SUMMER INTERNSHIP PROGRAM

AT

THE CALCUTTA MEDICAL RESEARCH INSTITUTE

(C.K. BIRLA HOSPITALS, KOLKATA)

From- 12th May 25 to 26th July 25

A Report by Dr. Reshmi Mitra

(MBA- Hospital & Health Management)

2024-2026

Under the mentorship of- Dr. Sandesh Kumar Sharma

IIHMR UNIVERSITY

CK BIRLA HOSPITALS
CMRI

TO WHOM IT MAY CONCERN

INTERNSHIP COMPLETION CERTIFICATE

This is to certify that **Dr. Reshmi Mitra**, a student of **MBA in Hospital and Health Management** at **IIHMR University, Jaipur** has successfully completed her Summer Internship at **C.K. Birla Hospital, CMRI (Kolkata)** from **12th May 2025 to 26th July 2025.**

During the tenure of her Internship under the Medical Administration Department, she was actively engaged in the various Hospital operations and administrative activities under the guidance and supervision of **Dr. Gourabdeep Bhattacharjee and Dr Soumik Rudra Roy**.

Her performance was satisfactory and she adhered to the Organizational norms and discipline throughout the Internship duration.

I, on behalf of our Organization, wish her all the best in future academic and professional pursuits.

26/7/2025

Dr. Gourabdeep Bhattacharjee
Deputy Medical Superintendent,
C.K. Birla Hospital, CMRI,
7/2, Diamond Harbour Road,
Kolkata – 700 027.

DR. GOURABDEEP BHATTACHARJEE
DEPUTY MEDICAL SUPERINTENDENT
THE CALCUTTA MEDICAL RESEARCH INSTITUTE

09/24

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **Dr. Reshmi Mitra of** academic year 2024-26 of **Institute of Health Management Research, IIHMR University, Jaipur** 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: 29/07/2025

Dr. Sandesh Kumar Sharma

Associate Professor

IIHMR University, Jaipur

Clinical Audit Compliance in Inpatient Areas as per NABH Guidelines at a Tertiary Care Hospital (CMRI Hospital)

Dr. Reshmi Mitra (MBA- Hospital and Health Management)
Roll- 2050

Industry mentors- Dr. Gourabdeep Bhattacharjee
Dr. Soumik Rudra Roy
University Mentor- Dr Sandesh Kumar Sharma

Introduction

- CMRI was established in 1969, a leading multi-specialty hospital in Eastern India.
- Offers advanced care in:
  - Critical Care, Pulmo Care, Oncology, Neurosciences, Renal Transplants, etc.
- **Key Facilities:**
  - Robotic-assisted surgeries: Urology, Gynae, Joint Replacement, GI
  - 256-Slice CT, 1.5T MRI, 64-Slice CT
  - CR and PACS radiology systems
  - Advanced Cath Labs, Neuro ICU, Organ Transplants
  - Cosmetic/Reconstructive surgery
  - Psychiatry, pathology, international services, insurance, PG medical programs

Clinical Documentation

Accurate, real-time medical history, treatment, and care recording
Ensures:
- Patient safety
- Continuity of care
- Medicolegal compliance

Aim: Audit compliance of doctors' documentation practices in IPD
Involves: Doctors, nurses, allied health professionals
Support CMRI's NABH preparation and continuous quality improvement

Methodology:

The research was a **cross-sectional observational audit over 6 weeks at CMRI Hospital**. 120 inpatient records were selected **by Convenient sampling** to give representation from various specialties.

Active inpatient files available in the wards during the audit time were the inclusion criteria. Discharged files unavailable at the real-time were the exclusion criteria.

