SUMMER INTERNSHIP PROGRAM

At

SANTOKBA DURLABHJI MEMORIAL HOSPITAL, JAIPUR

From 12th May 2025 to 21st July 2025

A REPORT BY

STUTI BHARGAVA

Master of Business Administration

Health & Hospital Management

Roll no. - 2099

2024-26

under the Mentorship of

DR. MAMTA CHAUHAN

IIHMR UNIVERSITY

Santokba Durlabhji Memorial Hospital
cum Medical Research Institute

sdmh
the hospital that cares
Bhawani Singh Marg, Jaipur-302015

Our Ref. :
No. 1524

Date.....
21.07.2025

TO WHOMSOEVER IT MAY CONCERN

This certificate is awarded to Ms. Dr. Stuti Bhargava in recognition of having successfully completed her Internship 2025 in the Quality Department of this hospital for the period from 12.05.2025 to 21.07.2025

During the period of her internship programme with us she was found to be punctual, hardworking, and a keen learner.

We wish her all the best for her future endeavors.

Dr. Kriti Tambi
Head-Quality

Santokba Durlabhji Memorial Hospital
Bhawani Singh Marg, Bapu Nagar
JAIPUR Rajasthan-302015 INDIA

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that Dr. Stuti Bhargava of academic year 2024-26 of Institute of Health Management Research has prepared a poster with respect to her summer internship held during May-July 2025.

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

Date:25.07.25

(Signature of Faculty Mentor)

Dr. Mamta Chauhan

Professor

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Evaluating the Accuracy and Completeness of Inpatient Medical Records: A Medical Audit at SDMH

Brief History & Description About the organization-

SDMH Jaipur was founded by Padma Shri Khailshankar Durlabhji in 1971 in memory of his mother. It is the first private multispecialty hospital of Rajasthan and a non-profit charitable trust. The Prime Minister, Smt. Indira Gandhi, inaugurated the hospital and initially catered to the Armed Forces during the Indo-Pak war. With 525 beds, SDMH provides tertiary level care and stands for excellence in diagnostics, surgery and critical care. It also operates some philanthropic ventures such as Avedna Ashram ,Limb Fitting Centre and Project Prayatna and has one of the finest blood banks in the nation. The hospital is committed to delivering ethical, low-cost and humane health care to everyone

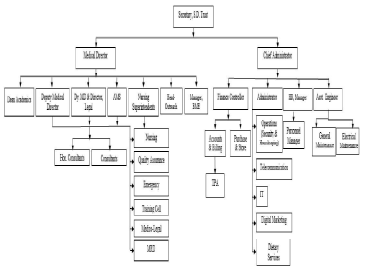
Vision

SDMH shall be an integrated quaternary healthcare hub for delivery of affordable quality medical care in an economically viable, regionally, nationally and internationally positioned institutional environment.

Mission

SDMH Is committed to providing high quality healthcare at most affordable rates, ensuring that all sections of society regardless of caste, creed or color have access to compassionate care. We dedicate our energy and efforts to making this a reality keeping the well.

Organizational Structure



SWOT Analysis

S Strength	1. Not-for-profit tertiary care hospital committed to quality healthcare. 2. Trusted healthcare provider with over 50 years of service. 3. Top blood bank serving Rajasthan and neighbouring states. 4. NABH accredited; listed among World's Best Hospitals 2024. 5.Experienced senior doctors and skilled clinical teams ensure high quality patient care.
W Weakness	1. Limited digitization; manual paperwork still common. 2. Occasional delays in discharge processing. 3. Feedback scanner difficult for elderly or illiterate patients. 4. Irregular housekeeping with poor record-keeping. 5. Some nurses struggle with digital tools, causes delays.
0 Opportunities	1.Technological upgradation. 2.Expanding medical tourism. 3.Digital Health Expansion supports continuity of care beyond hospital visits.
T Threats	1. Rising competition from other private hospitals. 2.Aggressive Marketing by other hospitals. 3.Retention of skilled healthcare professionals. 4.Advanced infrastructure available in other hospitals.

Aim

To measure and compare the accuracy and completeness of inpatient medical records in different wards, rooms and ICUs of SDMH through a structured quality audit.

