SUMMER INTERNSHIP PROGRAM

at

CK Birla Hospital RBH

From 12.05.2025 to 21.07.2025

A REPORT BY

Anupurva Nandi

Master of Business Administration

Hospital & Health Management

Roll no- 1908

2024-26

under the Mentorship of

Dr Mamta Chauhan,

Professor IIHMR UNIVERSITY

IIHMR UNIVERSITY, JAIPUR

CK Birla Hospitals
RUKMANI BIRLA HOSPITAL

RBH/2025/Jul/HRD/6859

Date: 21 Jul 2025

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Anupurva Nandi** has successfully completed her internship in the **Quality** Department from 12 May 2025 to 21 Jul 2025.

Her behavior was respectful, punctual, and in alignment with hospital policies. She showed enthusiasm to learn, adapt, and communicate effectively with staff members, while maintaining a professional attitude throughout the program.

We commend her dedication and discipline during the tenure and believe she has gained valuable exposure to the work culture and expectations of a healthcare environment. We wish a continued success in all future academic and professional pursuits.

For **CK Birla Hospital – RBH**

Ravi Kumar
Unit Head / Human Resources

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **Ms. Anupurva Nandi** 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: 26/07/2025

Dr Mamta Chauhan
Professor

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Summer Internship Program- CK BIRLA HOSPITALS, RBH JAIPUR

AN EVALUATION OF COMPLIANCE OF PROCEDURE CONSENTS IN CLINICAL PRACTICE

Presented by- Anupurva Nandi (1908 MBA HM29)

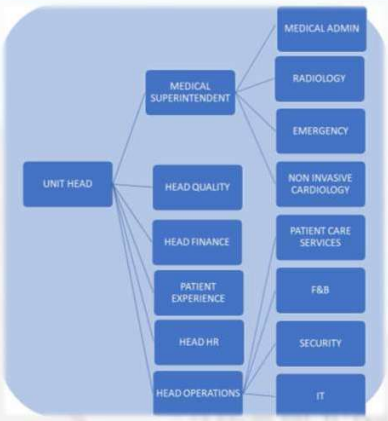
University Mentor- Dr Mamta Chauhan

Organisation Mantor- Dr Kalpana Bindal

Brief Description about Organisation

Rukmani Birla Hospital(RBH) is a multispeciality hospital with 230 beds that provides extensive inpatient and outpatient care. Based on three guiding principles of clinical excellence, ethics and patient centred care, this multispeciality facility provides for the needs of patients and ensures that that they and their families are well cared for by a staff of skilled physicians, attentive and caring nurses, well organised housekeeping and back office management. The three iconic landmarks of CK Birla Hospitals are RBH (Rukmani Birla Hospital), BMB (BM Birla Heart Research Centre), and CMRI (The Calcutta Medical Research Institute).

Organisation Structure



AIMS AND OBJECTIVES

AIMS- To assess how well procedure consent forms are filled out in the hospital and whether they meet hospital rules, legal standards, and ethical guidelines, ensuring patient rights and informed decision-making.

OBJECTIVES-

- To check if all required information is properly filled in the consent forms.
- To find out which part of the consent forms are often left incomplete or incorrect
- To compare how different types of consents are filled and whether they meet compliance standards.

VISION & MISSION

Vision- To deliver the highest quality of clinical excellence and patient care.

Mission- To establish Clinical Centers of Excellence with a solid foundation in research, academia, and evidence-based medicine to provide the best possible clinical and patient outcomes.

RESEARCH METHODOLOGY

Title:
An Evaluation of Compliance and Completeness of Procedure Consents in Clinical Practice

Study Design:
Descriptive cross-sectional study

Study Setting:
Conducted in a 230+ bedded multispeciality hospital, reviewing different procedure consent documentation related to various clinical procedures.

Study Duration:
May 2025 to July 2025

Sample Size:
A total of 305 procedure consent forms were reviewed.

Sampling Technique:
Convenient sampling method – consent forms from different procedures were selected based on availability during the study period.

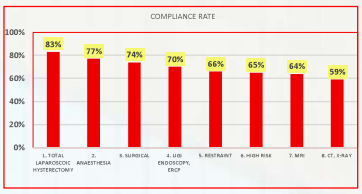
Data Collection Method:
Data was collected through a review of open files and consent forms associated with various clinical procedures.