Specifically developed " File Audit Toolkit" was used to collect data. All files were scanned against NABH documentation requirements for the following parameters:

- Progress notes (name, date, time)
- Consent forms
- Operative notes
- Legibility of handwriting
- Documentation of allergy status
- Medication orders

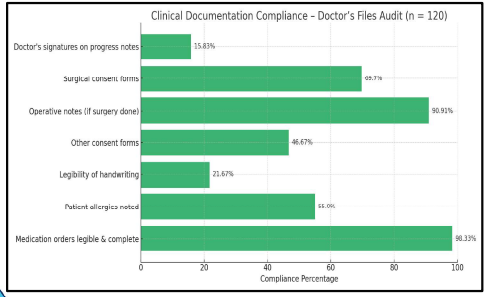
Daily audits were conducted under supervision with cross-checking done by the Quality Team. The findings were displayed graphically in the form of bar graphs. Confidential treatment of patient data was ensured, and hospital permissions were obtained for access to files.

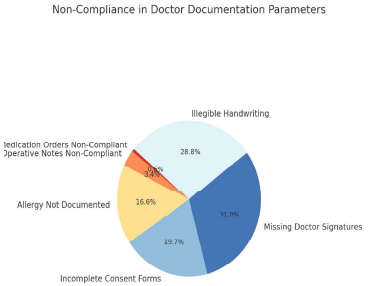
ANALYSIS

The findings of the audit were compared against NABH 5th edition documentation standards to measure the levels of compliance against critical parameters. Gaps were notably seen in the following areas:

- **Doctor signatures missing**
- **Illegible or incomplete progress notes**
- **Unrecorded status of allergy**
- **Incomplete consent documents**
- **Illegible handwriting in records**

A bar chart and pie graph were created to graphically depict the rate of compliance and identify critical areas of weakness. These graphics helped problem areas be easily seen and enabled targeted corrective measures.
Presented via bar graph and pie chart





SWOT Analysis

Strengths
- Availability of a customized checklist tailored to NABH standards
- Strong intent for quality documentation at CMRI
- High compliance was observed in medication orders and operative notes
- Presence of a dedicated medical admin/quality team

Weaknesses
- Poor legibility in handwritten notes
- Missing signatures and incomplete consent forms
- Lack of standardized training on documentation
- Documentation is often seen as a clerical task, not a clinical responsibility

Opportunities
- Integration of EMR with built-in compliance prompts
- Development of dashboards for real-time monitoring
- Use of mobile apps for spot audits and data collection
- Embedding documentation in doctor KPIs and appraisal system

Threats
- Medico-legal risks due to incomplete or illegible records
- Patient safety concerns from unrecorded allergies or vague orders
- Resistance from clinicians to new documentation workflows
- Compliance fatigue or lack of buy-in from clinical teams

Key Findings(RESULTS)

- ✔ 120 inpatient records audited
- ✔ Medication Orders compliance: **98.33%**
- ✔ Operative Notes completed: **90.91%**
- ✖ Allergy status missing: **45%**
- ✖ Consent forms incomplete: **53.33%**
- ✖ Initial Assessment signed with time: **15.83%**
- ✖ Handwriting legibility poor in **78%**

Recommendations (High-Priority)

- Appoint Documentation Champions – Senior resident per department
- Mobile-Based Audit Tracker – Google Forms or a simple app for spot checks
- Quarterly Dept-wise Reviews – Review documentation, retrain as needed
- Compliance Dashboard – Department-level tracking & reporting
- Mandatory Pre-Discharge Checklist – On-duty doctor sign-off on documentation
- Include in Doctor KPIs – Link documentation to performance
- EMR Real-Time Audit Integration – Smart prompts, auto-alerts for gaps

MY LEARNINGS

- Importance of accurate clinical documentation
- NABH documentation standards
- How to conduct live file audits
- Use of the random stratified sampling method
- Role of Doctors, nurses, and the Quality team in maintaining documentation standards.
- Linking documentation compliance to doctor KPIs improves seriousness.
- Use of EMR systems to reduce manual errors
- Hands-on exposure to quality assurance, audit processes, and hospital workflow.
- Discharge summary preparation and full discharge process.
- How to Audit Medical Typist Records