Objectives-

1.To assess adherence to documentation standards in inpatient medical records across wards, rooms, and ICUs.
2. To evaluate the overall level of compliance in record-keeping practices at SDMH.
3. To identify the specific areas in documentation that frequently show non-compliance.
4.To compare trends of compliance at wards, rooms and ICUs using pre-defined parameters.

Methodology

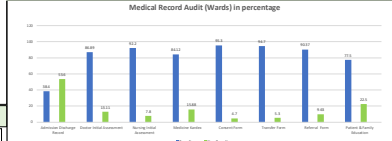
1. Study Design:
A cross-sectional observational study of inpatient medical records in wards,private rooms and ICUs of Santokba Durlabhji Memorial Hospital (SDMH), Jaipur was carried out
2. Sample Size:
Wards: 75 patient files
Rooms: 50 patient files
ICUs: 50 patient files
Simple random sampling was used to include files to avoid bias in representation of medical records.
3. Audit Tool:
The documentation in every file was evaluated with a structured checklist consisting of 31 parameters. Of these, 24 parameters were identified as largely consistent across settings. Thus, the focus was placed on 8 parameters that showed frequent non-compliance and could be particularly important to the accuracy and completeness of the record.These include:

- Admission & Discharge Record
- Doctor's Initial Assessment
- Nursing Initial Assessment
- Consent Forms
- Medication Kardex
- Transfer Forms
- Referral Forms
- Patient & Family Education

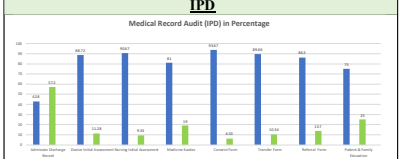
5. Data Collection:
Each file was manually reviewed, and scores were recorded as compliance or non-compliance based on checklist parameters.
6. Data Analysis:

- Non-compliance/compliance percentages were calculated for each of the 8 selected parameters.
- Comparative graphs were created to analyze trends across wards, rooms, and ICUs.
- Key areas of documentation gaps were identified for further quality improvement.

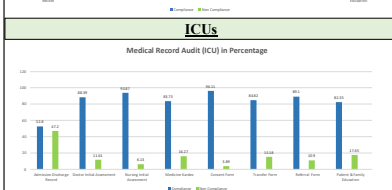
Wards



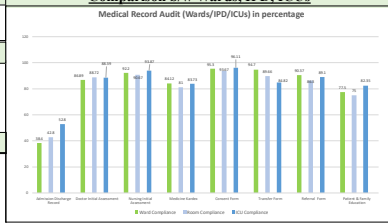
IPD



ICUs



Comparison b/w Wards, IPD, ICUs



	Ward Compliance	Room Compliance	ICU Compliance
Admission Discharge Record	38.4	42.8	52.8
Doctor Initial Assessment	86.89	88.72	88.39
Nursing Initial Assessment	92.2	90.67	93.87
Medicine Kardex	84.12	81	83.73
Consent Form	95.3	93.67	96.11
Transfer Form	94.7	89.66	84.82
Referral Form	90.37	86.3	89.1
Patient & Family Education	77.5	75	82.35

Key observations-

1.Admission & Discharge Record has the lowest compliance. This is the most critical gap area across all settings.
2.**Consent Form** shows highest compliance.
3.**Other Parameters** are mostly above **80–90%**, but still shows a need for improvement, especially in wards and rooms.
4. ICUs generally performed better in most parameters, showing higher consistency in documentation.
5. Non-Compliant Areas & Suggested Improvements-

Parameter	Lowest Compliant Area	Possible Reasons	Suggestions for Improvement
Admission & Discharge	Wards (38.4%)	Manual entry delays, workload, lack of real-time updates during patient transfer	• Staff training, introduce a checklist or reminder for completing this section during admission/discharge. • Implement a cross-verification system by the nursing incharge.
Medicine Kardex	Rooms (81%)	medication changes not recorded, in some files verbal order not signed, drug sensitivity test not completely recorded.	• Reinforce double-checking after every shift change, • Ensure timely signature of verbal orders by doctors .
Transfer Form	ICUs (84.82%)	Urgency in patient shift, incomplete handover	• Use pre-printed formats, checklist before transfer
Patient & Family Education	Rooms (75%)	In most cases entries were completed by the dietician and nursing staff while documentation by the doctor was often missing in some files.	• Regular awareness for nurses/doctors about the importance of educating patients and families, conduct random checks and counselling sessions to improve compliance
Referral Form	Rooms (86.3%)	Referral not always documented or signed	• Make it mandatory in workflow

Challenges Faced During Internship :

1.In some files, only a curvy line was present instead of a proper signature or name. This lead to confusion about whether it should be marked as compliance or non-compliance.
2.Adjusting to hospital routines and aligning with staff schedules for effective data collection.