Study Tools: Each consent form was systematically reviewed for key components including patient and doctor signatures, date and time, procedure details, documentation of risks and benefits, and witness signature, to assess completeness and compliance

Data Analysis:
The collected data was entered and analyzed using Microsoft Excel. Analysis included:
Calculation of percentages for compliance indicators
Graphical representation of findings (bar graphs)
Comparison between different types of procedures in terms of consent completeness

Ethical Consideration:
Confidentiality of patient data was strictly maintained. No identifying information was used in the analysis. The study was conducted with appropriate administrative permission and followed ethical guidelines for record-based audits.

OVERALL FINDINGS



INTERPRETATION-The overall compliance rate for consent documentation varies significantly across procedures. The highest compliance is observed in Total Laparoscopic Hysterectomy consents (83%), followed by Anaesthesia (77%), Surgical (74%), and UGI Endoscopy/ERCP consents (70%). Restraint, High-Risk, and MRI consents show moderate compliance ranging between 64–66%, while the lowest compliance is noted in CT/X-Ray consents (59%).

FINDINGS

= />85%

1.Patient Identifiers(**Name, UHID**) in every consent.

2. Witness related details in **Surgical, Anaesthesia, Lap Hysterectomy, High Risk** consent.

3. Doctors Name, Sign in **Surgical, Anaesthesia, lap Hysterectomy** consent.

4. Patient Sign in **Surgical, Anaesthesia, Lap Hysterectomy, UGI Endoscopy, High Risk** consent.

5. Procedure Name in **Surgical, Lap Hysterectomy, UGI Endoscopy** consents.

50-90%

1. Date entries in **Surgical, Anaesthesia, Lap Hysterectomy, CT-Xray** consents.

2. Attendant related details in **Restraint, MRI, CT, X-ray** Consents.

3. Doctors name on Page 1 **in Anaesthesia, Lap Hysterectomy, Restraint, UGI Endoscopy, CT, X-Ray** Consents.

<50%

1. Patient related risks in **Surgical, High Risk** consent

2. Date entries in **Restraint, UGI Endoscopy, High Risk** consents.

3. Procedure name on Page 2 and **procedure related risks in Lap Hysterectomy** and **Surgical** consent.

4. Patient Name, Sign in **CT, X-Ray** consent.

SWOT ANALYSIS

STRENGTH

1. Improves Patient Safety and Rights: Ensures that patients receive all necessary information before procedures.
2. Supports Legal and Ethical Standards: Helps the hospital meet legal requirements and reduces the risk of litigations due to incomplete or missing consent.
3. Meets Accreditation Requirements: Shows compliance with NABH, JCI, and other standards.
4. Improves Documentation Quality: Promotes standardization and completeness in medical records.

WEAKNESS

1. Forms Not Completed: In clinical settings, not all consent forms are consistently or fully completed.
2. Staff Awareness Gaps: It's possible that many employees don't fully comprehend the documentation requirements.
3. Time Pressure: In a hurry, consents could be filled out incorrectly or with missing information.
4.Employee Turnover: Temporary or new hires might not adhere to the correct consent procedures

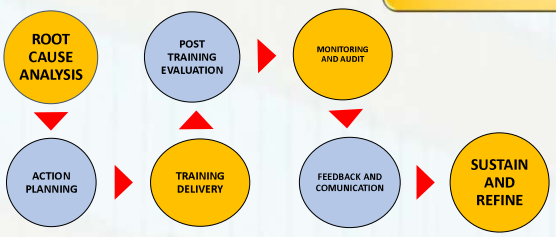
OPPORTUNITIES

1. Integrated EMR Alerts: Use the Electronic Medical Record (EMR) system to automatically remind staff members when consents are due or not yet complete.
2. Digital Consent Forms: Use of electronic formats with validation checks can improve completeness.
3. Language & Literacy Support: Make sure patients understand what they are consenting to by offering consent forms in several languages and using spoken or visual explanations.

THREATS

1. Legal Repercussions: Incomplete consents may result in patient complaints and legal obligations.
2. Risks to Audit and Accreditation: Failure to comply could lead to unfavorable comments made during NABH/JCI inspections.

