

Summer Training

At

Fortis Hospital, Mohali

From 10th May 2021 to 2nd July 2021

A Report

By Dr Riddhi Jasrotia

MBA Hospital & Healthcare Management

2020-22



Organisation Certificate



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TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Dr. Riddhi Jasrotia** has completed her internship in "Medical Administration" and has worked on a Project "Gap analysis of MSOT and MyFortis doctor app" of Fortis Hospital Mohali from 10th May '21 to 2nd July '21.

She possesses a keen observation and incorporates herself with confidence.

We wish her success in her future endeavors and pursuit of her career goals.

For Fortis Hospital

Urvashi Kanwar

Manager - Learning & Development, Human Resource



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Fortis SPECIALITY Hospital

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Acronyms/Abbreviations

Acronym/Abbreviation	Full Form
FHM	Fortis Hospital Mohali
JCI	Joint Commission International
NABH	National Accreditation Board of Hospitals
MSOT	Multi Speciality Operation Theatre
OT	Operation Theatre
IPD	In patient department
OPD	Outpatient department
PAC	Pre Anaesthesia Check up
Pre OP	Pre Operative
Post OP	Post Operative
Cath Lab	Catheterization Laboratory
PCR	Pre Cath Lab Room
CCU	Critical Care Unit
ICU	Intensive Care Unit
DMAIC	Define, measure, analysis, improve, control
NPT	Non productive time
App	Application
PDA	Personal Digital Assistant

Observational Learning

Introduction



Fortis Healthcare was founded by Shivinder Mohan Singh and Malvinder Mohan Singh in 1996. Later it was owned by IHH Healthcare Berhad Company. It is one of the largest healthcare organizations in India with 36 healthcare facilities (including projects under development), 4000 Operational beds and over 400 diagnostics centers. Apart from India, it is also present in United Arab Emirates (UAE) & Sri Lanka.

The vision of the organization is aimed at Saving and adding value to other's lives and its mission is to become a healthcare organization which will be known around the globe for its patient care and clinical services.

Teamwork, ownership, patient centricity, innovation and integrity are some of the values of this organization.

Fortis Hospital Mohali (FHM) was established in the year 2001 in sector 62 Mohali, Punjab, India. It was the first Fortis Hospital to be established. It has been Internationally Accredited by Joint Commission International (JCI) since 2007(renewed for the 5th consecutive time in 2019) and is also the proud recipient of accreditation from National Accreditation Board of Hospitals (NABH), India (renewed for the 4th time in 2017) (1).

The hospital is divided into mainly four blocks – OPD, IPD, emergency and oncology with five floors and 348 Operational beds (159 ward beds divided between ward A1, A2, A3, A4 & A6 and 189 ICU beds) and 85 non census beds.

Mode Of Data Collection

The data was collected by directly observing the departments, on a day-to-day basis, asking open ended questions to the staff and noting down all the observations.

Department – Wise Observations

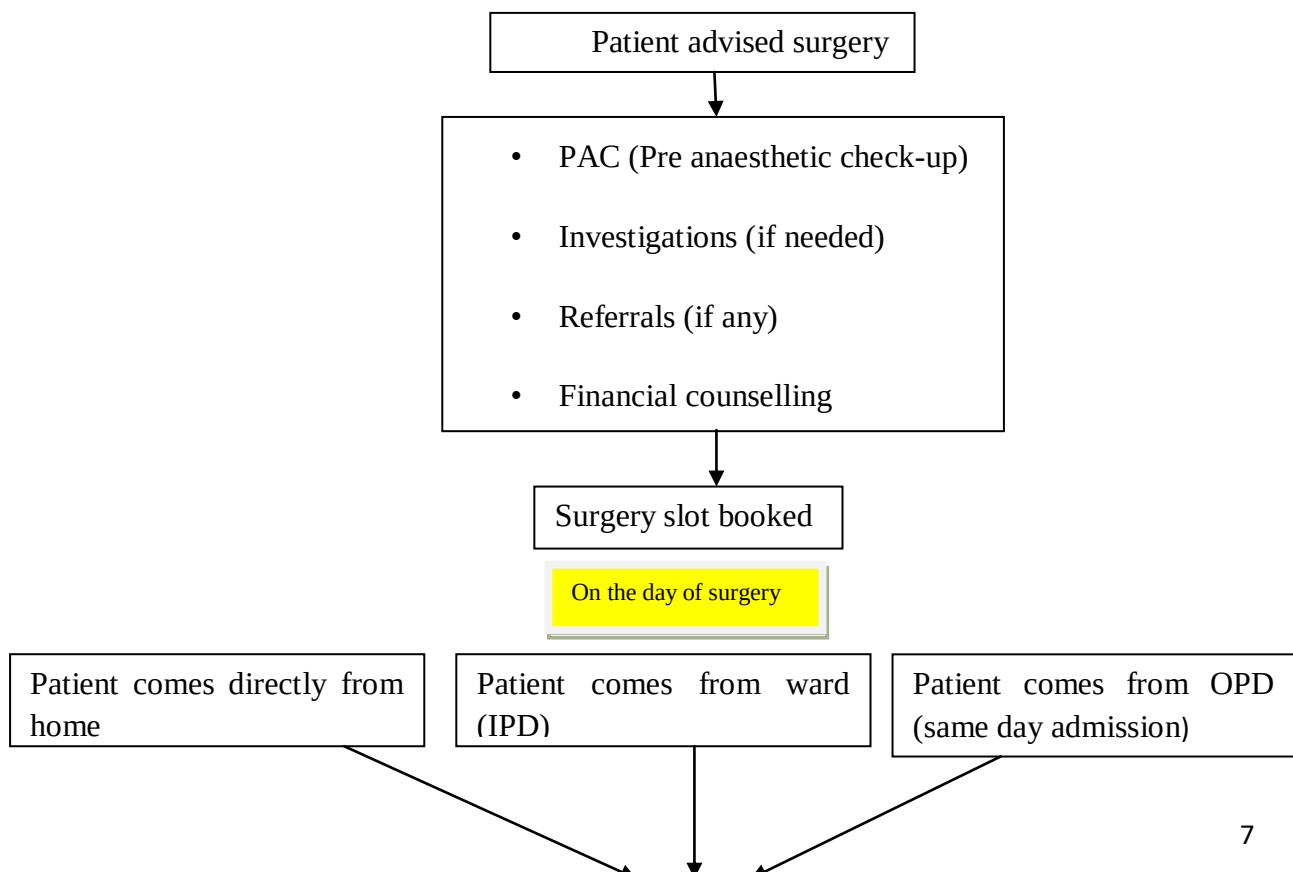
Multispeciality Operation Theatre (MSOT)