Major Learnings During Internship

1.Gained hands-on experience in clinical documentation standards and audit procedures.
2. Acquired the ability to review patient records and detected inconsistencies.
3.Understood the role of documentation in quality care.
4.Improved interpersonal and communication skills while coordinating with nursing staff.
5.Realization of the gap between ideal practices and practical implementation, and the need for continuous training and monitoring

Suggestions for the Organization (SDMH):

1.Increase or encourage digitization to improve efficiency and accessibility.
2.Promote timely filling and signing of all the necessary form by the relevant personnel.
3.Promote team discussions to share best practices in documentation & compliance.
4.Digitize audit checklist to reduce paperwork & improve monitoring.
5.Conduct regular infection control training sessions and enforce stricter monitoring to ensure proper glove usage and hand hygiene practices among staff.

Difference between Practical Exposure at SIP Organization and Theoretical Understanding from IIHMR University -

Aspect	Theoretical Understanding (IIHMR University)	Practical Exposure (SDMH Hospital)
Documentation Standards	Learned about ideal formats, complete records, and NABH compliance requirements.	Observed few incomplete records, missing signatures, and variation in compliance across departments.
Quality Management	Theoretical knowledge of continuous quality improvement, checklists, and audit protocols.	Participated in real-time audits; noticed gaps in checklist usage.
Use of Technology	Exposure to concepts like EMRs	Limited use of EMRs; much of the documentation and auditing was still manual.
Patient-Centered Care	Emphasis on patient safety, dignity, and engagement in care decisions.	Observed good clinical care.
Team Coordination	Studied interdisciplinary teamwork for quality and patient outcomes.	Coordination between nursing, doctors, sometimes may lacked clarity and consistency.
Infection Control Practices	Emphasis on strict adherence to hand hygiene, PPE use (like gloves), and standard precautions.	Observed that gloves were not consistently used by some nursing staff during minor procedures or file handling, especially in general wards.

Name-Dr. Stuti Bhargava
Roll no. – 2099
Stream- HM
Name of Faculty Mentor – Dr. Mamta Chauhan
Name of Organization Mentor- Dr. Kalpana Bindal
Organization Name- SDMH, Jaipur






Weekly Report (01 week to 10 week)

WEEKLY REPORT - 01

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

Name of the Student: Dr. Stuti Bhargava

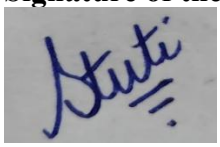
Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 1st **From: 12.05.25 to 17.05.25**

Activity Done	• Visited IPD & OPD, received orientation from the ma'am. • Visited the following departments for observation and better understanding-Renal, General Medicine, Pulmonary, Neurology, Gastroenterology & General Surgery. • Conducted ward audit using the checklist on each ward based on the parameters in the following departments- Gastroenterology, General Surgery, Pulmonary department
Linking theory (Classroom learning) with practice at your organisation	• Observed implementation of infection control protocols and biomedical waste management practices. • Applied patient safety principles & documentation practices in real time settings.
Gaps identified on the working area.	• Less Digital records, more written documents • Delay in the display of critical patient values on the system in some ward especially in Pulmonary ward. • Tissue papers are not being used after handwashing in some wards.
Suggestions for improvement	• Encourage digitalization to improve efficiency and accessibility. • Strengthen co-ordination between diagnostic departments and wards to ensure timely updating of patient reports.

Plan for the next week	Will be doing ward audit in the other department using the Ward Audit Checklist to observe and evaluate compliance with the specified parameters.

