SUMMER INTERNSHIP PROGRAM

At

Orange City Hospital & Research Institute

From 3rd May 2024 to 1st July 2024

A REPORT BY

Shruti Bhalchandra Kondekar

Master of Business Administration

Hospital and Health Management -28

2023-25

under the Mentorship of

Sandesh Kumar Sharma

NABH & ISO 9001:2015 Accredited Health Care Institute

Orange City Hospital & Research Institute

Owned by Ravi Nair Hospitals Private Limited

19 Pandey Layout, Veer Sawarkar Square, Nagpur - 440 015. Maharashtra, India.

9225260606 (24x7) Health Help Line www.orangecityhospital.org contact@ochri.org

Saving Lives; Saving Families.

CERTIFICATE

This is to certify that Ms. Shruti Kondekar of 28th batch of IIHMR University has worked with our organization for her summer internship from 03.05.2024 to 01.07.2024. The overall performance shown by her was excellent/good/average. This certificate is being issued to meet the requirements of the IIHMR University.

Date: 01.07.2024

(Signature of organization Mentor)

Name: Dr. Priya Maheshwari

Designation: Quality Head

Seal/Stamp of the Organization

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **Ms. Shruti Kondekar** of academic year 2023-25 of **INSTITUTE OF HEALTH MANAGEMENT RESEARCH** has prepared a poster with respect to her summer internship held during May-June 2024.

She has carried out work as per the guidelines. Her poster is approved for presentation.

Date: 22/07/2024

Dr. Sandesh Kumar Sharma

Associate Professor

IIHMR University Jaipur

COMPREHENSIVE AUDIT CHECKLIST FOR MEDICATION ERRORS IN CRITICAL CARE UNIT

UNDER THE MENTORSHIP OF - DR.SANDESH KUMAR SHARMA

ORANGE CITY HOSPITAL MENTORSHIP OF-DR. PRIYA LADDHA (QUALITY HEAD)

PRESENTED BY- SHRUTI KONDEKAR, MBA-HM-28th (1st Year) Roll No:- 1732

BRIEF HISTORY

The Orange City Hospital & Research Institute (OCHRI) was established in 2009 and is the only ISO 9001:2000 certified hospital in Nagpur that has maintained its certification consistently over the past four years. It is recognized as Central India's most trusted ISO and NABH healthcare provider. OCHRI is known for offering high-quality Medicare services through state-of-the-art facilities and the use of sophisticated technology. The Research Institute, located in Pande Layout, Nagpur, is operated by Ravi Nair Hospitals Private Limited (RNHPL).

BRIEF DESCRIPTION

The Orange City Hospital & Research Institute (OCHRI) is a leading multi-specialty hospital located in Nagpur, serving a significant portion of Central India's population. It has established itself as a trusted tertiary health and medical care centre in the country. Beyond its clinical services, OCHRI is actively engaged in various medico-social commitments through different forums. Notably, it has partnered with the Global Cancer Concern of India to offer home-based healthcare services for terminally ill cancer patients.

ORGANISATION VISION AND MISSION

Vision: To create a positive impact within available resources in the interest of patient care and to provide quality, comprehensive, curative and preventive medical services.

Mission: We are committed to promoting wellness and delivering comprehensive health care with compassion, competence and excellence.

S W O T ANALYSIS

Strengths:

- Improved patient safety
- Helps in educating and training new healthcare staff.
- Encourages adherence to established protocols.

Weaknesses:

- May be seen as additional paperwork by staff.
- Checklists need regular updates to stay relevant.
- Potential pushback from healthcare professionals.

Opportunities:

- Identifying error patterns and areas for improvement.
- Continuous education and improvement for healthcare staff.
- Demonstrates a commitment to patient safety, improving institutional reputation.

Threats:

- Possible legal consequences if checklists are not followed correctly.
- Ensuring all staff consistently use the checklist
- Possible legal consequences if checklists are not followed correctly.