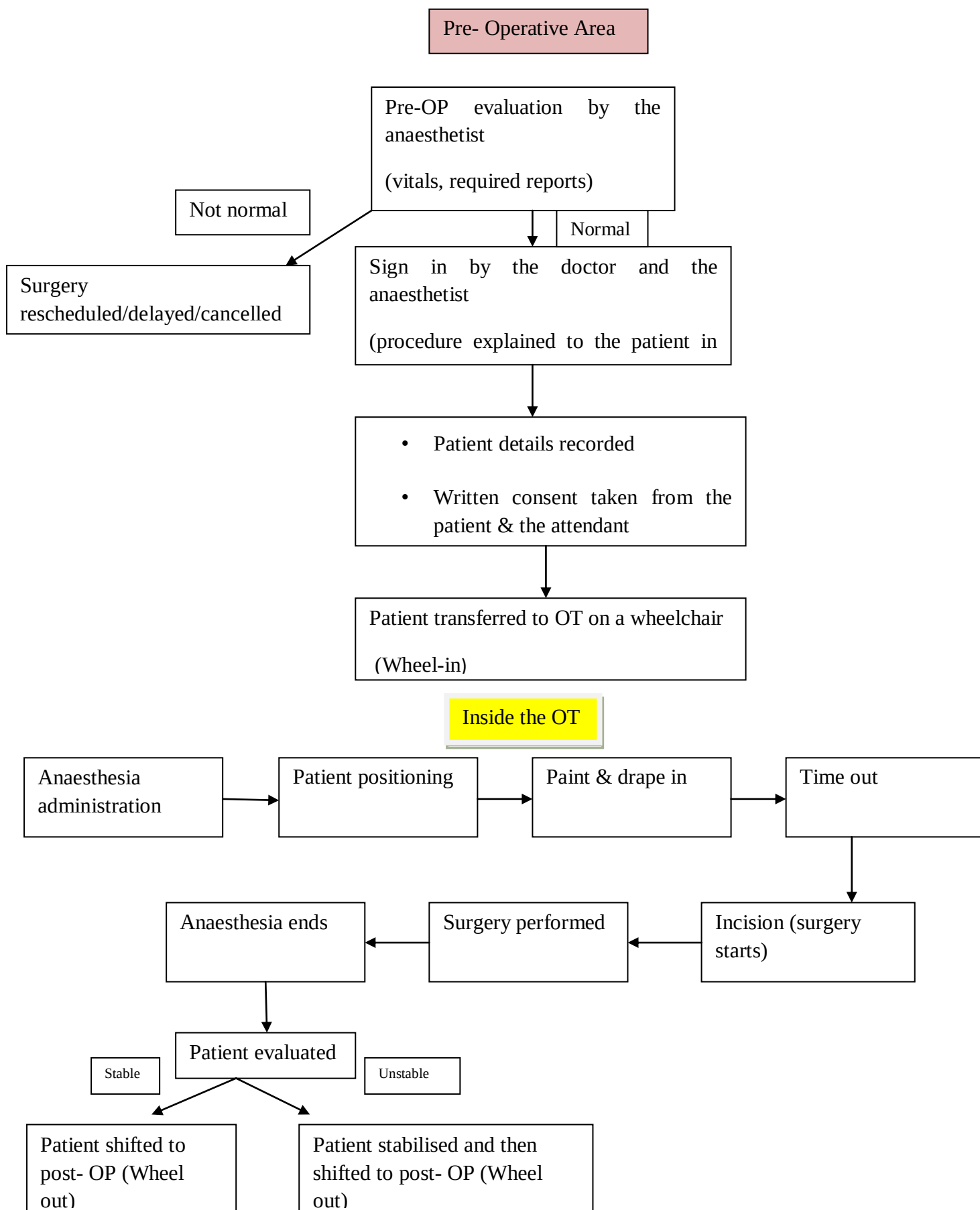
Situated on the first floor of the hospital, the MSOT complex consists of 9 Operation theatres (OTs), out of which 7 are being used for non-covid surgeries and 2 are reserved for surgeries of covid positive patients.

It has a pre-Operative area consisting of 10 beds, a post-Operative area which consists of 8 beds, a nursing staff of 35 nurses and 24 technicians.

The first surgery starts around 8-8:30 in the morning and about 22-23 surgeries are conducted every day in total i.e about 3-4 surgeries per Operation theatre per day.