Steps to improve the compliance of procedure consents



DIFFERENCE BETWEEEN PRACTICAL EXPOSURE AND THEORITICAL UNDERSTANDING

I learned a lot about the documentation procedures used in clinical settings during my internship on procedure consent compliance. Although I received a solid education in patient rights and ethical principles, my firsthand experience with hospital procedures exposed me to the real-world difficulties in putting appropriate consent paperwork into practice. I frequently saw problems like inadequate risk disclosure, missing signatures, and incomplete forms. Gaps in compliance were also caused by inconsistent training and differences in staff awareness. The quality of consent-taking was further impacted by practical issues like staff shortages, patient literacy levels, and time constraints. Additionally, I had the chance to watch audit procedures, which made it clear how important it is to keep an eye on things and raise staff awareness. This event highlighted how crucial it is to close the gap between theoretical and practical knowledge

CHALLENGES FACED DURING INTERNSHIP

Staff Cooperation: During consent form audits, it was frequently challenging to get the cooperation of busy clinical staff, which caused delays in data collection.

Medical Abbreviations: Since they weren't taught in school, it was difficult to understand some of the medical abbreviations used in consent forms .

Documentation Format: At first, it was challenging to evaluate compliance consistently because the hospital's consent form formats deviated from expectations.

LEARNINGS

- ❑ Understood the importance of proper consent documentation for legal and ethical safety
- ❑ Identified key reasons for incomplete consent documentation
- ❑ Learned how to collect, review, and analyze data using a structured approach.
- ❑ Realized the need for regular staff training and accountability
- ❑ Experienced challenges in coordination and communication during audits.
- ❑ Gained exposure to quality improvement methods and practical problem solving

Importance of Consent Compliance

Ethical: By guaranteeing that patients are fully informed and make their own decisions regarding their care, consent compliance respects patient autonomy. It increases patient-provider trust and upholds ethical standards in clinical practice.

Legal: Informed consent is required by law to safeguard patients and medical personnel. Legal repercussions, such as accusations of malpractice or negligence, may arise from missing or incomplete consent .

Medical: By guaranteeing knowledge of the risks, advantages, and available options, explicit and comprehensive consent promotes patient safety. It encourages proactive patient involvement in care and aids in error prevention.

Patient Rights and Safety : Making sure patients are well-informed safeguards their rights and encourages safer healthcare choices. It places a strong emphasis on openness and shared accountability in the provision of healthcare.

Quality of Care: Robust clinical governance is demonstrated by a comprehensive and standardized consent procedure. It leads to better treatment results and increases patient satisfaction.

Regulatory Requirements: As part of accreditation and quality programs, hospitals undergo routine audits for consent compliance. Institutional accountability and ongoing quality improvement are supported by appropriate documentation.

Key Reasons for Incomplete Consent Documentation

1. Consent forms are often filled out at the last minute, just before the procedure, leading to missing information or skipped sections.

2. Doctors and staff are often in a hurry due to a heavy workload, especially during peak hours or emergency cases, which reduces focus on proper documentation.

3. Witness not present during consent – Forms are signed later without an actual witness, or witness fields are left blank.

4. Neglect of Page 2 Entries – After completing Page 1, staff often overlook Page 2 due to time pressure and unclear responsibility, leading to incomplete documentation.

SUGGESTIONS FOR IMPROVEMENT

1. Assign a specific person to check consent completion- Designate a responsible staff member to review each consent form for completeness before the patient is taken for any procedure.

2.Ensure consents are not left for the last moment- Establish a standard practice where consent forms are filled out well in advance

3. Doctor-Only Consent Policy- Ensure that only the performing doctor or an authorized team of doctor takes the consent, to guarantee accurate communication of risks and uphold legal standards.

4. Mandatory Training and Awareness- Conduct periodic training sessions for doctors, nurses, and support staff on the legal, ethical, and clinical importance of complete and accurate consent documentation.

Week - 1

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 01 **From:** 12.05.2025 to 17.05.2025

