SUMMER INTERNSHIP PROGRAM

at

Fortis Memorial Research Institute, Gurugram

From 12 MAY 2025 to 21 JULY 2025

A REPORT BY

Pravesh Kumar

Master of Business Administration

(Hospital & Health Management)

IIHMR-U/01/2024-26/2035

2024-26

under the Mentorship of

Dr. Mamta Chauhan

(Professor)

Fortis MEMORIAL
RESEARCH INSTITUTE
GURUGRAM

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21st July, 2025

To Whomsoever It May Concern

This is to confirm that **Mr. Pravesh Kumar** had been an **Intern** from **May 12th, 2025** to **July 21st, 2025** at **Fortis Memorial Research Institute** in the **Quality** department.

During his training he exhibited a high level of professionalism and a tremendous zest for learning.

We wish **Mr. Pravesh Kumar** all the best in his future endeavor's.

For Fortis Hospitals Limited

Shalini Vij
Training and Development
Senior Manager - HR

Head of Department

Dr. M[illegible] Rohini (PhD)
Head - Quality Department
Fortis Memorial Research Institute
Sector-44, Gurugram-122002, Haryana

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **Mr. Pravesh Kumar** of academic year 2024-26 **Institute of Health management Research** has prepared a poster with respect to his summer internship held during May-July 2025.

He has carried out work as per the guidelines. His poster is approved for presentation.

Date: 30/07/2025

Dr. Mamta Chauhan

Professor

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Evaluating TAT in Blood Transfusion: A Quality Improvement Study at FMRI

Faculty Mentor - Dr. Mamta Chauhan

Presented by - Pravesh Kumar (2035) MBA - HM

Organisation Mentor - Dr. Monika Patni

Brief History and Description:

- Fortis Memorial Research Institute (FMRI), Gurugram, was established in 2013 as a multi-specialty quaternary care hospital.
- Spread over 11 acres, it features advanced medical technology and world-class infrastructure.
- The hospital has 330 beds, including 99 ICU beds and 25 emergency beds, with 15 modern operation theatres.
- FMRI holds JCI, NABH, and NABL accreditations, ensuring global standards in care and diagnostics.
- It is known for excellence in critical care, oncology, transplants, and robotic surgery.

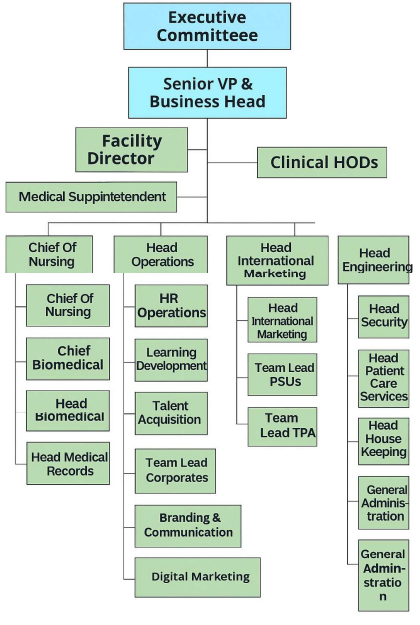
Vision:

"To create a world-class integrated healthcare delivery system in India, entailing the finest medical skills combined with compassionate patient care."

Mission:

"To be a globally respected healthcare organization known for clinical excellence and distinctive patient care."

Organization Structure:



Internship Project:

Project Title: Blood Transfusion Audit
Internship Site: Fortis Memorial Research Institute , Gurugram
Duration: June – July 2025
Department - Quality Department

Objectives:

- To assess the compliance of blood transfusion practices with NABH and internal hospital guidelines.
- To identify gaps in documentation, monitoring, and patient safety during transfusions.
- To evaluate the effectiveness of communication between departments involved in the transfusion process.
- To provide actionable insights for improving quality and safety in blood transfusion services.

Key Findings:

- Post-audit phase showed improved compliance in consent, vitals, and timing records.
- Staff awareness and understanding of transfusion protocols improved after targeted training sessions.
- Regular audits, digital monitoring, and interdepartmental coordination are essential to ensure patient safety.