Practical Exposure

- Performed real-time audits of 120 inpatient records with a standardized checklist.
- Located documentation deficiencies such as incomplete signatures and poor handwriting.
- Worked with physicians, quality officers, and medical admin for data gathering.
- Involved in documentation review based on NABH guidelines.
- Applied the DMAIC framework practically to evaluate and enhance documentation adherence.
- Made compliance reports and visual data presentations (bar graphs).
- Recommended implementable solutions such as dashboards, audits, and training modules.
- Witnessed multidisciplinary collaboration in patient care and documentation.
- Assisted in quality discussions and clinical rounds.
- Learned how documentation affects discharge readiness and hospital ratings.

Theoretical Learning

- Acquired knowledge of NABH 5th edition documentation guidelines.
- Understood the significance of clinical documentation in patient safety and legal protection.
- Learned the organization and elements of full inpatient records.
- Learned about the impact of poor documentation on accreditation and quality measures.
- Applied the DMAIC model of quality improvement step by step.
- Understood important audit parameters such as consent, allergy status, medication orders.
- Learned to calculate percentages of compliance and interpret audit data.
- Reviewed the effect of compliance on hospital processes and patient experience.
- Learned to prepare Corrective and Preventive Action (CAPA) plans.
- Reviewed literature and quality manuals regarding healthcare documentation.

Challenges faced by me

- Challenge in retrieving inpatient real-time files because of patient confidentiality measures.
- Lack of complete or missing documentation rendered the analysis challenging.
- Ink or messy handwriting made it challenging to interpret accurately.
- Resistant or reluctant coordination from overworked clinical staff.
- Different documentation styles between departments resulted in inconsistency.
- Challenge in adapting real-life practices to perfect NABH standards.
- Few digital tools with fast audit capabilities (manual verification took long).
- Having to ensure professional communication while indicating compliance deficiencies.
- Handling and presenting a high volume of audit information succinctly and clearly.

Conclusion:

Audit of 120 records using structured checklists.

High compliance in;
- Medication orders (98.33%)
- Operative notes(90.91%)

Low compliance in :
- Signature on progress notes.
- Allergy documentation
- Handwriting legibility
- Issues: Incomplete signatures, consent gaps, illegibility, - Medicolegal risk
- DMAIC Framework enabled structured gap analysis.
- Visualized compliance data supports targeted interventions.

Final Summary:

- Supports CMRI's goals of patient safety and clinical excellence.
- Embedding:
- Micro Audits.
- Standardized templates
- Doctors training
- Drives long-term quality gains.
- Performance-linked compliance encourages accountability.

1st Week Report

Name of the Organization: C.K. BIRLA Hospital (The Calcutta Medical Research Institute)

Department of Summer Internship Program: Medical Administration and Quality Department

Name of the student: Dr. Reshmi Mitra

Roll no: 2050 **Stream:** MBA- Hospital and Health Management

Week: 1 **From:** 12/5/2025 to 17/5/25

ACTIVITY DONE	• Understood the vision, mission, and goals of the organization. • Participated in the data collection for NABH accreditation from clinical departments for the upcoming clinical audit. • Observed hospital structure through facility tour.
LINKING THEORY with PRACTICE at ORGANIZATION	• Understood the NABH accreditation process and its practical implications for quality assurance. • Observed real-time hospital operations and department coordination, linking theoretical frameworks of hospital administration and quality control.
GAPS IDENTIFIED in the WORKING AREA	• Mild communication gap among departments and staff. • A complex hospital layout may cause navigation and coordination difficulties. • Delayed data collection from clinical departments for audits.
SUGGESTIONS for IMPROVEMENT	• Introduce regular inter-departmental meetings to improve communication. • Create a clear signage system or a hospital map to aid navigation. • Implement a checklist to monitor the progress of NABH data collection**.**
PLAN FOR THE NEXT WEEK	• Observe and document the current communication flow among departments. • Explore quality improvement initiatives and interact with the quality assurance team for deeper insights**.**