The following is the process flow of patients to the OT:

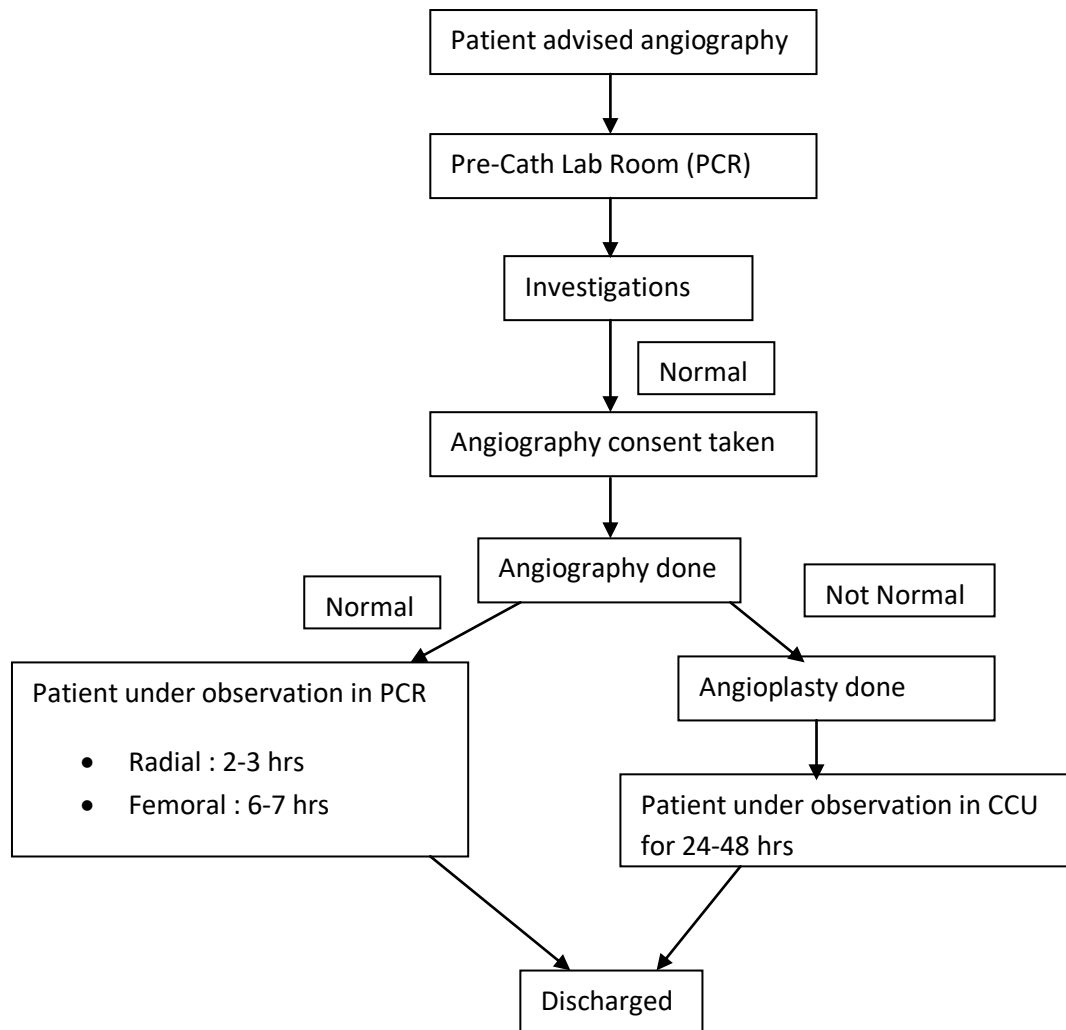




Catheterization Lab

Situated on the second floor of the hospital, the Cath Lab consists of 3 Catheterization lab (2 functional, 1 non-functional currently), 2 control rooms for the cath lab, a waiting area, a pre-cath lab room (PCR) and an inventory and sterilization room.

The following is the process flow of angiography patients in the lab:



Conclusion

The MSOT complex of the hospital runs smoothly but can be made more efficient if the staffs in the pre-OP area are increased and a little more organized.

The cath lab does not have a printed list of the patients to refer to, which makes it unorganized. One of the angiography rooms inside the cath lab was not working; it should be repaired to accommodate more patients in a day.

Project Report – 1: Gap Analysis of MSOT Complex

Introduction

The MSOT complex in the hospital conducts around 20-24 surgeries per day, but this can be increased easily if the gaps in the MSOT complex are addressed and worked upon.

In a study based on improving the quality of Operation theatres, R. Rohini et. al. used the define, measure, analysis, improve and control (DMAIC) technique of six sigma to improve the utilisation of Operation theatres(2).

After a careful review of a study published by Khushboo Gaur to reduce the non-productive time in the Operation theatre a tertiary care hospital, it was observed that dividing the non-productive time (NPT) into three parts and calculating the average non-productive time in each Operation theatre was a good way to quantify the observations recorded inside the theatres and will be very helpful in giving relevant recommendations(3).

A study based in a 1000 bedded tertiary care hospital on Operation theatre utilization and most common causes that lead to delays, highlighted the fact that with proper communication and utilisation of resources, the time wasted at the starting of each surgery can be saved which can lead to better utilization of Operation theatres(4).

Another study suggesting better utilization of Operation theatre(5) and another one based on better time utilization in the Operating rooms of a teaching hospital(6), both of them concluded that by recording the time spent on each step, knowing the scheduled time of the surgery and recording the reasons for the delays, the utilization of the theatres can be increased largely.

In a retrospective study done by Dr. Mekela Jaya Krishna in 2017, it is seen that the utilization of operation theatres is optimum i.e. 85%, although long waiting lists can be cut short by recruiting more professionals, adding more OT tables and allocating more budget to OT complex (7).

In a study by N. Lakshmi Bhaskar, the utilization of OTs is found to be around 72.51% , which is optimum and it is seen that most of the hours were scheduled for elective surgeries while unscheduled hours were used for emergency surgeries(8).

In another study based on operation theatres, it is found that the operating time which is allotted, is 91.5% utilised. The major reasons for cancellation of surgeries are insufficient operating time and performing emergency surgeries during the time allotted for elective procedures(9).