Activity Done- I visited the HR department to have my documents verified. At first, we filled out a form then our documents were collected after that we gained a brief understanding of the HR department and its policies. After a few minutes Deputy Medical Superintendent arrived to conduct our orientation. She provided an insightful overview of Hospital Operations including the processes and how the departments like medical administration and quality, works. Since I have 3 years of experience in medical operations, I chose Quality department. I attended Basic Life Support (BLS) training where I learned about CPR, how to perform it and in which situation it should be administered. After that I visited to Upper Ground, Lower Ground and 4th floor to observe and find out the non-compliances in the operations. There I found some non-compliances and noted them in my diary for further communication. I also checked files of In-Patient Department IPD for auditing. In the 4th floor I saw Labour Room, Maternal Triage, Neonatal Intensive Care Unit(NICU), Special Newborn Care Unit (SNCU) and other Mult speciality wards. In the SNCU department I observed phototherapy units, radiant warmer beds, incubator beds, bassinet. I attended 3 sessions. The sessions are quality, infection control and fire safety. After that we got a Out Patient Department (OPD) check list from Mam and we went to OPD for auditing. There I audited all the signages to ensure proper display and assessed whether patients received priority based on their severity and needs. I also noted how feedback is collected and how the babies are cared in the OPD. Then we went to blood bank, there the Medical Officer of the blood bank provided us some information about the blood donation process, equipment's of blood bank, donor counselling and the documentation process of the blood bank. We received deep insights about Medical Record Department. There I got to know about the role and responsibilities of MRD department and how they work. How the Medico Legal Cases files are managed and maintained. I also learned about how different types of registers like death register, Leave Against Medical Advice (LAMA) register, Medico Legal Cases (MLC) registers are maintained. Then I went to OT (Operation Theatre) department. There was Operation Theatre (OT) manager, who provided knowledge about the OT department. Robotic surgery is also being done here and how it works everything was explained by him. Then I went to CSSD department there I saw sterilization process and all the registers that are

maintained in the CSSD. I also learned that the expiry dates must be mentioned on every sterilized items. Post lunch we visited to Lab and TPA department. After that I went to OPD again for auditing. We visited to general ward to know the process there. Later I went to IT department and received information about the IT department. I also Learned about how doctors and nurses and other staffs are using EMR and EHR and how EMRs and EHRs facilitate the smooth functioning of patient care. Then we went to patient care Services Department to know the process. Later we went to OPD for auditing. I attended a session on marketing. Learned about healthcare marketing and sales. I learned about how the hospital manages its marketing and sales. Then we had a session of quality. After that we received an emergency auditing checklist from our mam. Then we went to Emergency department for auditing based on our checklist.

Linking theory (Classroom learning) with practice at your organisation- In the class I learned about Operation Theatres (Ots) and here I observed how the OT works, why the zoning is a very essential part of OT. In the class we learned about National Accreditation Board for Hospitals and Healthcare Providers (NABH) here we are observing how quality department plays its role in the NABH accreditation of the hospital. I learned about how Electronic Medical Record (EMR) and Electronic Health Record (HER) is working in real life. In the marketing how the 4ps are working efficiently. We learned about Medical Record Department (MRD) department but how it actually works in the hospital, I learned about that.

Gaps identified on the working area- Poor communication, limited use of telemedicine, lack of cleaning supervision.

Suggestions for improvement- Daily briefing at the start of the Out Patient Department (OPD), train staffs on how to triage patients for telemedicine, conducting random audits and cleanliness inspection.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

Week - 2

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 02 **From:** 19.05.2025 to 24.05.2025

Activity Done- I got a Ward auditing checklist from mam and according to that checklist I audited all the parameters like predefined initial assessment, time frame for doing and documenting initial assessment. Initial nursing assessment, staff training, summary given to all including Leave Against Medical Advice(LAMA), content of discharge summary, Cardiopulmonary resuscitation (CPR) policies, care of vulnerable patients, consent taken by the doctor conducting the procedure, documented procedures of various clinical procedures, nursing plan of care documented in the patient record, allocating of patient accordance with current guidelines, verbal orders, narcotic drug procedure, medication orders, medication administration documentation, communication with patients and relatives, hand hygiene surveillance, housekeeping, reuse of instruments and equipment's , segregation of bio medical waste, open and easily accessible fire exits without any obstruction etc. I checked the files and properly audited them according to this checklist to identify any cases of noncompliance. I interviewed the nursing staff about how they document their nursing records and the processes they follow. I also checked how doctors prescribed diets, how dietitians follow those orders, and how the information is documented in the electronic health record system. I also observed how the codes like Rapid Response Team(RRT) and code blue are announced, and how the Rapid Response team managed the patients. I also observed the mock drill of code blue, how the cardiac arrest patients are managed.

I recorded the discharge time of the patient and the exact time they left the room, followed by the arrival time of the housekeeping team. I also noted the duration taken for room preparation and cleaning, documenting each step of the process.

I checked all procedure consents including surgical, anaesthesia, radiological, hemodialysis, endoscopy consents, ensuring they are properly filled out by the doctors and noting any instances of noncompliance.