Signature of student:

Approved by IIHMR University Mentor:

2nd Week Report

Name of the Organization: C.K. BIRLA Hospital (The Calcutta Medical Research Institute)

Department of Summer Internship Program: Medical Administration and Quality Department

Name of the student: Dr. Reshmi Mitra

Roll no: 2050 **Stream: MBA- Hospital and Health Management**

Week: 2 **From: 19/5/2025 to 24/5/25**

ACTIVITY DONE	• **Conducted clinical audit in departments for the purpose of Summer Internship project titled "Clinical Audit Compliance in Inpatient Areas as per NABH Guidelines at a Tertiary Care Hospital"** • **Assisted in designing an awareness program for Cervavac.** • **Contributed to planning the training topics for senior and junior resident doctors.**
LINKING THEORY with PRACTICE at ORGANIZATION	• **Applied theoretical knowledge of quality assurance through clinical audits.** • **Utilized public health education concepts to develop Cervavac awareness program.** • **Incorporated training management principles in planning resident training modules.**
GAPS IDENTIFIED in the WORKING AREA	• **Lack of proper and structured staff training programs.** • **Communication gaps among team members.**
SUGGESTIONS for IMPROVEMENT	• **Implement regular and structured training sessions for all staff levels.** • **Conduct periodic communication workshops and feedback sessions.**
PLAN FOR THE NEXT WEEK	• **Continue clinical audits in other departments.** • **Finalize and initiate the resident doctor training modules.**

Approved by IIHMR University Mentor:

3rd WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 Stream: MBA-HM

Week no: From: 26/5/25 to 31/5/25

Activity Done	➢ Continued clinical audit of live patient files at CMRI. ➢ Attended the World Emergency Day programme on 27th May. ➢ Attended the COVID protocol meeting with senior authorities to understand the hospital's plan for managing the surging cases.
Linking theory (Classroom learning) with practice at your organisation	➢ Applied theoretical knowledge of clinical documentation standards and quality audits while reviewing patient files. ➢ Understood the real-world implications of emergency preparedness through the World Emergency Day programme. ➢ Gained insight into hospital administration and decision-making during the COVID protocol meeting.
Gaps identified on the working area.	➢ Ongoing communication gap between departments. ➢ Occasional lapses in proper documentation by healthcare staff.
Suggestions for improvement	➢ Implement regular inter departmental meetings to streamline communication. ➢ Conduct refresher training sessions for health workers on accurate and timely documentations ➢ Introduce checklist-based audits to ensure no documentation is missed.
Plan for the next week	➢ Participate in ongoing hospital activities and meetings as scheduled. ➢ Monitor and document the implementation of COVID-related protocols.

Signature of the Student

Approved by the IIHMR University's Mentor

4th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 Stream: MBA-HM

Week no:4 From: 2/6/25 to 7/6/25

Activity Done	➢ Continued with the clinical audit of live patient files as part of the hospital quality assessment process. ➢ Conducted a focused audit of Total knee replacement patient files in the Medical Records department. ➢ Examined the discharge planning steps and interdepartmental involvement in TKR patient management.
Linking theory (Classroom learning) with practice at your organisation	➢ Applied concepts of hospital operations and patient discharge workflow learned in the hospital management classes. ➢ Utilized theoretical knowledge of clinical audit methodology and quality assurance in reviewing patient records. ➢ Real-time exposure helped relate academic lessons on communication gaps and bottlenecks to real hospital settings.
Gaps identified on the working area.	➢ The hospital has not yet implemented an EMR system. Patient documentation is still maintained manually. ➢ In some TKR cases, other departments did not immediately act upon discharge readiness from the medical side.
Suggestions for improvement	➢ Strongly recommend implementation of an EMR system, to digitize and streamline patient records and reduce turnaround time. ➢ Introduce a daily discharge coordination meeting or a digital discharge tracker across departments.