Signature of the Student



Approved by the IIHMR University's Mentor

Dr. Mamta Chauhan

WEEKLY REPORT – 02

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

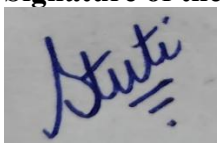
Name of the Student: Dr. Stuti Bhargava

Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 2nd **From: 19.05.25 to 24.05.25**

Activity Done	• Learned how to conduct medical record audits using a standard checklist. • Audited multiple patient files from General Surgery, SIDS ward 1 & 2, RGHS and Semi deluxe room. • Identified documentation non-compliances and partial compliances.
Linking theory (Classroom learning) with practice at your organisation	• Applied theoretical knowledge of documentation standards and patient safety protocols in real-world hospital settings. • Reinforced concepts of quality assurance, legal compliance, and NABH standards through hands-on record audits. • Understood the critical role of complete and timely documentation in ensuring patient safety and care continuity.
Gaps identified on the working area.	• Some forms were left incomplete or unsigned. • Need for more training of nurses on documentation related questions.
Suggestions for improvement	• Encourage timely completion and signing of all required forms by concerned staff. • Promote team discussions to share best practices in documentation and compliance.
Plan for the next week	Audit additional patient files from other departments

Signature of the Student



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WEEKLY REPORT – 03

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

Name of the Student: Dr. Stuti Bhargava

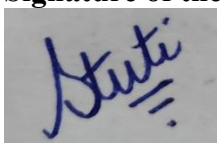
Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 3rd **From: 26.05.25 to 31.05.25**

Activity Done	• Conducted ward and patient file audits in multiple units: Daycare, General Medicine, Twin Sharing Room, Executive Room, Renal Sciences Ward, and SIDS ICU. • Gained in-depth understanding of the functioning of Daycare services, including patient flow, documentation practices, and short-term treatment protocols. • Learned about some ICU protocols -APACHE monitoring, high-risk medication handling, and emergency preparedness. • Reviewed documentation for completeness and compliance with hospital standards. • Observed nursing shift handovers, medication management, patient care practices, and privacy issues in shared rooms.
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of hospital quality standards and NABH guidelines during documentation review. • Implemented concepts of patient safety and risk assessment. • Used health management skills to identify gaps in nursing documentation and handover processes.
Gaps identified on the working area.	• Some forms were left incomplete or unsigned. • Fall risk assessments not uniformly documented

Suggestions for improvement	• Implement regular internal audits to ensure compliance. • Strengthen supervision to ensure doctors sign all necessary documentation
Plan for the next week	Audit additional patient files from other departments

Signature of the Student



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WEEKLY REPORT – 04

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

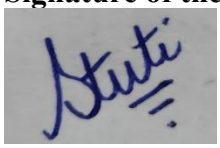
Name of the Student: Dr. Stuti Bhargava

Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 4th **From: 2.06.25 to 7.06.25**

Activity Done	• Conducted ward and patient file audits in multiple units: Neurology Ward I & II, Joint Replacement Ward, Deluxe rooms, Gastroenterology ICU ,Neurology ICU, Pulmonary ICU. • Identified documentation gaps that could impact patient safety.
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of hospital quality standards and NABH guidelines during documentation review. • Understood practical relevance of clinical indicators, patient safety goals, and audit tools in real-time hospital settings
Gaps identified on the working area.	• Some forms were left incomplete or unsigned. • Fall risk assessments not uniformly documented • Surgical safety checklists not consistently signed by relevant staff. • Housekeeping records were either missing or inconsistently maintained.
Suggestions for improvement	• Implement regular internal audits to ensure compliance. • Strengthen supervision to ensure doctors sign all necessary documentation • Digitize audit checklists to reduce paperwork and improve monitoring.
Plan for the next week	Audit additional patient files from other departments

Signature of the Student



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Dr. Mamta Chauhan

WEEKLY REPORT – 05

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

Name of the Student: Dr. Stuti Bhargava

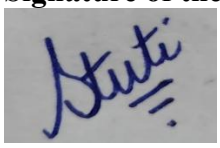
Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 5th **From: 9.06.25 to 14.06.25**

Activity Done	• Conducted ward audits and patient file audits in the Neurosurgical ICU, Surgical ICU, Semi-deluxe room, Neonatal ICU, Medical ICU, and Paediatric ICU • Identified documentation gaps that could impact patient safety. • Learned about ICU protocols, such as APACHE monitoring, high-risk medication handling, and emergency preparedness.
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of hospital quality standards and NABH guidelines during documentation review. • Understood practical relevance of clinical indicators, patient safety goals, and audit tools in real-time hospital settings
Gaps identified on the working area.	• In Restraint form reason for removal, order given for removal, discontinued date and time was not mentioned in some files. • Incomplete and unsigned documentation in critical areas • Surgical safety checklists not consistently signed by relevant staff. • General environment cleaning checklist was not signed by the nurse in-charges. • In some ICUs, General Environment Cleaning record entries for the morning shift were missing, as the staff completed entries for all three shifts together at night instead of recording them in real time.
Suggestions for improvement	• Strengthen supervision to ensure doctors sign all necessary documentation • Implement daily checks for environment checklist completion