Linking theory (Classroom learning) with practice at your organisation- In classroom I learned the importance of accurate, complete and timely documentation and in organisation I directly observed that how much the full compliance of all the documents is important. In classroom I gained understanding of infection spread and how to prevent them and in organisation I observed how they follow hand hygiene protocols, using Personal protective equipment (PPE) and maintaining aseptic techniques during procedures.

Gaps identified on the working area- Sometimes the housekeeping team cleaned the room quickly and this is a compromise on cleanliness. Sometimes the procedure consents are not filled out correctly.

Suggestions for improvement- To address the cleaning issue I recommend to implement regular training sessions for the housekeeping team to emphasize the importance of thorough cleaning. To improve compliance of the consents I suggest creating a checklist to ensure all forms are filled out correctly.

Signature of the Student- Anupurva Nandi - Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK- 3

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 03 **From:** 26.05.2025 **to** 31.05.2025

Activity Done- I got a list of High Dependency Unit (HDU) and Intensive Care Unit (ICU) auditing list. In the HDU and ICUs I checked how they maintain infection control measures, including hand hygiene and other related practices. I checked patients' admission time, the time they arrived to the ICU or HDU and when their assessment was started and completed by the doctors. I checked the expiry dated of the medicines, Central Sterile Serviced Department (CSSD) items and other medical equipments to ensure compliance with safety standards. I also reviewed whether the prescriptions were written in capital letters as per standard documentation guidelines to ensure clarity. Additionally, I checked if the patient's nutrition assessments were being updated on daily basis in accordance with clinical protocols. I checked whether all the procedure consent forms were thoroughly and correctly filled out by the attending doctors, ensuring they include all required patient details, signatures and relevant procedural information as per hospital policy. I checked surgical consents, anaesthesia consents, blood transfusion consents, haemodialysis consents etc.

I got a blood bank audit checklist. There I checked the implementation of safe injection practices to ensure compliance with infection control protocols; I checked the waste segregation process there to ensure that biomedical waste was being correctly separated according to the hospitals colour coded system. I took interviews of the staff regarding the counselling process provided to blood donors, as well as the current availability and management of blood supply.

I got a radiology audit checklist, there I checked standardized reporting of results, As Low As Reasonably Achievable (ALARA) – patients screened for safety, imaging signages-radiation hazard, Pre Conception and Pre-Natal Diagnostic Techniques (PC-PNDT) act, informed consent, Route Cause Analysis (RCA), Corrective and Preventive Action (CAPA) documentation of errors and incidents, scope, adequate infrastructure.

Linking theory (Classroom learning) with practice at your organisation- I learned about infection control like hand washing and safe injection, I saw how these things are being practiced in the hospital. I also learned about sorting medical waste in the right way, in my organisation i saw how the staff are

sorting the medical waste in a right way according to the hospitals colour coded system.

Gaps identified on the working area- I noticed hand washing was not always done every time which can increase the risk of infection. Initial assessment completeness often takes more time than expected, which can delay the prompt delivery of patient care.

Suggestions for improvement- Regular training and reminders for staff on the importance of hand hygiene should be conducted. Installing more visible hand sanitizer stations and putting up clear signages that encourage hand washing before and after patient contact. To reduce delays in initial assessments, setting clear timelines and monitoring completeness regularly can help.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK- 4

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 04 **From:** 02.06.2025 **to** 07.06.2025

Activity Done- I got a laboratory audit checklist. In the lab I checked the documented procedures for sample collection, processing, Turn Around Time(TAT) of report releasing of the tests, quality assurance programs documentation, calibration of equipments , documented lab safety programme , Human Immunodeficiency Viruses(HIV) consent, hand hygiene, use of PPE, instructions for hand washing displayed, safe injection practices, segregation of bio-medical wastes, Preventive Maintenance (PM Labels) on equiments and expiry, safe exit plan, open and easily accessible fire exits without any obstruction, documented plan for handling fire and non-fire emergencies etc.

I thoroughly checked all the procedure consents like surgical consents, anaesthesia consents, High risk consents, Magnetic Resonance Imaging (MRI), Computed Tomography (CT), XRAY consents, Blood transfusion consents etc. I identified the non-compliances and noted them and later I informed mam about the non-compliances.

I got dialysis audit checklist. There I checked emergency drug management, sterilized sets are stored properly with expiry dates and storage conditions, policies and procedures to prevent infection, training records for staff, records of HIV/hepatitis B testing of staffs, machine documentation and calibration records, nephrologist to patient ratio, lockable refrigerator for medication storage, dialyser cleaning protocol, quality assurance programme documentation, consent completion, emergency codes etc.