Recommendations:

- Mandatory timestamping for blood request, issue, and transfusion
- Ensure all consent forms have patient and doctor signatures
- Barcode system to match patient ID and blood bag
- Use a digital tool or app to monitor TAT and alert delays
- Regular staff training and sensitization to transfusion protocol

Methodology:

- Study Design: A before-after audit study was conducted to evaluate compliance and turnaround time TAT in blood transfusion practices.
- Setting: Department of Transfusion Quality, Fortis Memorial Research Institute, Gurugram.
- Study Duration: 15 June to 21 July 2025 (37 days)
- Study Population: All IPD patients (wards and ICUs) 150 patients who received blood transfusions during the study period.

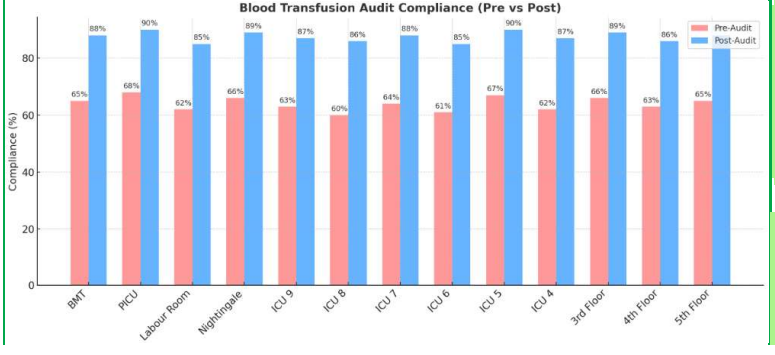
Pre-Audit Phase
- Period: 15 June to 25 June 2025
- Sample Size: 75 transfusion cases
- Method: Random sampling of IPD cases to assess baseline compliance (consent forms, timing, vitals)

Intervention Phase
- Period: 26 June to 30 June 2025
- A 5-day improvement initiative was carried out for nursing and clinical teams, focusing on correct documentation, transfusion timing, and checklist use.

Post-Audit Phase
- Period: 1 July to 21 July 2025
- Sample Size: 75 transfusion cases
- Method: Random sampling of IPD cases to measure improvement in compliance and reduction in TAT

Selection Criteria
- Inclusion: All IPD patients (wards, ICUs) who underwent blood transfusion
- Exclusion: OPD and intra-operative transfusion cases

Visual Insights:



Challenges Faced:

- Transfusion time often missing in records, especially in ICU and night shifts
- Consent forms often incomplete or missing signatures
- Difficulty in retrieving old records post-discharge
- Staff hesitancy in providing full details during real-time checks
- No baseline TAT data available for benchmarking

Major Learnings:

- Gained hands-on experience in conducting a clinical audit aligned with NABH and hospital quality standards.
- Understood the end-to-end blood transfusion process, including request initiation, cross-matching, issuance, and post-transfusion monitoring

Practical Exposure and Theory

Practical
- Observed the complete blood transfusion process in real hospital settings.
- Identified documentation gaps and worked with staff to improve compliance.
- Collaborated with nursing and quality teams during the audit process.

Theory
- Learned transfusion protocols, NABH standards, and audit procedures.
- Understood the role of communication and coordination in patient safety.

Suggestions for Improvement

- Implement a digital TAT tracking tool integrated with HIS
- Create a central transfusion dashboard for real-time compliance
- Include TAT audits in monthly department-wise CQI indicators
- Design SOP for night staff to ensure round-the-clock compliance
- Introduce a transfusion audit checklist for nurses

Week 1 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 1

From: 12th May 2025 to 17th May 2025

Activity Done	During the first week of my internship in the **Quality Department at FMRI**, I was introduced to the core functions and responsibilities of the department. I learned about the role of the **Quality Assurance team** in ensuring compliance with **NABH** standards, internal audits, and continuous quality improvement. I was familiarized with various **quality indicators**, the **incident reporting system**, **form management**, and the functioning of the **Rapid Response Team (RRT)** in clinical emergencies. I also observed how **community and patient feedback** is recorded, monitored, and analyzed as a part of service quality enhancement.
Linking theory (Classroom learning) with practice at your organisation	My experience this week was directly linked to subjects like **Hospital Planning and Quality Management**. During classroom sessions, I studied **hospital accreditation standards (like NABH)**, **incident reporting**, **quality indicators**, and the role of the **Quality Department** in maintaining patient safety and service excellence. Working in the Quality Department at FMRI allowed me to witness how these concepts are actively implemented in a hospital setting. I observed how the department ensures **compliance with NABH standards**, monitors **infection control practices**, manages **incident reporting systems**, and conducts **internal audits**. This practical exposure has deepened my understanding of