	• Digitize audit checklists to reduce paperwork and improve monitoring
Plan for the next week	• Audit additional patient files from other departments

Signature of the Student



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WEEKLY REPORT – 06

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

Name of the Student: Dr. Stuti Bhargava

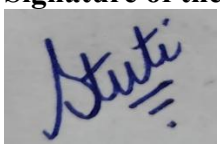
Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 6th **From: 16.06.25 to 21.06.25**

Activity Done	• Conducted ward audits and patient file audits in t CHDU, Labour & Delivery Room, and Paediatric ICU. • Identified documentation gaps that could impact patient safety. • Audited Cath Lab procedure forms to assess pre- and post-procedure documentation and Cath lab consent form. • Worked on compiling and analyzing data for the final internship report titled "Medical Record Audit in Inpatient Setting."
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of hospital quality standards and NABH guidelines during documentation review. • Understood practical relevance of clinical indicators, patient safety goals, and audit tools in real-time hospital settings
Gaps identified on the working area.	• Incomplete and unsigned documentation in critical areas • In CHDU, Cath Lab forms were often partially filled in some files. • General environment cleaning checklist was not signed by the nurse in-charges. • Restraint form reason for removal, order given for removal, discontinued date and time was not mentioned in some files.
Suggestions for improvement	• Strengthen supervision to ensure doctors sign all necessary documentation

	• Implement daily checks for environment checklist completion.
Plan for the next week	• Audit additional patient files from other departments • Continue analyzing findings and compile department-wise summaries for the report. • Work on data visualization (charts/tables) and finalize the key recommendations.

Signature of the Student



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WEEKLY REPORT – 07

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

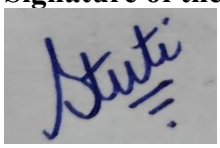
Name of the Student: Dr. Stuti Bhargava

Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 7th **From: 23.06.25 to 28.06.25**

Activity Done	• Observed OPD & IPD admission counters and their processes. • Visited enquiry and lab registration counters in OPD. • Covered 3 floors of the OPD building to understand the process.
Linking theory (Classroom learning) with practice at your organisation	• Saw the practical side of queue management, documentation, and patient interaction. • Observed how front desk operations affect patient experience. • Understood how infrastructure gaps (like limited lifts) directly impact service efficiency and patient satisfaction
Gaps identified on the working area.	• Enquiry staff got confused during rush hours, leading to patient miscommunication. • Manual lab registers are used — prone to error. • Short staffing at IPD admission caused delays during leave of staff. • OPD lifts are small and few — causing long waits.
Suggestions for improvement	• Add support staff during peak hours at enquiry. • Digitize lab registration fully. • Ensure backup staff for IPD admission. • Improve lift capacity or assign priority lift for patients
Plan for the next week	• Visit remaining 2 OPD floors including Blood Bank. • Observe processes at TPA (Third Party Administrator) and MRD (Medical Records Department).

Signature of the Student



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WEEKLY REPORT – 08

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

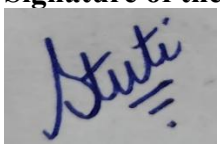
Name of the Student: Dr. Stuti Bhargava

Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 8th **From: 30.06.25 to 05.07.25**

Activity Done	• Observed 2 OPD floors to understand departmental workflow & patient movement. • Visited the Blood Bank and observed key procedures. • Visited TPA department to understand discharge procedures (same-day and 24-hour) and documentation flow.
Linking theory (Classroom learning) with practice at your organisation	• Applied classroom knowledge of hospital support services, discharge policies, and quality control. • Observed the use of token systems and vitals screening as part of OPD management. • Understood how advanced machines like NAT improve safety and efficiency in blood services.
Gaps identified on the working area.	• OPD lifts are small and few — causing long waits. • Token numbers not updating properly on OPD screens, causing confusion. • Delays in discharge in TPA due to missing documents in some cases.
Suggestions for improvement	• Regular tech check for number display systems • Ensure pre-discharge document checklist to reduce delays. • Assign support staff to assist nurses with vitals monitoring.
Plan for the next week	• Visit the Medical Records Department (MRD) to observe file handling, storage, and record compilation. • Observe Endoscopy procedures, focusing on documentation, consent, and coordination with nursing and technical staff. • Continue working on final report and presentation.