In a study conducted by Garg et. al. to find out the reasons for cancellation of scheduled surgeries, most of the reasons were attributable to the lack of time of theatre utilization, some medical reasons and some last-minute changes in planning by the surgeons. It is concluded that all of these reasons can be avoided by proper planning and coordination between the operation theatre team(10).

Rationale: Operation theatre complex is the core of any hospital. It is the most expensive department in terms of equipping, staffing and maintaining. It constitutes major capital cost in any hospital and hence, it must be used effectively and productively, to do justice to its cost. To achieve maximum utilization of OTs, it is essential to coordinate activities and personnel.

In order to determine the gaps in the utilization of Operation theatre, we must first determine where there is time wastage which leads to underutilization of Operation theatres. One way of determining this is to calculate the non-productive time during each surgery. Also, a delayed start time gives a clear indication of the time that is being wasted in the beginning of the surgery and which can be utilized in a better way.

Research question: What are the gaps present in the utilization of Multi Speciality Operation Theatres in Fortis Hospital, Mohali?

General Objective: To observe day to day functioning of MSOTs in Fortis Hospital Mohali, identifying the gaps present and giving recommendations for the same.

Specific Objectives

- To observe the functioning of pre-Operative area of MSOTs
- To identify the gaps present in MSOTs
- To give recommendations to improve the functioning of MSOTs

Methods & materials

All the relevant OT processes in the MSOT complex consisting of 7 functioning, non-covid OTs, a pre-OP area consisting of 10 beds and a post OP area consisting of 8 beds, were observed for a period of 3 weeks. The observations were made on all working days, except Sundays, and for elective surgeries only. The first surgery in every OT usually started around 8:30 am.

Research design: This is a cross sectional study conducted in Fortis Hospital, Mohali.

Sample Size: 21 patients admitted in MSOT for surgery.

Sampling Technique: Purposive Sampling

Study Period: From 20th May to 7th June, 2021

Mode of data collection: The observations were made on all working days, except Sundays, from 8 am to 4 pm.

Steps taken into consideration while observation:

The following steps were observed and the time at each of them was noted down, along with the reasons for any delays:

- Patient brought/came into pre op
- Sign in by the surgeon and anaesthetist
- Wheel in (patient shifted to OT)
- Start of administration of anaesthesia
- Patient positioning
- Paint & Draping

- Time out
- Incision/surgery start time
- Surgery end time
- Anaesthesia end time
- Wheel out (patient shifted to post op)

Data compilation, analysis and interpretation

The following parameters were calculated using the information available by observing:

- Delayed start time: The difference between the planned start time and the actual wheel-in time was noted down in each surgery (wherever present) and the reasons for the same were noted down
- Non-Productive time (NPT)1: From wheel in to start of anaesthesia
- NPT 2: From paint & drape completion/ patient positioning to incision
- NPT 3: From end of anaesthesia to wheel out

The scheduled time of the surgery was also noted down and the most common reasons for any delay from the schedule were observed

Analysis was done using MS Excel.

Result: Out of the 21 cases observed, the following 16 cases had a delayed start time.

Table 1.1: Surgeries that had a delayed start time

Surgery name	Pre-op	Sign-In	Wheel-In	Planned start time	Wheel out	Planned end time	Delayed start
Lap Chloe	10:40	11:31	12:35	11:00	14:12	13:00	01:35
TLH	11:50	12:18	12:24	11:00	15:05	14:00	01:24
Hysteroscopy &	14:35	15:20	15:40	14:30	17:30	16:30	01:10

Polypectomy							
VP Shunt	07:00	09:06	09:11	08:30	10:40	12:30	00:41
Left Laproscopic Donor Nephrectomy	07:15	08:20	09:11	08:30	13:55	14:30	00:41
Feeding Jujenostomy	*	08:40	09:10	08:30	10:31	10:30	00:40
Hysteroscopy	09:30	10:05	10:35	10:00	11:40	11:30	00:35
FESS	07:30	08:55	09:05	08:30	11:15	10:30	00:35
Lap Chloe	09:30	10:45	11:03	10:30	13:20	12:30	00:30
Laser TURP	09:15	10:25	10:30	10:00	*	12:30	00:30
Robotic Radical Hysterectomy	08:00	08:15	09:30	09:00	13:50	14:00	00:30
Laser TURP	09:15	10:25	10:30	10:00	*	12:30	00:30
LSCS	08:00	08:55	08:55	08:30	10:42	11:30	00:21
Colposcopy	08:00	08:35	08:51	08:30	10:15	10:30	00:21
RIRS	11:02	11:07	11:20	11:00	12:53	13:00	00:20
Cervical Encirclage	08:00	08:20	08:45	08:30	10:20	11:00	00:15

* Time not recorded due to unforeseeable circumstances

On an average, each surgery was delayed by 39 minutes. There were various reasons for the delay, the most common ones were:

- Patient arriving late in the pre-OP area/ brought late from the IPD
- Delays in sending the admission papers to MSOT from IPD
- Patient's attendant is not present in the pre-OP area to sign the consent for surgery – time wasted in waiting for the attendant
- Nursing staff unavailable in the pre-OP area to shift the patient to OT
- OT team unavailable
- OT not ready for surgery
- Anaesthesia team unavailable in pre-OP area to sign in on patient's file

- Surgeon arrives late, results in delayed sign in
- Miscellaneous reasons/ Motion wastage

Non-Productive Time (NPT)

Out of the 21 cases observed, the following 19 cases had a non-productive time of more than 10 minutes.

Table 1.2: Surgeries that had a NPT of more than 10 minutes.