DIFFERENCE BETWEEN THEORETICAL AND PRATICAL UNDERSTANDINGS

Theoretical	Practical
. Fundamental frameworks	. Practical exposure
. Analytical tools	. Skill development
. Leadership practices	. Experience learning

USEFULNESS OF INTERNSHIP

- Understanding Hospital Operations
- Practical Experience
- Specialization Insights

CHALLENGES

- **Administrative Tasks:** Interns may be required to handle administrative duties, which can be time-consuming and detract from clinical learning.
- **Communication:** Effective communication between different departments and staff members is essential but can be challenging to maintain consistently.
- **Patient Feedback:** Collecting, analysing, and responding to patient feedback to improve service quality while maintaining confidentiality and sensitivity can be challenging.

TASK PERFORMED DURING INTERNSHIP

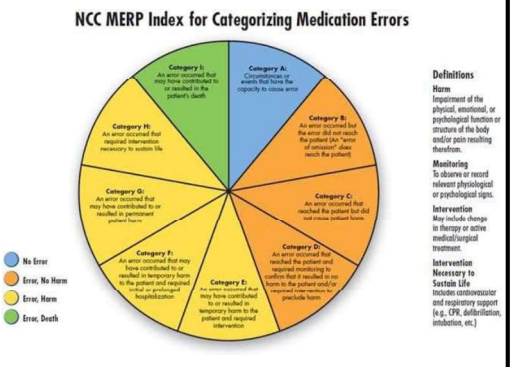
- The roles and responsibilities of all departments within the hospital as a member of the quality department."
- To conduct an audit of medication errors. To prepare for this, I read the NABH guideline book.
- Audit review checklist for 100 patients regarding medication errors."
- To conduct an audit on LASA (Look-Alike, Sound-Alike) drugs. To gain the necessary knowledge, I advised to read relevant articles. then tasked with creating a checklist for the audit.
- Developed the LASA drug checklist and conducted the audit in various departments where medications are stored, such as the pharmacy, CCU, casualty, wards, ambulance, etc.

PROJECT

OBJECTIVES

1.To ensure medication are prescribed and administered according to guidelines and best practices.

2.To Identify medication errors, omissions and inappropriate prescriptions to reduce the risk of adverse drug events.



METHODOLOGY

1. Study Design
- Type of Study: Observational, prospective study.

2 Population:
. Patients in a critical care unit.

3 Sample Size:
100 prescription.

3. Inclusion Criteria
- Patients prescription in CCU
- Patients receiving medication through any route (oral, intravenous, etc.).

4. Exclusion Criteria
- Patients not admitted in CCU

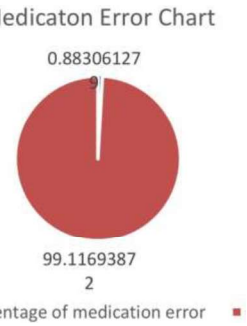
DATA OF MEDICATION ERROR IN PATIENTS PRESCRIPTION

DOCTORS	
No/wrong dose	16
No/wrong frequency	3
Illegible handwriting	108
Non-usage of capital letters for drug names	29
PHARMACIST	
No/wrong labelling	2
NURSES	
Improper Dose	7
No documentation of drug administration	8
Incomplete/improper documentation by nursing staff	4
Documentation without administration	10
Others	33

Result:

Graphical Representation:

The percentage of medication errors identified in the audit of the medication chart review checklist is 88.31%.



SUGGESTION

For Doctors:

1. Dosing and Frequency Errors
2. Illegible Handwriting
3. Non-Usage of Capital Letters for Drug Names

For Nurses:

4. Improper Dose
5. No Documentation of Drug Administration
6. Incomplete/Improper Documentation by Nursing Staff
7. Documentation without Administration

Annexure-E

Week no: 1

Name of the Organisation: Orange City Hospital & Research Institute

Area/ Department/ Project of Summer Internship Program: Quality department

Name of the Student: Shruti Kondekar

Roll no: 1732 **Stream: MBA-HM 28**

Week no: 01 **From: 03-05-2024 to 04-05-2024**

Activity Done	• Understanding roles and responsibilities of hospitals of all departments as a quality department. • Taking daily MRD audits. • Conducted audits of critical care unit of daily five patient files to ensure accuracy and completeness. • Completed daily five medication chart review checklists to enhance patient safety and regulatory compliance. • incident site visit at ICU and CCU WARDS.
Linking theory (Classroom learning) with practice at your organisation	• Previous hospital visits for our college gave me prior information of the departments in the hospital which made me easy to recognize the specific departments.
Gaps identified on the working area.	• Incomplete documentation of patient records, which can lead to errors in treatment and care. • Wastage of manpower due to lack of technology.
Suggestions for improvement	• Enhance documentation practices. • Ensure adherence to protocol.
Plan for the next week	• Conduct quality audits. • Attend trainings. • Assist with quality improvement project. • Seek feedback.