Linking theory (Classroom learning) with practice at your organisation-In class we learned about infection control, proper documentation and Standard Operating Procedure (SOPs) of different departments. During the lab and dialysis audit I checked proper documentation and SOPs, equipment calibration, hand hygiene and PPE use, biomedical waste segregation and emergency plans.

Gaps identified on the working area- I identified that the use of PPE in the lab is insufficient. In the dialysis unit the storage of medical equipment is not proper**.**

Suggestions for improvement- Conducting regular, mandatory training sessions on the importance of PPE, proper usage and the risk associated with non-compliance. Regularly train staff on safe medication handling.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK - 5

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no- 05 **From:** 09.06.2025 **to** 14.06.2025

Activity Done- I got endoscopy audit list. In the endoscopy I checked CPR policy and procedure, staff trained in CPR, communication of CAPA measures, documented procedures of various clinical procedures, informed consent taken by the doctor performing procedures, availability of equipment and manpower to manage patients who have gone into a deeper level of sedation, medication storage, inventory, expiry dates, storage conditions, emergency crash carts, high risk medications, narcotic drugs procedure, hand hygiene, instructions of hand washing displayed near every hand washing area, PM labels on equipments, calibration records, safe exit plan, open and easily accessible fire exits without any obstruction, spills management plan of hazardous material.
Checking the procedure consents thoroughly and noted the non-compliances carefully and informed mam about it.

Linking theory (Classroom learning) with practice at your organisation-In class we learned the importance of PPE use, hand hygiene and obtaining proper consent to ensure patient safety and infection control and in my organisation, I was able to apply this knowledge by checking PPE usage, monitoring hand hygiene and checking consents.

Gaps identified on the working area- During this auding I found a gap that the consents that are taken in the endoscopy before any procedure, are not properly filled.

Suggestions for improvement- Providing clear guidelines to staff and doctors on how to fill out consent forms properly, conduct regular training sessions to reinforce the importance of accurate documentation.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK - 6

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 06 **From:** 16.06.2025 **to** 21.06.2025

Activity Done- I got a active file audit sheet. According to that sheet I checked Initial assessment of doctors and nurses, assessment and reassessment, consents, fall, pain, vitals, nursing care plan, input/output, restraint.

In the doctors and nurses' initial assessment I checked Emergency (ER) nursing assessment time, ER assessment time(doctor), Patient arrival time in ward/ICU, nursing assessment completion time, Doctor assessment completion time, Resident Name, Resident Sign, Resident Date and time, consultant name, consultant sign, consultant date and time. In the assessment and reassessment, I checked doctor progress notes, diet initial assessment within 24 hours. I checked Informed consents, Blood transfusion consents, HIV consents. In the fall, pain, vitals, nursing care plan I checked the assessment and reassessment. I checked if there is any restraint consent and its appropriate completion. Checking the procedure consents thoroughly and noted the non-compliances carefully and informed mam about it.

Linking theory (Classroom learning) with practice at your organisation- In research methodology class, I learned about data collection methods through observation and analysis. Here, I apply those methods by observing and analysing files to identify non-compliances using real time, quantitative data.

Gaps identified on the working area- Sometimes, the initial assessment sheet and doctor progress notes lack proper signatures along with the Employee Identification.

Suggestions for improvement- Implement a mandatory checklist or electronic prompt to ensure that every initial assessment and doctor progress note is signed and includes the employee ID.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK - 7

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 07 **From:** 23.06.2025 **to** 28.06.2025

Activity Done- I got a MRD auditing sheet. According to that I checked medical records store in safe and secure place, Medico Legal Case (MLC) and death files storage locked or not, regular pest control in medical record storage including its records. Medical records committee meetings need to be done on regular intervals; I checked its last minutes and meeting conduction. Patient file complete and up to date in chronological order, all forms and consents should be named, signed, dated and timed, open and close audits of medical records, deficiencies need to be noted and corrective actions need be taken, staff interview about retention policy of records, staff interview about how to discard records. I also checked birth and death registers, ICD coding.

Linking theory (Classroom learning) with practice at your organisation- In classroom, we learned about proper medical record management, legal compliance, and documentation standards. During the MRD audit, I applied this by checking secure storage, complete patient files, audits, and committee meetings.