	how quality assurance is embedded into everyday hospital operations to maintain high standards of patient care and safety.
Gaps identified on the working area.	During the first week, I observed some gaps in the organisation's functioning. Although NHM is a government-supported program, the **induction curriculum provided to us was not followed properly**. We had to wait for long hours for departmental speakers, which led to **poor time management** and reduced learning efficiency during the initial days.
Suggestions for improvement	I would strongly suggest that the **Quality Department** adopt a more **structured and time-efficient approach** in onboarding and assigning responsibilities to interns. A well-defined schedule for departmental introductions, training on quality protocols, and hands-on tasks would not only enhance the learning experience but also ensure better alignment with the department's operational goals. Efficient planning and timely execution of activities can significantly improve intern engagement and contribute to the **continuous quality improvement** initiatives within the hospital.
Plan for the next week	• Study **NABH standards** in detail • Observe how **internal audits and clinical reviews** are conducted

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 2 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 2

From: 19th May 2025 to 24th May 2025

Activity Done	During the second week of my internship in the Quality Department at FMRI, I was actively involved in several key audits related to clinical quality and patient safety. These included: • **Antimicrobial Stewardship (AMS) Audit:** I participated in evaluating the appropriate use of antibiotics across departments, ensuring adherence to hospital AMS guidelines and rational prescribing to curb antibiotic resistance. • **Chemotherapy Process Audit:** I observed the complete chemotherapy workflow, including prescription validation, preparation, administration, and post-treatment monitoring to ensure safe and standardized practices. • **Prescription Audit:** I reviewed prescriptions to assess completeness, correctness, and alignment with hospital protocols, focusing on dosage accuracy, drug interactions, and documentation quality. These activities provided practical exposure to the auditing processes that support safe and effective patient care.
Linking theory (Classroom learning) with practice at your organisation	At FMRI, I saw how the concepts of management are used in real situations. Through the audits, I understood how different teams work together to ensure that medicines are prescribed correctly, errors are reduced,

	and hospital policies are followed. This practical experience helped me better understand how quality and safety are managed in a hospital.
Gaps identified on the working area.	During the audits, I noticed inconsistent documentation across departments. In some cases, patient records lacked timely updates or complete prescription details, which can impact audit accuracy and patient safety tracking.
Suggestions for improvement	I recommend conducting regular refresher sessions for clinical staff on documentation standards and the importance of audit readiness. Implementing automated documentation prompts in the Hospital Information System (HIS) can improve consistency and ensure protocol adherence.
Plan for the next week	• Conduct a **Surgical Prophylaxis Audit** to evaluate the appropriate use and timing of antibiotics before surgery. • Perform audits focused on the use of **three or more antibiotics** in single prescriptions to assess polypharmacy risks and compliance with AMS guidelines.

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 3 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 3

From: 26th May 2025 to 31st May 2025

Activity Done	In the third week of my internship, I worked on several important audits and quality improvement tasks. These included: • **Surgical Prophylaxis Audit:** I checked whether antibiotics were being given correctly before surgeries – the right drug, at the right time, and for the right duration as per hospital policy. • **Audit on 3 or More Antibiotics:** I reviewed cases where three or more antibiotics were prescribed together. I analysed whether such combinations were justified and followed the Antimicrobial Stewardship guidelines. • **Reviewed JCI Guidelines:** I spent time revising the **Joint Commission International (JCI)** standards being followed at FMRI. This helped me understand global best practices for hospital quality and patient safety. • **Worked with the Team Leader (TL):** I assisted the Team Leader in the Quality Department with follow-ups and planning **corrective and preventive actions** based on audit findings. I learned how the department handles issues and improves hospital processes.