Week no: 2

From: 6 May 2024 to 11 May 2024

Activity Done	• Taking daily MRD audits. • Conducted audits of critical care unit of daily eight patient files to ensure accuracy and completeness. • Completed daily eight medication chart review checklists to enhance patient safety and regulatory compliance. • Incident site visit at ICU and CCU WARDS. • Review the drug policy in the pharmacy, CCU, and wards. • Examine the review papers related to LASA drug policies for additional insights. • Gone through all the SOP's present in all the wards and CCU ward.
Linking theory (Classroom learning) with practice at your organisation	• All information taught in classroom about various departments in hospital made me understand about various things such as process flow, roles and responsibility of staff of various department made easy in participating in audit and asking question.
Gaps identified on the working area.	• Incomplete documentation of patient records, which can lead to errors in treatment and care. • Lack of knowledge among staff about fire type and fire plan to be used in different situtions. • Communication challenges.
Suggestions for improvement	• Enhance documentation practices.
Plan for the next week	• Conduct quality audits.

	• Working on NABH assessment. • Assist with quality improvement project. • Seek feedback. • Go through LASA drugs policy in detail.

Week no: 3

From: 13 May 2024 to 18 May 2024

Activity Done	• Conducted audits of critical care unit and ward of daily five patient files to ensure accuracy and completeness. • Completed till now 50 medication chart review checklists. • Incident site visit at ICU and CCU WARDS. • Review the LASA drug in the pharmacy, CCU, and wards. • Reviewed all the crash carts for LASA drugs in each ward and CCU to ensure they are arranged correctly according to LASA drugs policy list. • First, researched proper drug storage guidelines in hospital. Then, reviewed the NABH guidebook to ensure medications are stored appropriately and available where needed. • Afterward, created a high-risk drug checklist.
Linking theory (Classroom learning) with practice at your organisation	• Able to link classroom learning with practical application. The theoretical knowledge gained in classroom, such as patient care protocols, and medical ethics, has been instrumental in helping me perform my duties effectively.
Gaps identified on the working area.	• Insufficient communication between staff. • Outdated equipment. • Lack of standardized procedure. • Inadequate documentation.

Suggestions for improvement	• Enhance the practices of documenting nurses' handover notes and doctors' notes in patient files.
Plan for the next week	• Work on the checklist of high-risk drugs. • Visit each ward to audit the storage of high-risk drugs in the central storage area, fridge, and crash carts.

Week no: 4

From: 20 May 2024 to 25 May 2024

Activity Done	• Conducted audits of critical care unit and ward of daily five patient files to ensure accuracy and completeness. • Completed till now 80 medication chart review checklists. • Incident site visit at ICU and CCU WARDS. • Visited each ward to audit the storage of high-risk drugs in the central storage area, fridge, and crash carts. • Work on the checklist of high-risk drugs in CCU, General wards and in pharmacy.
Linking theory (Classroom learning) with practice at your organisation	• Research methods module was helpful. • Swot analysis-learnt in POM class.
Gaps identified on the working area.	• This week no gaps were seen as per the work given to me
Suggestions for improvement	• Patient variability • Staff compliance • Data accuracy

Plan for the next week	• Work on the checklist of high-risk drugs storage in Ambulance, Cath lab, Radiology • Work on the checklist for internal audits. • Visit each ward to audit the clinical and non- clinical area • Incident site visit at ICU and CCU WARDS. • Work on the checklist of Hand Hygiene.