SURGERY NAME	NPT 1	NPT 2	NPT 3
Right leg debridement	00:41	00:02	00:15
Chemoport Insertion	00:14	00:01	00:10
LSCS	00:28	00:07	00:10
Hysteroscopy	00:08	00:03	00:05
RIRS- Stage 1(D) stenting	00:11	00:04	00:08
FESS	00:28	00:16	00:08
Lap Chloe	00:13	00:05	00:07
TLH	00:08	00:30	00:05
D & C	00:15	00:27	00:10
V P Shunt	00:06	00:07	00:05
Laser TURP	00:34	00:16	00:00
LSCS	00:13	00:03	00:12
Parathyroidectomy+ FS	00:16	00:03	00:05
Lt Lap Donor Nephrectomy	00:12	*	*
Robotic Radical Hysterectomy	*	00:27	00:10
Colposcopy+Biopsy of cervix+DC+ polypectomy+ biopsy of endometrium	00:08	00:09	00:10

Lap Chloe	00:09	00:04	*
Feeding jujenostomy	00:09	00:02	00:09
Cervical Encirclage	00:15	01:01	00:05
Lap Chloe	00:10	00:05	00:05
TOTAL AVG NPT	00:35		

* There was no NPT to be recorded

Analysis: Average non-productive time was calculated by considering NPT1, 2 and 3 per surgery.

Result: On an average, each surgery had a non-productive time of 35 minutes inside the operation theatre. The most common reasons for the same were:

- Surgeon is busy on rounds or in OPD, hence, not available on scheduled time, for the surgery
- Surgeon is called inside the OT, after painting & draping of the patient is done. The surgeons arrive and then scrubs, which leads to an increase in the non-productive time
- General Duty Assistant unavailable in OT after the completion of surgery to shift the patient from OT to post OP area.

General Gaps present in MSOT

- Surgery delayed as suction/ debrider stopped working mid surgery
- Time out not done in many surgeries
- No staff available at IPD's entrance (in hospital) to guide the patient/attendant or to give directions to OT (especially early morning)

Conclusion & Recommendations

Conclusion

The study was conducted in Fortis Hospital, Mohali, which is the first Fortis Hospitals that was established. The objective of this study was to observe and analyse any gaps that were present in MSOT complex, situated on the first floor of the hospital and give recommendations for the same. The study was conducted by directly observing 21 patients from pre-OP area, all the way to the post OP area, any delays and reasons for the delays in surgeries were noted down, general gaps present in MSOTs were observed, time wastage was calculated by dividing it into two parts: Delayed start time and non-productive time and recommendations were given for the same to the management and the OT committee of the hospital.

It was found that average delayed start of surgery was 39 minutes in each surgery and an 35 minutes was average non-productive time inside the OT in each surgery. Some other general gaps observed in the MSOT were:

- Surgery delayed as suction/ debrider stopped working mid surgery
- Time out not done in many surgeries
- No staff available at IPD's entrance (in hospital) to guide the patient/attendant or to give directions to OT (especially early morning)

Recommendations

The recommendations were given keeping the reasons of the delay in mind and based on the fact that if time is saved in the beginning of any surgery and the surgery is conducted as per schedule, it can lead to better utilisation of MSOT. The non-productive time per surgery gives us a fair idea of how much time can be saved in each surgery on an average, so that more surgeries can be scheduled and completed in a day.

Few Recommendations are:

- Patient should be explained the importance of arriving on time with all the required documents during slot booking (Delay in one surgery can lead to delay in subsequent surgeries)
- At least one attendant of the patient should be informed to stay until the patient is wheeled inside the OT.
- Any delays due to the staff (IPD/surgeons/anaesthetist) should be recorded along with the reasons to help the OT to be more efficient in future
- Surgeons should be called before beginning paint & drape/ positioning to accommodate scrub time with that.
- One GDA should be allotted the duty of shifting the patient from OT to post OP everyday to avoid increase in NPT
- Time out must be done in every surgery
- Signage/Map to OT should be put on IPD/OPD's entrance to save time
- All technical instruments (suction, debrider etc) should be checked at the start/end of the day for their functioning
- A Lay-up room can be set up for laying of sterile trolleys which can be brought prepared inside the OTs to save NPT.

Project Report -2: Gap Analysis of My Fortis Doctor App

Introduction

The hospital already had an application named My Fortis, which was running smoothly and was liked equally by the consultants as well as the patients. The organization had to break up with the previous partner and wanted to launch a new app with add on features to comply with the ever-changing environment and hence this new app was launched. The previous app was made dysfunctional as soon as the new app was launched and integrated with the hospital information system.

This new app was launched in the first phase, with very minimal features when the study was conducted.

The research paper, written by C. Lee Ventola in 2014 on the benefits of mobile devices and apps for healthcare professionals explains how healthcare apps have transformed the lives of Healthcare professionals (HCPs). The paper gives clear distinction between the remote devices that were used to maintain records by the healthcare professionals and the current healthcare apps. It talks about how the apps are helpful in information gathering and management, communication, patient and health record management along with being convenient to use, more efficient, accurate and productive(11).

A study based on mobile apps demonstrates the kind of healthcare apps that are downloaded more widely and encourages the use of health care apps to improve patient care(12).

Since the Health care providers are able to download medical apps on the mobiles, it has opened several opportunities for a lot of clinical resources being made available via apps(13).

Medical apps have many uses like they can help simulate the surgical procedures, help in prescribing drugs online, help in diagnosis and treatment of patients, online learning, billing etc (14).

Most of the apps are not meant to replace the web portal, but rather complement it to make things easier for everyone (15).

In a study, it was concluded that people mostly prefer downloading a free app rather than a paid one, initially but will readily do the in-app payments and paid upgrades, if required later on. Some of the apps are provided with all the features free of cost, while others have a limited features in the free service and require a payment for the other features. Many of the renowned medical books and journals can be purchased at a subscription fee on some apps. Some medical apps may cost a lot initially, but can become cost effective after certain updates (16).