Plan for the next week	➢ Continue involvement in clinical audit activities focusing on surgical departments other than orthopaedics. ➢ Attend departmental discussions or hospital review meetings to observe administrative decision-making.

Signature of the Student

Approved by the IIHMR University's Mentor

5th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 Stream: MBA-HM

Week no: 5 From: 9/6/25 to 14/6/25

Activity Done	• Continued with clinical audits in inpatient departments. • Studied the mortality audit form and its components. • Analysed patient readmission data- most cases were planned readmissions. • Observed and understood the functioning of the Cath lab.
Linking theory (Classroom learning) with practice at your organisation	• Applied theoretical knowledge of clinical governance and quality assurance to real-time audit procedures. • Understood how mortality audit contributes to root cause analysis and quality improvement. • Correlated readmission data trends with hospital performance metrics like ALOS and ARPOB.
Gaps identified on the working area.	• Documentation for mortality audit is often delayed. • Treatment consent forms are not standardized across all departments.
Suggestions for improvement	• Streamline the mortality audit process with regular training and department-wise accountability. • Introduce standardized consent form formats across all clinical departments.
Plan for the next week	• Continue clinical audit observations and documentation reviews. • Work on reviewing and improving the formats of treatment consent forms used in different departments.

Signature of the Student

Approved by the IIHMR University's Mentor

6th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 Stream: MBA-HM

Week no: 6 From: 16/6/25 to 21/6/25

Activity Done	▪ Continued clinical audit of live patient files. ▪ Studied features and components of surgical and non-surgical consent forms. ▪ Gained detailed understanding of CSSD processes.
Linking theory (Classroom learning) with practice at your organisation	▪ Applied knowledge of NABH documentation standards while auditing consent forms. ▪ Understood the legal and ethical implications of informed consent in real cases. ▪ Observed CSSD practices aligning with hospital infection control policies learned in theory.
Gaps identified on the working area.	▪ Incomplete or missing signatures on consent forms. ▪ Some CSSD areas had lapses in labelling, segregation, and tracking of sterilized items.
Suggestions for improvement	▪ Conduct training for medical staff on proper consent form documentation. ▪ Strengthen CSSD documentation and color-coded labelling for better traceability.
Plan for the next week	▪ Continue audit. ▪ Observe the pre-operative and post-operative consent process in live cases.

Signature of the Student

Approved by the IIHMR University's Mentor

7th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 Stream: MBA-HM

Week no: 7 From: 23/6/25 to 28 /6/25

Activity Done	• **Continued clinical audit for live doctor file.** • **Conducted additional audits focused on documentation errors made by medical transcriptionists and RMO's in discharge summaries.**
Linking theory (Classroom learning) with practice at your organisation	• **Applied theoretical knowledge of clinical governance and quality standards to assess real time documentation.** • **Practiced audit techniques to identify gaps in clinical records, aligning with NABH documentation standards and medico legal principles.**
Gaps identified on the working area.	• **Incomplete documentation by RMO's.** • **Frequent grammatical and formatting errors by medical transcriptionists.** • **Persistent communication gap between the admin team and consultants.**
Suggestions for improvement	• **Conduct regular sensitization sessions for RMO's on the importance of complete documentation.** • **Provide feedback and checklists to transcriptionists to reduce repetitive errors.**
Plan for the next week	• **Continue audits.** • **Monitor and document repeated documentation issues.**