Linking theory (Classroom learning) with practice at your organisation	At FMRI, I saw how the concepts of management are used in real situations. Through the audits, I understood how different teams work together to ensure that medicines are prescribed correctly, errors are reduced, and hospital policies are followed. This practical experience helped me better understand how quality and safety are managed in a hospital.
Gaps identified on the working area.	While doing the audits, I noticed that in some cases, **documentation was incomplete or delayed**, especially in surgical prophylaxis records. This can affect both patient care and audit outcomes.
Suggestions for improvement	The hospital can benefit from **refresher training sessions** for doctors and nursing staff on the importance of timely and complete documentation, especially in surgery and high-risk antibiotic usage. Also, a **checklist-based system** before surgeries may help ensure antibiotic protocols are followed more strictly.
Plan for the next week	• Continue conducting **audits on Chemotherapy** processes to ensure all safety steps and protocols are being followed. • Perform more **Surgical Prophylaxis Audits** to monitor antibiotic usage before surgeries and ensure compliance with guidelines. • Assist in preparing and reviewing the **Escalation–De-escalation Report** to track how antibiotic treatments are adjusted based on patient response and lab reports. • Support the **Quality Team in managing the 2nd floor** of FMRI by ensuring proper documentation, addressing quality-related issues, and coordinating with clinical staff for smooth functioning.

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 4 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 4

From: 02 June 2025 to 07 June 2025

Activity Done	During the fourth week of my internship, I was actively involved in several important audits and quality checks. My key tasks included: • **Nursing Audit in MRD (Medical Records Department):** Reviewed nursing documentation in patient files to ensure all required notes, assessments, and signatures were properly recorded. • **Prescription Audit:** Successfully completed an audit of **700 prescriptions**, verifying drug names, dosages, frequencies, and checking for any prescribing errors or missing information. • **Admission History and Physical Assessment Audit:** Checked if patients' admission histories and initial assessments were fully completed and signed.
Linking theory (Classroom learning) with practice at your organisation	This week's experience closely related to classroom topics such as **Hospital Record Keeping** and **Documentation Standards**. While classroom learning helped me understand the theory behind audits and compliance, working at FMRI showed me how these processes are practically implemented. The audits gave me insight into the importance of complete documentation, rational use of antibiotics, and proper biomedical waste segregation in maintaining patient safety and quality care.

Gaps identified on the working area.	Some nursing records in MRD lacked proper signatures, dates, or complete information. A few admission records were missing complete physical assessments or had delays in documentation.
Suggestions for improvement	Conduct short **training refreshers for nursing and housekeeping staff** on proper waste segregation and timely documentation. Introduce **checklists** or **reminder boards** in departments to ensure key documentation steps are not missed. Regular monitoring and feedback can help ensure **100% compliance** with hospital policies.
Plan for the next week	• Begin working on my own **Quality Improvement Project (QIP)**, identifying a focused area for improvement within the hospital and planning steps for data collection, root cause analysis, and intervention. • Assist the Quality Team in **preparing for upcoming internal audits**, including documentation reviews and compliance checks. • Support in **updating compliance records** related to **NABH** and **JCI standards**, ensuring that the required formats and quality indicators are up to date. • addressing quality-related issues and coordinating with clinical staff for smooth functioning.

Signature of the Student

Pravesh Kumar

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Week 5 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 5

From: 09 June 2025 to 14 June 2025

Activity Done	In the fifth week of my internship, I was assigned a project on **Blood Transfusion Safety Audit**. Alongside this, I carried out multiple audits and quality checks. Key tasks included: • **Blood Transfusion Safety Audit (Project):** I began working on a specific project associated with auditing the **blood transfusion process** across different departments. This included verifying documentation like consent, pre-transfusion checks, administration steps, and nurse awareness about transfusion protocols and adverse reactions. • **Outside Medication Report Audit:** Audited records to ensure that medications brought by patients from outside were properly documented and approved by doctors. • **Initial Assessment & Reassessment Audit (ER Department):** Evaluated patient files in the Emergency Room to ensure timely initial assessment and periodic assessments according to hospital protocols. • **Moderate Early Warning Signs (MEWS) Audit:** Checked inpatient records for proper use and documentation of MEWS scores to detect early signs of patient deterioration.
Linking theory (Classroom learning) with practice at your organisation	This week's activities reflected what I've learned in **Hospital Quality Management**, **Clinical Documentation Standards**, and **Patient Safety Procedures**. The blood transfusion audit helped me connect theoretical knowledge about transfusion safety protocols