In another study it was seen that although interns and residents were provided with fully functional personal digital assistants (PDA) software applications, still there was under utilisation seen. More steps should be taken to increase awareness and facilitate their use(17).

It was seen in another study that healthcare students had a positive attitude towards PDA and it is a valuable tool for everyone(18).

Rationale: Mobile communication and growing computation are combined in the form of smart phones and their users are increasing exponentially, including people in the healthcare field. There is hardly any person these days without a smart phone.

Applications or mobile apps are programs that are developed to run on a computer/tablet/mobile/laptop to accomplish a given task easily. Nevertheless, some healthcare providers are still reluctant to use them(19).

Mobile based applications and web portals are the need of the hour in the healthcare sector, especially after Covid-19. The stationary computers which have been used since decades, do not provide mobility, such vast variety of features or all information at the tips of fingers. Mobile based applications not only make the handling and maintenance of patient records easier, it also helps in better communication, increases efficiency and productivity, helps save a lot of time and energy, patient monitoring, clinical decision making, consulting, better information gathering and referencing.

Despite all the benefits that the apps offer, they need to be ethical and standards should be set to keep a check on their validation and to ensure their proper usage(20).

The study was expected to find out the limitation present in the new application so that they can be corrected for smooth functioning of the app.

Research question: What is the view/opinion of consultants (doctors) of Fortis Hospital, Mohali on the new My Fortis Doctor App that was launched?

General objective: To know the opinion of consultants (doctors) on the new My Fortis Doctor web portal and mobile application that had been launched for their use.

Specific Objectives

- To learn the functioning of the new My Fortis Doctor web portal and mobile application by attending online and offline meetings
- To coordinate with the IT, Marketing and OPD staff to form a team to visit the consultants and take their feedback
- To ask the consultants for their views/opinions and record the same
- To analyse the feedback given by the consultants and give recommendations for betterment of the app

Methods and materials

Primary data was collected from 30 consultants (doctors) by conducting face to face interview and asking open ended questions.

Research design: This is a qualitative study conducted in Fortis Hospital, Mohali.

Sample Size: 30 consultants (doctors) of the hospital

Sampling Technique: Purposive Sampling. The consultants were chosen based on their availability to answer the questions.

Study Period: From 8th June to 22nd June 2021

Mode of data collection: Face to face interview with consultants

The responses were collected and sent to the relevant department to look into.

Following are some of the questions that were asked:

- Are you aware about the new My Fortis Doctor App that has been launched?
- If yes, have you downloaded the app?
- Did you face any problem while downloading it?
- Are you facing any issues with the app?
- Are there any features you want to see in the update?

Data Compilation, Analysis and Interpretation

The responses were received from 30 consultants by asking open ended questions to know about their views and feedback about the application and the web browser. These responses were then analysed by grouping the similar kinds together and then segregated on the basis of the departments they were concerned with. The key findings are given in tabular form.

Result:

Table 2.1: The gaps present in the app along with the number of consultants facing them and the departments they were concerned with

Gaps	Number of consultants facing this issue	Department
Not able to edit patient details.	30	Call Centre
Not able to reschedule appointment with Doctor on the app	30	Call Centre
Not able to see previous appointment	30	OPD
An error message flashing on the	15	IT

screen after/ before logging in		
The app self logs out after logging in	14	IT
A message containing 'please wait' flashing on the screen 4-5 times before opening anything	10	IT
Appointments not shown in the correct sequence	18	IT, OPD
Mobile numbers, UHIDs of the patients unavailable	30	IT
Font size too small	05	IT
Scheduling for doctors unavailable	30	Call Centre
Unable to separately view the physical patients and teleconsultation patients' list on the app	25	IT, Call Centre
Doctors cannot see the status of the patient via app (has arrived/is late/ not arrived/ is waiting)	30	OPD
Unable to mark the patient as attended/unattended/not-arrived on the app	30	Call Centre

Conclusion & Recommendations

Conclusion

The study was aimed at analysing the gaps present in the newly launched My Fortis Doctor App and web portal by directly interviewing the consultants. The feedback was then sent to the relevant departments and their responses were recorded.

The app was just launched in its first phase with very limited features and still had many technical glitches and issues. It was launched with an objective to make things easier for the consultants as well as the patients and was expected to run smoothly with more features, but the experience of the consultants was not delightful at all. The previous app was made dysfunctional as soon as this app was launched, and it was integrated with HIS as well and the consultants had no choice but to use this app.

Recommendations:

- The app should have been launched after conducting a proper trial run, to rule out most of the technical glitches.
- A trial team of consultants should have been made to use the app initially, to get their views on it and make the changes accordingly, before launching it for everyone's use
- The team involved in the designing and development of the app should have taken suggestions from a few consultants to understand things from their perspective as ultimately the app was made to help consultants.

