, mortuary
1	Admission desk, eye and dental department, skin and cosmetic department, pathology, physiotherapy
U	HR Department, marketing, medical admin, billing, quality, finance
2	Gastroenterology, OT, endoscopy, colonoscopy, dept of anaesthesiology
3	DP Ward, ICU, HDU, kidney and liver transplant
4	Bronchoscopy unit, RICU, AC special ward
5	Labour room, paediatric HDU, paediatric ward, neonatal ICU, paediatric ICU, twin sharing cabin
6	ICU, Twin sharing cabin, oncology day care ward
7	Executive cabin, ICU II, suites
8	Neuro ICU, infection control and ethics, simulation lab, academics, nursing classroom, matron's office
9	MRD, uroflowmetry, management canteen, dietician room, data centre, conference room

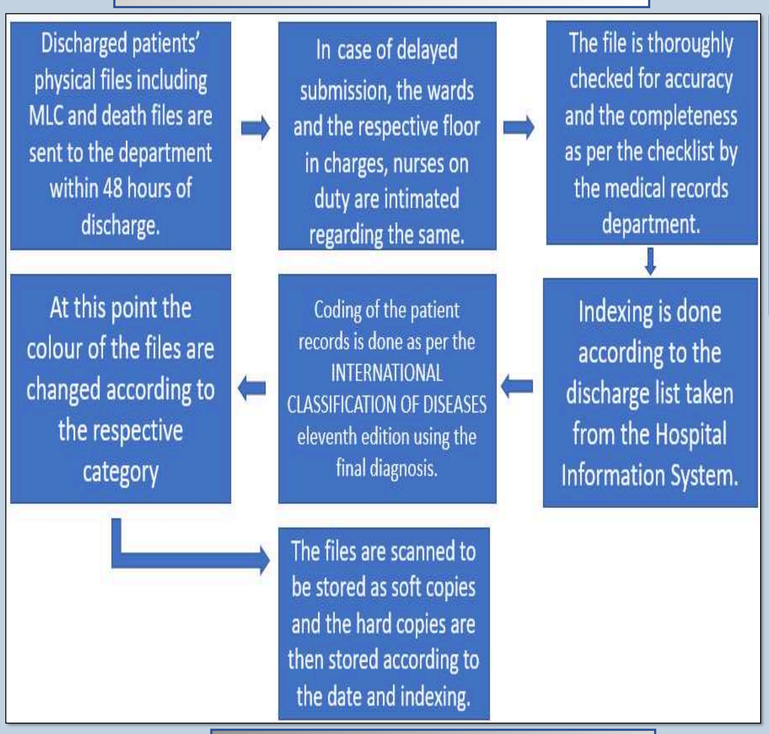
Learning and value additions done during internship

- Worked in the Medical Records Department, located on the 9th floor.
- The MRD of a hospital stores records of the patients who have been primarily treated at the in-patient ward or emergency ward of a hospital.
- Have been involved in receiving files from the ward, auditing files, storing files according to their dates and index number.
- In a patient file, data is stored in a sequential event from admission to discharge according to the CMRI checklist.
- Files are stored as hard copies which are then scanned to be stored in the HIS.
- Files (last 3 months records) were stored in the department while all the previous ones are outsourced.
- In-patient files and death files are retained for a period of 10 years after being outsourced, post which the hard copies are destroyed. Medico legal case files are retained for 15 years. Any file which has an pending case on it in the court, is kept until the case is closed.