Signature of the Student



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Dr. Mamta Chauhan

WEEKLY REPORT – 09

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

Name of the Student: Dr. Stuti Bhargava

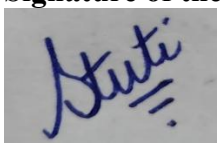
Roll no: 2099 **Stream: MBA (Hospital and Health Management)**

Week no: 9th **From: 07.07.25 to 12.07.25**

Activity Done	• Revisited departments where earlier patient medical record and ward audits were conducted to recheck for improvements. Reviewed if the previously identified gaps were addressed or still persisted. • Conducted Patient Experience Survey Feedback in different wards to assess service quality.
Linking theory (Classroom learning) with practice at your organisation	• Applied classroom knowledge from Hospital Quality Assurance to evaluate whether improvements were made after the audits. • Used understanding of Patient Satisfaction Indicators to collect and analyze patient feedback. • Linked the role of accurate documentation with both effective hospital functioning and meeting accreditation requirements.
Gaps identified on the working area.	• In some wards housekeeping checklist was not timely filled. • General Cleaning environment checklist was not signed by in charges even if tasks were performed. • Food quality was a consistent point of dissatisfaction in patient feedback.
Suggestions for improvement	• Conduct regular audits of housekeeping checklist documentation with monitoring by supervisors. • Make incharge signatures mandatory on all checklists to ensure accountability. • Re-evaluate hospital kitchen services or vendor contract to improve food quality.

Plan for the next week	• Continue with the work from this week, including follow-up on patient feedback collection and ward checklist reviews. • Continue compiling observations and begin finalizing content for the internship report and presentation

Signature of the Student



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Dr. Mamta Chauhan

WEEKLY REPORT – 10

Name of the Organisation: Santokba Durlabhji Memorial Hospital, Jaipur

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

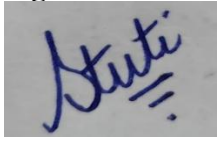
Name of the Student: Dr. Stuti Bhargava

Roll no: 2099 **Stream**: MBA (Hospital and Health Management)

Week no: 10th **From**: 14.07.25 to 19.07.25

Activity Done	• Conducted quality assessment and patient delight experience feedback survey across IPD wards & rooms. • Collected patient data from register and calculated average waiting time for MRI and CT scan.
Linking theory (Classroom learning) with practice at your organisation	• Applied hospital operations knowledge to calculate time taken for CT/MRI. • Realized the importance of data-driven decision making and continuous monitoring in healthcare settings. • Applied principles of Quality Management and Patient-Centered Care in real-time by conducting patient satisfaction surveys.
Gaps identified on the working area.	• Few patients were not satisfied with the taste of the food available. • Delay in CT & MRI testing. • Some patients experienced long discharge wait times.
Suggestions for improvement	• Implement a real-time digital tracking system for patient movement. • Introduce slot-based appointment scheduling to manage peak-time loads. • Establish a standardized feedback review process to address the concerns promptly. • Review and streamline discharge protocols to reduce patient wait time. • Conduct monthly food taste surveys to improve patient satisfaction.

Signature of the Student



Approved by the IIHMR University's Mentor

Dr. Mamta Chauhan

Compiled Reporting Format

Name of the Organisation: Santokba Durlabhji Memorial Hospital

Department: Quality Assurance

Name of the Student: Dr. Stuti Bhargava

Roll no:2099 **Stream:** MBA (Health & Hospital Management)