Week no: 5

From: 27 May 2024 to 01 June 2024

Activity Done	• Conducted audits of critical care unit and ward of daily five patient files to ensure accuracy and completeness. • Work on the checklist of high-risk drugs storage in Ambulance, critical care unit, General wards, OT, Casualty, Pharmacy. • Made the checklist of internal audits that are nutrition therapy and Blood bank/Transfusion services • Visit each ward to audit the clinical and non- clinical area
Linking theory (Classroom learning) with practice at your organisation	• Research methods module was helpful. • Swot analysis-learnt in POM class.
Gaps identified on the working area.	• This week no gaps were seen as per the work given to me
Suggestions for improvement	• Patient variability • Staff compliance • Data accuracy

Plan for the next week	• Make the checklist for internal audits like day care, Nursing • Visit each ward to audit the clinical and non- clinical area • Do the internal audits of nutrition therapy and Blood bank/Transfusion services

Week no: 6

From: 03 June 2024 to 08 June 2024

Activity Done	• Visited each ward to audit the clinical and non -clinical area • Made the checklist for internal audits like day care, nursing. • Done with the internal audits of nutrition therapy and Blood bank/Transfusion services.
Linking theory (Classroom learning) with practice at your organisation	• Facilitate hands on training • Case based learning
Gaps identified on the working area.	• This week no gaps were seen as per the work given to me
Suggestions for improvement	• Resource Allocation

	• Staff compliance
Plan for the next week	• Try to complete the clinical checklist making by this week • Do the internal audits of nursing care and day care. • Do medication checklist.

Week no: 7

From: 10 June 2024 to 15 June 2024

Activity Done	• Done with the internal audits of nursing care and day care. • Made the checklist of internal audits that are Dialysis unit, recovery room, ICU, NICU, PICU, HDU, Recover room, palliative care, special care wards and wards. • Visit each ward to audit the clinical and non- clinical area • Working on data collection and evidence for NABH audit in the hospital • Work on checklist of Hand hygiene in each wards including CCU.
Linking theory (Classroom learning) with practice at your organisation	• Research methods module was helpful. • Essential of hospital services- found link in quality chapter.
Gaps identified on the working area.	• Spill management • Lack of knowledge among staff about fire type and fire plan to be used in different situations

	• Not proper hand hygiene is done among staff, consultant, RMO and doctors
Suggestions for improvement	• Spill management • Staff compliance
Plan for the next week	• Trying to complete the clinical checklist making by this week. • Try to compile the 100-medication checklist

Week no: 8

From: 17 June 2024 to 22 June 2024

Activity Done	• Working on checklist of Hand hygiene in each ward. • Completed the clinical areas checklist making in this week. • Compiled the 100-medication checklist • Started making of non-clinical areas checklist
Linking theory (Classroom learning) with practice at your organisation	• Field visit • Join conferences and workshops • Guest lecture and seminars
Gaps identified on the working area.	• Not proper hand hygiene is done among staff, consultant, RMO and doctors

Suggestions for improvement	• Hand hygiene
Plan for the next week	• Trying to complete the non-clinical areas checklist making by this week. • Creating a report on Drug medication checklists According to Hospital Report Format. • Completing of Hand hygiene checklist.

Week no: 9

From: 24 June 2024 to 1 July 2024

Activity Done	• Completed Checklist of Hand hygiene in each ward. • Completed the non-clinical areas checklist making in this week. • Created a report and submitted on topic Drug medication checklists According to Hospital Report Format. • Created a report and submitted on topic High Risk Drug Checklists According to Hospital Report Format.
Linking theory (Classroom learning) with practice at your organisation	• The knowledge I gained in the classroom about the several hospital departments helped me to comprehend a variety of topics, including the roles and responsibilities of the staff members in those departments and how to participate in audits and ask questions.

Gaps identified on the working area.	• Staff are not much aware about the emergency codes • They are not trained properly for spill management
Suggestions for improvement	• Awareness about all the emergency codes • Spill management