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Annexure

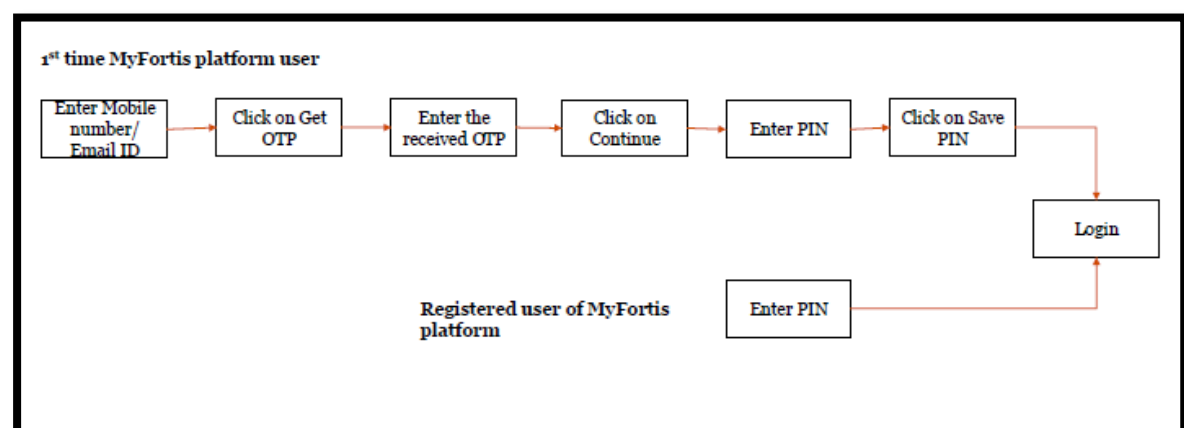
MSOT

Observations in each surgery
Patient's attendant was late; waited for the attendant before signing and wheeling in the patient. Patient was passing stool, hence surgeon was called in late.
Patient was taken to vascular OT instead of OT-6 (as planned previously) to save time as vascular OT was already clean & ready
Patient brought in pre-OP area at 14:35pm although surgery was scheduled from 14:30pm (Motion wastage). OT team was unavailable after patient was brought in pre-OP, hence, delayed sign-in
10 minutes wasted as no GDA was available to transfer the patient from OT table to gurney and shift to post-OP
Sign-in delayed as admission papers had not arrived in pre-OP from IPD because the patient was insured but insurance was denied and hence the patient was paying herself. 2 minutes wasted after the arrival of surgeon to get the required instruments asked by her and sterilising them.
Motion wastage from 11:07 am to 11:19 am (no one available to shift the patient from pre OP to OT). Patient's hair from hand had to be removed after taking inside the OT, for insertion of cannula (2 minutes wasted in this). No male nursing staff/GDA available in OT to seat the patient for SA (2 minutes wasted). Surgeon did not scrub in till 11:55 am although surgery was scheduled from 11 to 1. Time wasted in bringing in equipments required for the surgery from the other OT after administration of Anesthesia.
Patient called in early and made to wait for more than an hour in pre-OP. Patient's attendant's signature missing in certain forms, hence further delay in wheeling in of the patient. Assistant surgeon scrubbed in at 10:15 am, asked for debrider or suction; debrider was not working so suction brought in after 10 minutes.
No OT or anesthetist was free till 11:15 am so sign in was delayed. Set of instruments required for the surgery were sent to Covid OT and then to autoclave. They returned from autoclave by 12:30 pm, so the patient was wheeled in at 12:35 (although surgery was scheduled from 11 am)
The surgery was scheduled from 11 am; patient reported in IPD at 11:15 am and was sent to pre-OP at 11:35. Patient was made to wait in pre-OP till 12:20 pm. Surgeon was called in at 13:25 pm; came in at 13:40 (camera was not ready for the surgery & surgeon was not free)

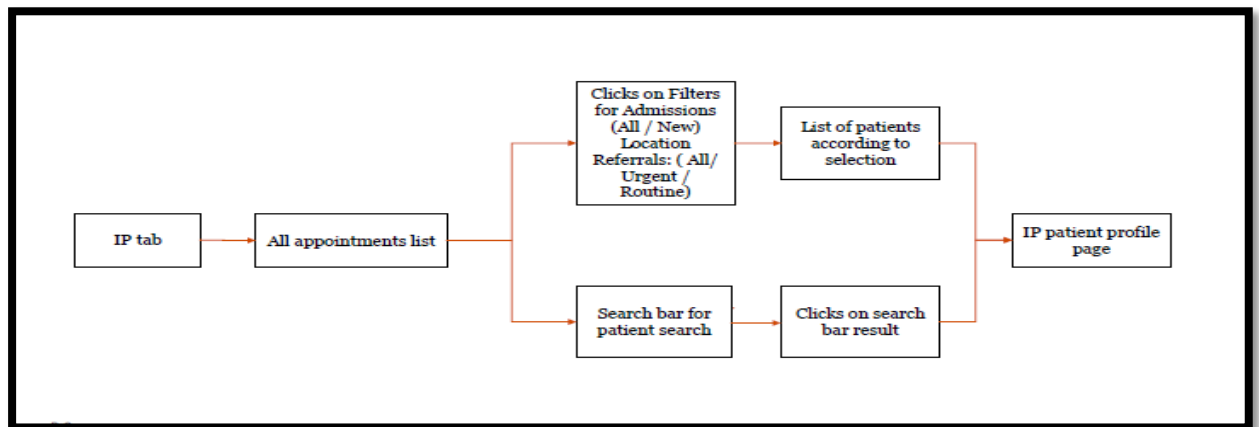
Patient came late from home to pre-OP. After wheel-in, patient not shifted to OT table as there was some confusion about switching OT table with another OT (5 minutes wasted). No GDA was available to help position the patient (2 minutes wasted). Surgeon was busy with rounds; came inside OT at 12:13 (was called at 11:45). Surgeon asked for gentamycin and saline after starting; they were brought in after that (10 minutes wasted)
Surgeon arrived at 9:05 am; patient's head shaved off in OT (2-3 mins wasted)
Anesthetist called in at 10:57 after preparing the site of anesthesia by assistant anesthetist. Anesthetist came in at 11:03 m; surgeon walked in at 11:33 am
Patient came in the hospital at 6 am
Surgeon walked in at 12:05 (waited for the surgeon to check position and then started paint & drape)
Surgeon signed in but forgot to take covid consent, which led to delay.
OT was not ready, surgeon called in at 10:50; came at 11:05 am (was in OPD)
Surgeon came in pre-OP at 10:42 am (some investigations were not conducted beforehand); surgery was paused for 12 mins as suction was not working
Patient's attendant not present in the pre OP area; consent had to be taken on call as attendant was not in the hospital