Signature of the Student

Approved by the IIHMR University's Mentor

8th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 **Stream: MBA-HM**

Week no: 8 **From: 30/6/25 to 05/7/25**

Activity Done	• **Conducted medical typist audit.** • **Contributed to Clinical vigilance activities.** • **Attended session on NABH 6th Edition implementation** • **Provided time-to-time admin-related suggestions and recommendations as an intern**
Linking theory (Classroom learning) with practice at your organisation	• **Applied knowledge of clinical documentation standards during the typist audit.** • **Understood NABH standards through practical exposure to accreditation implementation.** • **Practiced hospital administration principles through real-time issue handling.**
Gaps identified on the working area.	• **No new gaps identified.**
Suggestions for improvement	• **Continued need for regular audits to minimize documentation errors.** • **Encourage the use of prompt feedback mechanisms to improve administrative efficiency.**
Plan for the next week	• **Will contribute and participate actively in any upcoming administrative or clinical activities.**

Signature of the Student

Approved by the IIHMR University's Mentor

9th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 **Stream: MBA-HM**

Week no: 9 **From:07 /6/25 to 12/7/25**

Activity Done	• **Participated in clinical vigilance activities.** • **Studied and understood the MDT form and its relevance.**
Linking theory (Classroom learning) with practice at your organisation	• **Applied theoretical knowledge of clinical audits and quality indicators by observing real time clinical vigilance processes.** • **Gained insights into practical application of MDT documentation, interdepartmental collaboration and patient care planning.**
Gaps identified on the working area.	• **Lack of clarity among some staff regarding the purpose and benefit of MDT documentation.**
Suggestions for improvement	• **Conduct regular orientation sessions for clinical staff on the importance and correct method of filling MDT forms.**
Plan for the next week	• **Participate in discharge summary audits.** • **Assist in tracking clinical documentation gaps.**

Signature of the Student

Approved by the IIHMR University's Mentor

10th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 **Stream: MBA-HM**

Week no: 10 **From:14 /6/25 to 19/7/25**

Activity Done	• Continued Medical typist audit. • Participated in clinical vigilance. • Followed up on previously assigned tasks. • Audited MDT forms.
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of clinical documentation audit and compliance. • Understood real time use of MDT forms in patient care coordination. • Learned how quality indicators are monitored through clinical vigilance.
Gaps identified on the working area.	• No new gaps identified.
Suggestions for improvement	• Regular training sessions for typists to reduce documentation errors. • Encourage timely filling of MDT forms to maintain proper patient care flow • Reinforce importance of clinical vigilance among staffs for patient safety.
Plan for the next week	• Follow up on feedback shared with respective departments. • Continue with regular assigned tasks.

Signature of the Student

Approved by the IIHMR University's Mentor

11th WEEK REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 **Stream: MBA-HM**

Week no: 11 **From:21 /6/25 to 26/7/25**

Activity Done	• Conducted Crash cart Audit. • Understood biomedical engineering operations at CMRI hospital.
Linking theory (Classroom learning) with practice at your organisation	• Applied knowledge of hospital safety protocols during Audit.
Gaps identified on the working area.	• No new gap identified.
Suggestions for improvement	• Assigning dedicated staff for timely crash cart maintenance.
Plan for the next week	• Internship concluded

Signature of the Student

Approved by the IIHMR University's Mentor

COMPILED REPORT

Name of the Organisation: CK BIRLA HOSPITALS (THE CALCUTTA MEDICAL RESEARCH INSTITUTE)

Area/ Department/: MEDICAL ADMINISTRATION

Name of the Student: Dr. RESHMI MITRA

Roll no: 2050 **Stream: MBA-HM**

Activity Done	• Understood the vision, mission, and goals of the organization. • Participated in the data collection for NABH accreditation from clinical departments for the upcoming clinical audit. • Observed hospital structure through facility tour. • Conducted clinical audit for the purpose of Summer Internship Project. • Assisted in designing an awareness program for Cervavac. • Contributed to planning the training topics for senior and junior resident doctors. • Attended the COVID protocol meeting with senior authorities to understand the hospital's plan for managing the surging cases. • Continued with the clinical audit of live patient files as part of the hospital quality assessment process. • Conducted a focused audit of Total knee replacement patient files in the Medical Records department. • Aimed to identify documentation lapses and delays in the discharge process, specifically for TKR cases. • Examined the discharge planning steps and interdepartmental involvement in TKR patient management. • Studied the mortality audit form and its components. • Analysed patient readmission data- most cases were planned readmissions. • Studied features and components of surgical and non-surgical consent forms.