Activity Done	• On the first day of my internship, I was given an orientation session by Dr. Kalpana Ma'am during which I visited the IPD & OPD to gain an understanding of the hospital departments and service delivery. • In the first week of my internship, I observed the functioning across several IPD including -Renal Sciences, General Medicine, Pulmonary, Neurology, Gastroenterology & General Surgery. The aim was to familiarize with the departmental workflows and patient care standards and after that I was trained how to conduct Ward Audits using a NABH based standard checklist which I later independently conducted in the Pulmonary and General Surgery wards focusing on several parameters such as Medication management, utility & safety, infection control practices etc. • In the second week, initially ma'am taught me how to do inpatient medical record file audit using the standard NABH based checklist where I assessed patient files for documentation accuracy, completeness after which I conducted ward audit and inpatient medical record file audit (both admission file as well as the discharge file) across several departments. • During the 5 week period, I conducted ward audit and patient medical record file audit

	across several departments -General Surgery, SIDS ward 1 & 2, and Semi deluxe room , Daycare, RGHS ward , General Medicine ward 1 and 2 , Twin Sharing Room, Executive Room, Renal Sciences Ward, Pulmonary Ward ,SIDS ICU, Neurology Ward I & II, Joint Replacement Ward, Deluxe rooms I and II, Gastroenterology ICU ,Neurology ICU, Pulmonary ICU, Neurosurgical ICU, Surgical ICU, Semi-deluxe room, Neonatal ICU, Medical ICU, and Paediatric ICU, CHDU, Labour & Delivery Room. The audit focused on identifying which can impact patient safety and quality of care. During audits, I also gained in-depth understanding of the functioning of Daycare ward. • In the 7th week I observed OPD & IPD admission processes including front desk work, billing and registration. I also visited lab registration counters to understand the process of testing, sample collection, reporting and how it gets approved. • I also visited enquiry in the OPD where I observed how they assist in resolving queries and ensure smooth patient flow. • Observation was made across OPD floors to understand departmental patient movement, patient waiting time which is essential indicators of service efficiency. • I also visited the Blood Bank and observed key procedures and get an insightful knowledge of machines used there. • At the TPA department, I understood the discharge procedures (same-day and 24-hour) for the patients and the critical role of quality department plays in ensuring correct documentation, timely file completion and policy adherence. • In the 9th week, I revisited the departments where earlier patient medical record and ward audits were conducted to check for the improvement. Reviewed if the previously

	identified gaps were addressed or still persisted emphasizing the importance of continuous quality monitoring. • During the 9th and 10th week I initially compiled the questions which ma'am has given for making feedback form in google form after that I approved the feedback form and then started conducting feedback survey with the title "Quality Assessment and Patient Delight Experience Feedback Survey" in different wards and private rooms to evaluate service quality from patient's perspective. • Additionally, I collected patient data from register and calculated average waiting time for MRI and CT scan contributing towards identifying process delays and suggesting potential improvements.
Linking theory (Classroom learning) with practice at your organisation	• I observed the implementation of infection control protocols and biomedical waste management practices as per the NABH standards across the inpatient settings. This gave me a clear understanding of how hospital acquired infection risks are managed and minimized through strict practices. • I applied theoretical knowledge of documentation standards and patient safety protocols in real-world hospital settings and this reinforced the importance of structured formats, proper signatures, timely entries and completeness of patient records. • Through the audit process, I understood the critical role of complete and timely documentation in ensuring patient safety and care continuity and preventing medical errors all of which are important for patient safety. • I witnessed the practical side of queue management, documentation, and patient interaction at OPD registration counters and front desk areas, where small delays and

	gaps can significantly impact the patient experience and satisfaction. • I understood how front desk operations serve as the first point of contact for the patients and how the responsiveness and efficiency of staff directly influence perception of hospital quality and trust. • Understood how infrastructure gaps (like limited lifts) can create service delays and affect both operational efficiency and patient satisfaction. • I applied classroom knowledge of hospital support services, quality control to assess how discharge processes, housekeeping in real time function and where quality intervention may be required. • I observed the use of token systems and vitals screening desks as part of OPD several departments, providing insight about effective flow management during peak hours. • During my visit to the blood bank, I learned how advanced machines like NAT improve safety and efficiency in blood services. • I applied my classroom knowledge from Hospital Quality Assurance to evaluate post audit improvements specially by comparing initial and follow up audits. This helped in identifying departments that showed progress and those that needed further intervention. • I employed my understanding of Patient Satisfaction Indicators by conducting and analysing Patient Experience Feedback Surveys focusing on parameters such as their expectation from hospital v/s their experience, cleanliness. • By conducting Patient satisfaction survey, I practically applied the principles of Quality Management and Patient-Centered Care recognizing that continuous feedback and responsiveness to patient needs are crucial for service excellence.