Compiled Reporting Format

Name of the Organisation: Orange City Hospital & Research Institute

Area/ Department/ Project of Summer Internship Program: Quality Department

Name of the Student: Shruti Kondekar

Roll no: 1732 **Stream: Hospital and Health Management**

Activity Done	1. Medication Chart Review Checklist • To gain a deeper understanding of the medication chart review checklist, Readed the NABH guideline book and familiarized myself with the A to I errors of medication. • Following this, conducted an audit of the medication chart review checklist in the A wing ward, B wing ward, and CCU. • Over the course of one month, audited 100 patients' medication charts, reviewing 5 to 8 patients daily. • Compiled all the collected data into an Excel sheet, identified the medication errors, plotted the graph. • Created a report in the organization's format and submitted to organisation. 2. LASA Drug Checklist • To gain a comprehensive understanding of the NASA drug checklist, first thoroughly studied the articles related to Look-Alike Sound-Alike (LASA) drugs, which were provided by the head of the quality department. This foundational knowledge allowed me to grasp the critical aspects and implications of LASA drugs within medication management. • Took the initiative to prepare a detailed LASA drug checklist tailored to our specific needs. This checklist aimed to mitigate the risks associated with LASA drugs by ensuring accurate identification and handling of these medications. Once the checklist was finalized, I embarked on an extensive audit process. • The audit was conducted across various critical areas within the healthcare facility, including the A wing ward, B wing ward, and CCU. Additionally, I extended the audit to the pharmacy, casualty, operating theatre (OT), ambulance services, deluxe rooms, and the physiotherapy department. The objective was to ensure that the LASA drug checklist was implemented and adhered to uniformly across all relevant departments.

	• Over a period of 15 days, meticulously audited the LASA drug checklist, ensuring that all protocols were followed and identifying any discrepancies or areas of improvement. • After completing the audit, compiled all the collected data into an Excel sheet, meticulously organizing the information for thorough analysis. This allowed me to identify patterns and pinpoint specific areas where LASA drug errors were most prevalent. • With this data, plotted a graph to visually represent the frequency and distribution of errors. • Prepared a comprehensive report detailing the findings of the LASA drug checklist audit. The report included an analysis of the data, graphical representations of the error patterns, and specific recommendations for enhancing the accuracy and safety of LASA drug management. The report was formatted according to the organization's standards, ensuring clarity and coherence for all stakeholders involved. 3. Internal Audits: • To ensure thorough and effective internal audits for both clinical and non-clinical areas, I embarked on the task of creating a comprehensive checklist on clinical and non- clinical areas. • I audited several clinical areas, including physiotherapy, the operating theatre (OT), the nursing station, the dietician services, the blood bank and transfusion services, and the ambulance services. 4.Hand Hygiene Checklist: • I also audited the hand hygiene checklist in each ward, including the A wing ward, B wing ward, CCU, deluxe ward, and casualty. 5. MRD Audits: • Routine Audits: Performed daily audits in the Medical Records Department (MRD) to ensure accuracy and completeness of patient records, focusing on OT and ICU patients.
Linking theory (Classroom learning) with practice at your organisation	The internship activities were deeply intertwined with principles of management and organizational behaviour. Key aspects included: • Planning and Organizing • NABL and NABH Assessments: Required meticulous planning, organization, and attention to detail. • Project Management: Initiating and wrapping up projects such as tubing disconnection analysis and surgical safety checklist compliance involved detailed planning and strategic thinking. • Quality Management

	Internal Audits: The significance of quality management and ongoing improvement was underlined by carrying out internal audits and finding deficiencies. Incident Reporting and Investigations: Taking part in these processes strengthened knowledge about safety procedures and risk management. • Data Analysis and Critical Thinking
Gaps identified on the working area.	During my internship, the following gaps were identified: • Documentation ➢ Inconsistent Documentation: Disparities in departmental documentation procedures. • Staff Awareness ➢ Lack of Awareness: The significance of following safety checklists and other compliance standards was not completely understood by certain staff members. • Hand Hygiene ➢ Hand hygiene among the staff, nurses, Doctors and RMO was found to be inadequate. • Spill management ➢ Spill management among the staff was not adequate. ➢ The staff lacked proper knowledge about spill management.
Suggestions for improvement	To address the identified gaps, the following improvements are recommended: • Standardized Training Programs ➢ Training: Implement comprehensive training sessions to ensure consistent compliance with the spill management and hand hygiene • Equipment Maintenance ➢ Regular Equipment Maintenance: Ensure regular maintenance and timely availability of equipment to avoid delays. • Staff Awareness Campaigns ➢ Awareness Campaigns: Organise awareness campaigns to inform employees of the need of adhering to hand hygiene, Spill management, Emergency Codes and other regulations, emphasising the implications for patient safety and care quality.

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Signature of the Student

Shruti Kondekar

Approved by the IIHMR University's Mentor

Dr. Sandesh Kumar Sharma