Process mapping of making a typical patient record

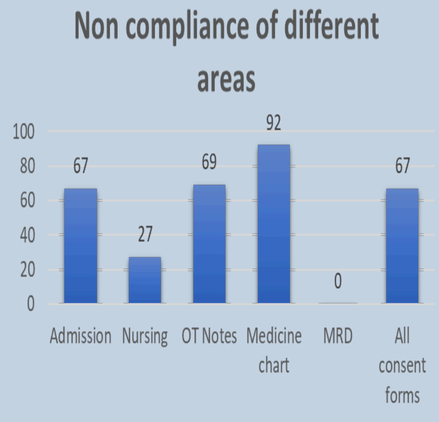
Arrival of patient, issue of token number	
Patient waits until his token number is displayed in the reception monitor	
Registration, filling up of the required demographic details in the HIS and deposition of consultant fee	Admission form is prepared
Unique MRN number is generated and OPD registration file is handed over to patient while guiding them to the chamber	
In cases where the doctor asks the patient to get admitted, The attendants of the patient are told to fill the consent form, Declaration form related to Mediclaim patients, submit ID proof, PAN card, etc.	
All the details of the patient, including diagnosis, diet preferred, type of bed chosen are entered into the HIS post which a GDA takes them to their respective wards	Discharge summary starts getting documented
Resident Doctors and nursing staff of the respective ward take the patient history within an hour of admission into the ward	Patient history sheet is made
Daily progress notes are written by doctor and nurses in which pain scores, intakes, fall assessments are recorded. Diet can be modified at this point	Doctors progress notes, nursing progress notes, nursing handover checklists, humpty dumpty sheet, pain assessment sheet, intake output chart, medicine chart are prepared
Nursing staff places request for medicines through the HIS which are sent to ward by the GDA from the pharmacy	
The patient or surrogate requires to sign the relevant consent forms in presence of an witness, relevant tests are carried out, pre anaesthesia evaluation is done and the surgery is conducted	Preparation of all consent forms, test reports operation consumption checklist and surgical safety checklist are made
Probable discharge order is given by consultant during evening round one day prior to confirmed discharge. Rough discharge summary is written by the RMO which is finalized by consultants.	Discharge summary is ready and drafted to make 2 copies
After the entire discharge process, final bill is cleared at the cash counter and the patient is discharged with all the required documents	Final bill is prepared and attached to patient file

Workflow of MRD



Auditing of files and calculation of noncompliance

- Audit of 10 files were done on an average each day over a duration of 4 weeks and therefore, a total of 200 current closed files were audited
- Sampling: Convenience sampling
- Inclusion criteria: surgical files.
- Exclusion criteria: Death files, day care files, pediatric files



Areas	Individual compliance(%)	Average compliance (%)
ADMISSION		
Name and signature of relatives	61	33
Relationship with patient	52	
NURSING		
Nursing admission assessment	98	73
Nursing progress note	76	
Pain assessment	99	
OT NOTES		
Start/End time	87	31
Steps	97	
Doctor's Name with signature	36	
Date and Time	94	
MEDICINE CHART		
Drug name in capital letters	83	8
Doctor's full name	87	
Date	93	
MRD		
ICD Coding	100	100
Fully completed	100	
ALL CONSENT FORMS		
Patient's Signature	100	37
Surrogate signature with reason	86	
Witness sign, Name	77	
Doctor's Name, Signature	87	
Legibility of Signature	37	
Surrogate name with relationship	57	

SWOT Analysis of MRD

STRENGTHS

- 100% compliance of the MRD Staff with NABH guidelines
- Strict adherence to process mapping of the department
- Maintenance of internal and external register for providing documents to anyone

WEAKNESS

- Understaffed
- Absence of highly experienced staffs in the department
- Huge wastage of paper

OPPORTUNITIES

- Probability to shift MRD to the ground floor is high, which can improve the patient experience.
- Probability to install CCTVs will ensure no confidentiality breach or file misplacement

THREATS

- The files are outsourced via a company named IRC where the confidentiality can be breached
- Misplacement of files
- Occasional attack by rodents.

Challenges faced during internship

- Limited exposure to MRD only

Usefulness

- Helped in decision making towards stream selection
- Health Management Information System Module; will be able to ask relevant concerns and will be able to relate.

Suggestions

- Increased frequency Training of the nurses and doctors to increase compliance with NABH guidelines.
- Electronic record keeping instead of maintaining hard copies.
- Recruitment of more staffs as well as retaining experienced staffs
- Maintaining the confidentiality of the records while outsourcing