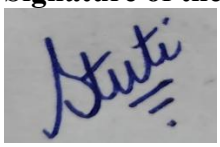
Gaps identified on the working area.	**1. Documentation and Record maintenance-** • More of manual documentation was observed with limited digitization which may increase the risk of data loss and error. • Some forms were left incomplete or unsigned may be because of manual entry delays, workload, lack of real-time updates during patient transfer. • Delay in the display of critical patient values on the system in some ward especially in Pulmonary ward which can lead to delay in timely clinical decisions. • Surgical safety checklists not consistently signed by relevant staff may comprising the patient safety. • Housekeeping records were either missing or inconsistently maintained may be due to inadequate supervision or negligence during busy hours and shift changes. • In Restraint form reason for removal, order given for removal, discontinued date and time was not mentioned in some files. • In some ICUs, General Environment Cleaning record entries for the morning shift were missing, as the staff completed entries for all three shifts together at night instead of recording them in real time. • In CHDU, Cath Lab forms were often partially filled in some files raising concerns about the completeness of procedural documentation. **2. Operational & Infrastructural challenges-** • In some cases, Enquiry staff got confused during rush hours, leading miscommunication. • Manual lab registers are used for record keeping which are prone to error. • Short staffing at IPD admission counter caused delays during leave of staff.

	• OPD lifts are small leading to prolonged patient waiting time and crowding. **3. Discharge and Diagnostic Delays** - • Delays in discharge of TPA patients were noted in some cases which may be due to incomplete or missing documentation. • Patient reported long waiting times for CT & MRI testing may be suggesting scheduling inefficiencies. • Some patients experienced long discharge wait times specially during high patient load periods. **4. Infection Control and Facility Hygiene -** • Tissue papers/Drying agents are not being used after handwashing in some wards. • General environment cleaning checklist was not signed by the nurse incharges which may be due to the workload. **5. Food services and hospitality -** • Patient feedback mentioned dissatisfaction with food quality especially regarding taste and variety.
Suggestions for improvement	**1. Documentation & Compliance -** • Encourage digitalization to improve efficiency and accessibility. • Strengthen co-ordination between diagnostic departments and wards to ensure timely updating of patient reports. • Encourage timely completion and signing of all required forms by concerned staff. • Promote team discussions and knowledge sharing sessions among the staff to share best practices in documentation and compliance. • Implement regular internal audits with corrective action plans and follow-up reviews to ensure compliance across departments. • Strengthen supervision to ensure doctors sign all necessary documentation as it is lacking in the documentation of some files.

	2. Digitalization & Process upgradation- • Digitize audit checklists to reduce paperwork and improve monitoring. • Introduce slot-based appointment scheduling to manage peak-time loads. **3. Staffing & Infrastructure -** • Deploy additional support staff during peak hours at enquiry desks and OPD counters to manage patient load efficiently. • Ensure backup staff for IPD admission counter to manage the admission procedure efficiently. • Improve lift capacity or assign priority lift for patients for smooth functioning in OPD. • Regular tech check for number display systems to prevent from patient dissatisfaction. **4. Infection Control & Housekeeping -** • Conduct regular audits of housekeeping checklist documentation with monitoring by supervisors. • Make incharge signatures mandatory on all cleaning checklists to ensure accountability. • Implement daily checks for environment checklist completion. **5. Food & Hospitality Services -** • Re-evaluate hospital kitchen services or vendor contract to improve food quality and conduct monthly food taste surveys to improve patient satisfaction. **6. Feedback & Patient Experience -** • Establish a standardized feedback review to address the concerns promptly.
Key Learnings	• I gained hands-on experience in clinical documentation standards and audit procedures especially those aligned with NABH accreditation requirements. • I acquired the ability to critically review patient records and detected inconsistencies or documentation gaps. • Through multiple audits, I deeply understood the importance of timely and

	complete documentation in delivering quality care. • Improved interpersonal and communication skills while coordinating with nursing staff. • Realization of the gap between ideal practices and practical implementation, and the need for continuous training and monitoring • Understood patient registration, appointment scheduling, handling queries and the importance of communication and coordination in managing patient flow.

Signature of the Student



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