My Fortis Doctor Application

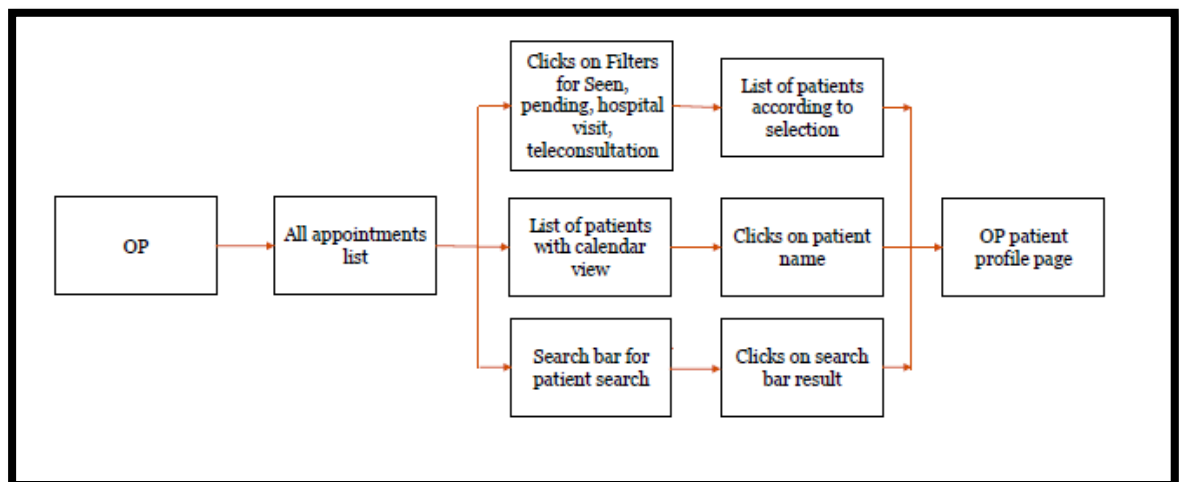
Steps for doctors' login



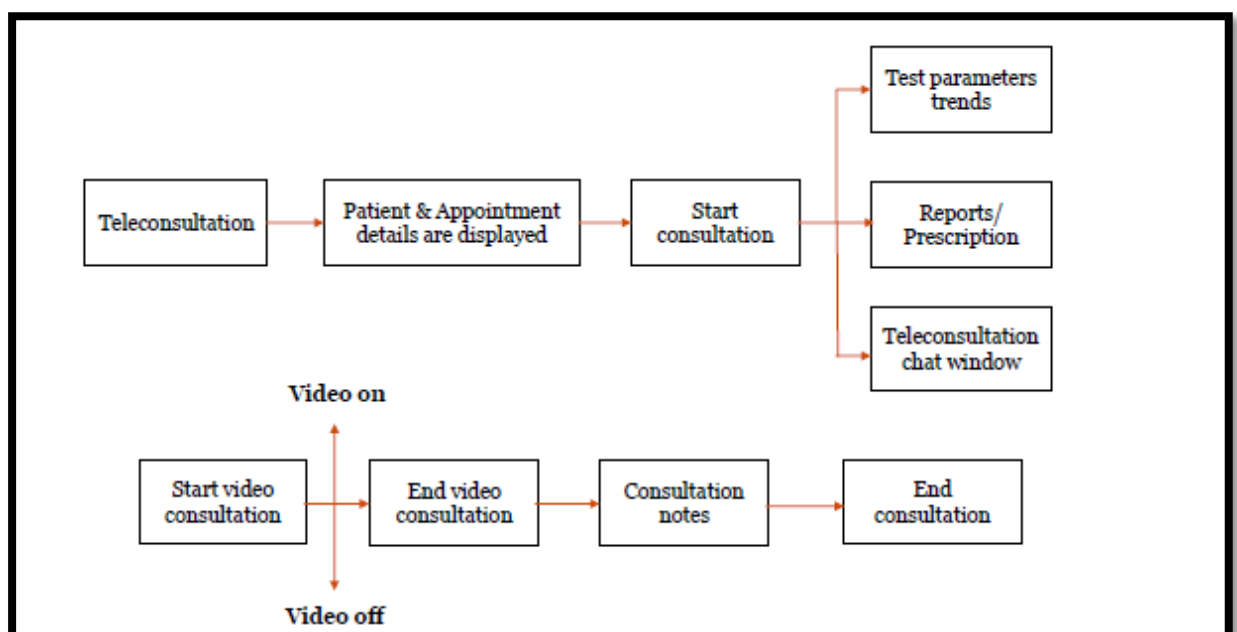
Steps to view full list of scheduled in-patients (IP) for the day



Steps to view full list of scheduled out patients (OP) for the day



Tele Consultation flow:



Sr. No.	Name of the department	Interacted with (name & designation)
1.	Medical Administration	Dr. Bhavna Ahuja (Medical Superintendent)
1.	OPD	Dr. Ajninder Kaur (OPD head), Reena Thakur (Manager)
2.	MSOT	Dr. Amit Kumar (OT head, anaesthesia director), Dr Harinder Sidhu (OT incharge), Dr. Pooja Dogra (OT Manager), Raj Kaur (head nurse)
3.	Cath Lab	Dr. Satish Singh (Medical Coordinator)
4.	Clinical Research	Mr. Piyush Ahuja (Clinical research & ED coordinator)
5.	Medical Record Room	Mr. Naresh Kumar
6.	Clinical Pharmacology	Mr. Ashwini Sharma
7.	IPD	