	with actual hospital practices. I also saw how tools like MEWS and reassessment audits contribute to early intervention and better patient outcomes.
Gaps identified on the working area.	Some blood transfusion cases lacked full documentation, such as **nurse verification or exact administration time**. **MEWS scoring** was inconsistently recorded in some ER patient files. A few outside medication entries were missing proper validation or consultant notes.
Suggestions for improvement	Conduct brief sessions with staff on the **importance of complete transfusion documentation**. Integrate **MEWS reminders** into the electronic health record system. Enforce stricter checks for recording and validating outside medications to avoid confusion during treatment.
Plan for the next week	Continue working on the **Blood Transfusion Audit** and compile findings Conduct **follow-up audits** on transfusion safety and related protocols Assist in **Clinical Documentation** and **Pain Assessment Audits** Begin preparing a **progress summary** for internal review

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 6 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 6

From: 16 June 2025 to 21 June 2025

Activity Done	In the sixth week of my internship, I was involved in several quality and compliance-related tasks. My main activities included: • **Schedule H1 Sales Data Compilation:** The Schedule H1 Sales Report for the period of May 1, 2025, to May 31, 2025, was created by myself.This task involved reviewing pharmacy records to check for the sale of Schedule H1 drugs (such as certain antibiotics or controlled medications). Since no sales occurred during this period, a **zero-entry report** was submitted in accordance with compliance requirements. • **AMS (Antimicrobial Stewardship) Tracker Update:** I updated the **AMS Tracker** by entering recent data from various departments. This included: o Reviewing antibiotic prescriptions o Updating escalation/de-escalation decisions o Checking alignment with hospital's AMS guidelines These updates help the hospital ensure proper antimicrobial usage and support infection control standards.
Linking theory (Classroom learning) with practice at your organisation	This week's tasks directly related to academic topics such as **Regulatory Compliance**, **Pharmacy Management**, and **Infection Control Practices**. In classroom learning, I studied the significance of tracking Schedule H1 drug usage and monitoring antimicrobial prescriptions. By working on these tasks at FMRI, I gained practical insight into how hospitals

	maintain compliance, prevent antimicrobial resistance, and prepare for audits through consistent record-keeping and analysis.
Gaps identified on the working area.	**AMS data collection** still depends on manual processes, which can lead to delays or errors. While **Schedule H1 records** were accurate, the reporting format could be improved for quicker monthly submissions.
Suggestions for improvement	Implement an **automated tracking system** for AMS data to reduce manual work and increase accuracy. Develop a **standardized Schedule H1 reporting template** for faster data entry and compliance submission. Conduct **regular pharmacy audits** to verify and cross-check sales and inventory documentation.
Plan for the next week	Complete the **MEWS (Modified Early Warning Score) Audit**, ensuring that patient scores are being recorded accurately and timely, and that any warning signs are being escalated according to protocol. Finalize the **Red Bin Waste Management Audit** by reviewing segregation practices, bin labelling, and staff compliance with biomedical waste guidelines. Support the Quality Team in **internal audit preparations** and in updating compliance documentation for **NABH and JCI standards**.

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 7 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 7

From: 23 June 2025 to 28 June 2025

Activity Done	During this week, I continued working on my assigned audit and also began a new project. The key activities included: • **Blood Transfusion Audit (Continued):** I carried on with data collection and analysis for the Blood Transfusion Audit. I focused on identifying compliance with transfusion protocols, including consent forms, cross-matching, timing of administration, and nurse verification steps. • **Started Project on LAMA (Leave Against Medical Advice):** I initiated a new project on patients who leave the hospital against medical advice (LAMA). My work included: o Collecting data from different departments on recent LAMA cases o Reviewing documentation for reasons behind patient decisions o Noting if counselling and risk communication were properly documented before discharge.
Linking theory (Classroom learning) with practice at your organisation	This week's work was aligned with academic topics such as **Patient Safety**, **Clinical Documentation**, and **Medical Ethics**. In classroom sessions, I studied how proper documentation and risk communication are essential when patients choose to leave against medical advice. By starting the LAMA project, I was able to apply this learning in a real hospital setting. Similarly, the Blood Transfusion Audit reinforced the importance of adhering to clinical procedures to guarantee patient security and compliance