	• Gained detailed understanding of CSSD processes. • Conducted additional audits focused on documentation errors made by medical transcriptionists and RMO's in discharge summaries. • Studied and understood the MDT form and its relevance. • Conducted Crash cart Audit. • Understood biomedical engineering operations at CMRI hospital.
Linking theory (Classroom learning) with practice at your organisation	• Understood the NABH accreditation process and its practical implications for quality assurance. • Observed real-time hospital operations and department coordination, linking theoretical frameworks of hospital administration and quality control • Applied theoretical knowledge of quality assurance through clinical audits. • Incorporated training management principles in planning resident training modules. • Applied theoretical knowledge of clinical documentation standards and quality audits while reviewing patient files. • Applied concepts of hospital operations and patients discharge workflow learned in the hospital management classes. • Utilized theoretical knowledge of clinical audit methodology and quality assurance in reviewing patient records. • Understood how mortality audit contributes to root cause analysis and quality improvement. • Correlated readmission data trends with hospital performance metrics like ALOS and ARPOB. • Applied knowledge of NABH documentation standards while auditing consent forms. • Understood the legal and ethical implications of informed consent in real cases. • Observed CSSD practices aligning with hospital infection control policies learned in theory. • Practiced audit techniques to identify gaps in clinical records, aligning with NABH documentation standards and medico legal principles.

	• Applied knowledge of clinical documentation standards during the typist audit. • Gained insights into practical application of MDT documentation, interdepartmental collaboration and patient care planning. • Learned how quality indicators are monitored through clinical vigilance.
Gaps identified on the working area.	• Mild communication gap among departments and staff. • A complex hospital layout may cause navigation and coordination difficulties. • Delayed data collection from clinical departments for audits. • The hospital has not yet implemented an EMR system. Patient documentation is still maintained manually. • Communication gaps between departments such as clinical units, MRD, billing, nursing, continue to cause delays. • In some TKR cases, other departments did not immediately act upon discharge readiness from the medical side. • Documentation for mortality audit is often delayed. • Treatment consent forms are not standardized across all departments. • Incomplete documentation by RMO's. • Frequent grammatical and formatting errors by medical transcriptionists.
Suggestions for improvement	• Introduce regular inter-departmental meetings to improve communication. • Create a clear signage system or a hospital map to aid navigation. • Implement a checklist to monitor the progress of NABH data collection**.** • Implement regular and structured training sessions for all staff levels. • Conduct periodic communication workshops and feedback sessions.

	• Conduct refresher training sessions for health workers on accurate and timely documentations • Introduce checklist-based audits to ensure no documentation is missed. • Strongly recommend implementation of an EMR system, to digitize and streamline patient records and reduce turnaround time. • Introduce a daily discharge coordination meeting or a digital discharge tracker across departments. • Streamline the mortality audit process with regular training and department-wise accountability. • Introduce standardized consent form formats across all clinical departments. • Conduct regular sensitization sessions for RMO's on the importance of complete documentation. • Regular training sessions for typists to reduce documentation errors. • Encourage timely filling of MDT forms to maintain proper patient care flow • Reinforce the importance of clinical vigilance among staff for patient safety.
Plan for the next week	• Observe and document the current communication flow among departments. • Explore quality improvement initiatives and interact with the quality assurance team for deeper insights**.** • Continue involvement in clinical audit activities focusing on surgical departments other than orthopaedics. • Attend departmental discussions or hospital review meetings to observe administrative decision-making. • Participate in discharge summary audits. • Assist in tracking clinical documentation gaps • Internship concluded

Signature of the Student

Approved by the IIHMR University's Mentor