Gaps identified on the working area.	**In some blood transfusion cases, documentation of start time or vital monitoring was incomplete.** **In a few LAMA cases, the reason for leaving and counselling notes were either missing or not detailed enough.**
Suggestions for improvement	Staff training on proper documentation of transfusion procedures. Introduce a **standard LAMA counselling checklist** to ensure all discussions are properly recorded and risks explained to the patient/family. Conduct regular audits of LAMA files to maintain quality and legal safeguards.
Plan for the next week	Continue working on both **Blood Transfusion Audit** and **LAMA Project** Finalize MEWS and Red Bin Waste Audit reports

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 8 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 8

From: 30 June 2025 to 05 July 2025

Activity Done	**Blood Transfusion Audit (Final Phase):** I completed data analysis and began preparing the final report with key observations, compliance scores, and suggestions for improvement. This marks the concluding stage of the project. **LAMA (Leave Against Medical Advice) Project (Ongoing):** Continued collecting and reviewing LAMA cases across departments. I focused on identifying documentation gaps, patient reasons for early discharge, and how effectively risk communication was recorded. **AMS (Antimicrobial Stewardship) Tracker Update:** I updated the AMS tracker with recent data **Audit of the Supply Chain Department (night shift, 8:00 PM–3:00 AM):** I assisted in an operational audit of the Supply Chain Department during night hours. This audit included observing inventory movement, storage conditions, staff handovers, and material issue processes to ensure 24/7 compliance and operational efficiency. **Support in Internal Audit Preparation:** Helped the Quality Team cross-check documentation and department readiness for upcoming **NABH and JCI internal audits**.
Linking theory (Classroom learning) with practice at your organisation	This week's work applied concepts from **Hospital Operations Management**, **Antimicrobial Stewardship**, and **Healthcare Quality Standards**. The AMS tracker update allowed me to apply what I've learned about antibiotic regulation and documentation,

	while the night audit gave me practical insight into how hospital logistics and supply chain function around the clock. The LAMA project, on the other hand, helped me understand the ethical and procedural aspects of discharge against medical advice.
Gaps identified on the working area.	**In several LAMA cases, incomplete documentation of patient/family counselling and risk acknowledgment was observed.** **In the Supply Chain Audit, delays in material handover recording were noticed during shift transitions.**
Suggestions for improvement	Introduce a **standardized LAMA documentation form** across all departments. Strengthen night-shift handover protocols in the Supply Chain Department to reduce manual delays. Ensure consistent updates in the AMS tracker by assigning departmental focal points.
Plan for the next week	Finalize and submit the **Blood Transfusion Audit Report** Support in conducting **mock audits** for NABH/JCI readiness

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 9 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 9

From: 07 July 2025 to 12 July 2025

Activity Done	**During this week, I focused on finalizing the Blood Transfusion Safety Audit and continued updating the AMS Tracker.** • **Finalizing Blood Transfusion Audit:** **I completed the compilation and review of blood transfusion practices across departments. The audit included multiple parameters such as documentation of consent, blood product verification, administration protocols, nurse cross-checks, and observation of the patient post-transfusion.** • **AMS Tracker Update:** **I continued updating the AMS Tracker with recent antibiotic prescription data.**
Linking theory (Classroom learning) with practice at your organisation	This week, I was able to apply theoretical knowledge from **Patient Safety** I saw firsthand how structured audits improve transfusion safety, and how antimicrobial tracking tools like the AMS Tracker help prevent resistance through responsible prescription monitoring. These real-world applications helped reinforce the role of quality assurance in safe clinical care delivery.
Gaps identified on the working area.	**In a few records, minor variations were observed in how staff recorded the timing of vitals or cross-check signatures.** **Documentation practices could be more**

	standardized.
Suggestions for improvement	**Include justification and patency confirmation whenever alternatives like central lines are used for transfusion.** **Regular internal audits should be continued to sustain adherence to transfusion safety standards.**
Plan for the next week	Begin drafting the final **Blood Transfusion Audit Summary Report** with analysis and action points

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Week 10 Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram

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

Name of the Student: Pravesh Kumar

Roll no: 2035

Stream: Hospital and Health Management

Week no: 10

From: 14 July 2025 to 21 July 2025

Activity Done	During this week, I completed the **Blood Transfusion Audit** as part of my quality and compliance responsibilities. • **Blood Transfusion Audit Completion:** Evaluating the transfusion process across departments was the main goal of the audit. It involved reviewing documentation practices, checking the proper consent forms, verification of blood components, transfusion start-end times, vital sign monitoring, and post-transfusion observation.
Linking theory (Classroom learning) with practice at your organisation	In class, I learned about patient safety and quality audits. This week, I saw how these concepts are applied in real hospital settings. The audit taught me how following clear steps and protocols during blood transfusion keeps patients safe.
Gaps identified on the working area.	Sometimes, vitals (like blood pressure or pulse) weren't recorded at the right times. In some cases, nurses forgot to sign the verification check. When central lines (instead of regular IVs) were used, reasons weren't always documented.
Suggestions for improvement	Use the same documentation format in all departments for consistency. Add a checklist for vital and nurse checks to avoid missing any step.

	Train staff regularly on the correct transfusion process.

Signature of the Student

Pravesh Kumar

Approved by the IIHMR University's Mentor

Compiled Summer Internship Report

Name of the Organisation: Fortis Memorial Research Institute (FMRI), Gurugram
Area/ Department/ Project of Summer Internship Program: Quality Department
Name- Pravesh Kumar
Stream: MBA Hospital and Health Management
Roll no.- 2035

Activity Done	Over the 10-week internship, I actively engaged in the operations of the Quality Department. My primary tasks included: • Conducting audits such as Surgical Prophylaxis, Chemotherapy, Prescription, Blood Transfusion Safety, Initial Assessment & Reassessment, MEWS, Outside Medication, and Documentation in MRD and ER. • Working on major quality projects like the Blood Transfusion Audit and the LAMA (Leave Against Medical Advice) Project. • Updating the Antimicrobial Stewardship (AMS) Tracker and preparing the Schedule H1 Sales Report. • Supporting hospital preparedness for NABH and JCI internal audits. • Participating in a night-shift audit of the Supply Chain Department. • Collaborating with the Quality Team to plan and implement Corrective and Preventive Actions (CAPA) based on audit findings.
Linking theory (Classroom learning) with practice	The internship helped bridge classroom learning with real-world hospital quality practices. I applied knowledge from subjects such as: • Hospital Quality Management – through audits and process standardization. • Patient Safety and Clinical Governance – during blood transfusion and MEWS audits. • Documentation Standards and Risk Communication – during LAMA case analysis and ER audits. • Regulatory Compliance and Infection Control – while working on Schedule H1 reports, AMS tracker, and NABH/JCI preparations. • Operations and Supply Chain Management – through involvement in night audits and biomedical waste compliance reviews.
Gaps identified on the working area	• Inconsistent and incomplete documentation across various departments (e.g., surgical prophylaxis, blood transfusion, MEWS). • Delays in shift handovers and material recording in the Supply Chain Department. • Lack of structured counselling documentation in LAMA cases. • Manual data entry dependency for AMS tracking and audit logs,

	increasing chances of error. • Variable adherence to transfusion safety protocols and incomplete justification when using central lines.
Suggestions for improvement	• Implement standardized checklists for critical processes such as blood transfusion, LAMA counselling, and surgical procedures. • Conduct refresher training programs for staff on documentation protocols, patient safety procedures, and regulatory compliance. • Automate AMS tracking and MEWS documentation to reduce errors and improve data consistency. • Strengthen handover systems in departments like supply chain to ensure seamless operations during off-hours. • Introduce department-wise focal points to ensure regular updates and accountability for compliance records.
Key Learnings	• Gained hands-on experience in auditing, quality improvement, and compliance management. • Understood the importance of accurate documentation and interdepartmental coordination in maintaining patient safety. • Developed skills in data analysis, stakeholder communication, and root cause analysis for implementing quality initiatives. • Learned how hospitals prepare for national and international accreditation standards such as NABH and JCI. • Experienced real-time challenges and applied problem-solving approaches for quality assurance in healthcare

Signature of the Student- Pravesh Kumar

Approved by the IIHMR University's Mentor