Gaps identified on the working area- Some files were missing important details like signatures, dates, or times on forms and consents.

Suggestions for improvement- Conduct regular file audits to check for missing signatures, dates, and times. Train staff on the importance of complete documentation and make it mandatory to review forms before filing.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK - 8

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 08 **From:** 30.06.2025 **to** 05.07.2025

Activity Done- I completed the data collection for my major project. After finishing the data collection phase, I started compiling and organizing the data to prepare it for analysis. This step is crucial to ensure the information is organized, structured and ready for meaningful analysis. I also began making a presentation on my project by structuring the content and highlighting the important findings. In addition to this I got a new project on evaluating outcome measures in robotic surgeries.

Linking theory (Classroom learning) with practice at your organisation- After completing the data collection for my major project, I began organizing and compiling the data, using methods and techniques I learned in research methodology classes.

Gaps identified on the working area- I have identified gaps in staff awareness related complete documentation of procedure consent forms.

Suggestions for improvement- Conduct periodic training sessions on consent form requirements, emphasizing the importance of complete documentation. Develop and implement a checklist to ensure all mandatory fields.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK - 9

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 09 **From:** 07.07.2025 **to** 12.07.2025

Activity Done- I collected patient data related to various surgical procedures like Malignant Hysterectomy, Benign Hysterectomy, Cholecystectomy, Ovarian Cystectomy, Endometriosis, Myomectomy. I collected data about Surgeon Name, Assistant Name, Surgical Modality, Patients Hospital ID, Date of Admission, Age, Body Mass Index(BMI), Parity, Prior Abdominal Surgery, Procedure Name, Diagnosis, Date of Surgery, Date of discharge, Wheel in time, Wheel out time, total operating time, incision time, skin opening time, skin closure time, estimated blood loss during surgery, firefly used, blood transfusion, intraoperative complications, length of stay-admission to discharge, length of stay-surgery to discharge.

Linking theory (Classroom learning) with practice at your organisation- In digital health classes we learned how technology enhances healthcare. Through digital health tools I collected data of the patients related to various surgeries.

Gaps identified on the working area- Sometimes different values or formats for the same data appear across various areas that causes inconsistency and confusion.

Suggestions for improvement- Implement standardized data entry protocols and provide regular training for staff on proper data maintaining and conduct routine audits.

Signature of the Student- Anupurva Nandi - Anupurva Nandi

Approved by the IIHMR University's Mentor

WEEK–10

Name of the Organisation: CK BIRLA HOSPITAL JAIPUR RBH

Area/ Department/ Project of Summer Internship Program: QUALITY DEPARTMENT

Name of the Student: ANUPURVA NANDI

Roll no: 1908 **Stream:** MBA IN HOSPITAL AND HEALTH MANAGEMENT

Week no: 10 **From:** 14.07.2025 **to** 19.07.2025

Activity Done- I continued the last project of collecting patient data related to various surgical procedures like Malignant Hysterectomy, Benign Hysterectomy, Cholecystectomy, Ovarian Cystectomy, Endometriosis, Myomectomy. I made my final presentation of my major project. I completed my major project and also finished making the PowerPoint presentation for it. I got it reviewed by ma'am. After completing my PPT, I presented and explained all the important points of my project.

Linking theory (Classroom learning) with practice at your organisation- This project experience helped me apply the concepts learned during my methodology classes, such as how to collect data systematically, organize information clearly, and analyse trends.

Gaps identified on the working area- While collecting patient data for various surgical procedures, I noticed that in very few cases, the discharge date mentioned in the patient record was incorrect.

Suggestions for improvement- Use hospital software that automatically records the actual discharge date/time when a patient is marked as discharged.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor

Compiled Reporting Format

Name of the Organisation: CK BIRLA HOSPITAL, RBH

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

Name of the Student: Anupurva Nandi

Roll no: 1908 **Stream:** MBA in Hospital and Health Management

Activity Done	During my internship in the Quality Department, I was actively involved in following tasks: • **Training & Initial Audits**: Attended Basic Life Support (BLS) training. Visited different hospital floors to look for non-compliances and observe procedures. I started with IPD file auditing. I explored areas such as the NICU, SNCU, labor room, maternal triage, and multispecialty wards. • **Sessions on Quality, Infection Control, and Fire Safety**: I Attended sessions on infection prevention strategies, fire safety procedures, and hospital quality standards. • **OPD & Emergency Audits**: I checked Signage, triage procedures, feedback gathering, and emergency preparedness using the given checklists. I found some compliance issues and recorded the results. • **Departmental Rotations**: I Visited and learned about the roles played by the Blood Bank, MRD, OT, CSSD, Lab, TPA, IT, Patient Care Services, and more. I observed Processes such as documentation systems, EMR/EHR use, and sterilization. • **Nursing interviews and ward audits**: Performed nursing interviews and ward audits based on criteria such as initial assessments, documentation schedules, discharge summaries, CPR policy, care of vulnerable patients, consent documentation, medication practices, hand hygiene, segregation of biomedical waste, and fire exit safety. • **Audits of Consent Forms:** Verified the completeness, signatures, appropriate documentation, and policy compliance of high-risk, surgical, anesthesia, dialysis, endoscopy, and radiological consents. reported non-compliances that were

	noticed. • **ICU/HDU Audits**: I checked patient nutrition evaluations, medication expiration dates, infection control procedures, and admission-to-assessment schedules and reviewed the prescription's clarity and consent paperwork. • **Blood Bank, Radiology, Lab, and Dialysis Audits**: These audits included high-risk medication handling, injection safety, biomedical waste handling, ALARA compliance, error documentation, equipment calibration, TATs, HIV consent, hand hygiene, fire safety, and audited counseling procedures. • **Endoscopy & Active File Audits**: In the endoscopy department I audited CPR training, CAPA documentation, informed consents, medication storage, emergency equipment availability, and infection control. I also audited live or open files. In the open file auditing I checked vitals, care plans, input/output, initial and reassessments, and consents for restraint were all examined. • **MRD Audit**: In the MRD Department I audited File safety, MLC/death file storage, pest control, meeting records, file completeness, ICD coding, retention and disposal policies. • **Consent Compliance for Major Project Work:** I • Collected and organized consent form data from various processes. I verified accuracy, timeliness, and completeness. I found some Gaps including last-minute documentation, incomplete second pages, and missing signatures. • **Surgical Outcome Data Collection**: Collected data for robotic and laparoscopic surgeries (Malignant/Benign Hysterectomy, Cholecystectomy, Myomectomy, etc.), including variables like BMI, surgery dates, OT times, blood loss, complications, and LOS. • **Project Completion & Presentation:** I Finalized project data and analysis. I prepared and delivered a PowerPoint presentation on project findings and recommendations.
Linking theory (Classroom learning) with practice at your organisation	• In classroom I learned about OTs and here I observed how the OT works, why the zoning is a very essential part of OT. In the class we learned about NABH here we are observing how quality department plays its role in the NABH accreditation of the hospital. I learned about how EMR and EHR is working in real

	life. In the marketing how the 4ps are working efficiently. • In classroom I learned the importance of accurate, complete and timely documentation and in organisation I directly observed that how much the full compliance of all the documents is important. In classroom I gained understanding of infection spread and how to prevent them and in organisation I observed how they follow hand hygiene protocols, using PPE and maintaining aseptic techniques during procedures. • I also learned about sorting medical waste in the right way, in my organisation I saw how the staff are sorting the medical waste in a right way according to the hospitals colour coded system. • In class we learned about infection control, proper documentation and SOPs of different departments. During the lab and dialysis audit I checked proper documentation and SOPs, equipment calibration, hand hygiene and PPE use, biomedical waste segregation and emergency plans. • In research methodology class, I learned about data collection methods through observation and analysis. Here, I apply those methods by observing and analyzing files to identify non-compliances using real time, quantitative data. • In classroom, we learned about proper medical record management, legal compliance, and documentation standards. During the MRD audit, I applied this by checking secure storage, complete patient files, audits, and committee meetings. • In digital health classes we learned how technology enhances healthcare. Through digital health tools I collected data of the patients related to various surgeries.
Gaps identified on the working area.	• Poor communication, limited use of telemedicine, lack of cleaning supervision. • Sometimes the housekeeping time cleaned the room quickly and this is a compromise on cleanliness. Sometimes the procedure consents are not filled out correctly.

	• I noticed hand washing was not always done every time which can increase the risk of infection. Initial assessment completeness often takes more time than expected, which can delay the prompt delivery of patient care. • I identified that the use of PPE in the lab is insufficient. In the dialysis unit the storage of medical equipment is not proper. • During this auditing I found a gap that the consents that are taken in the endoscopy before any procedure, are not properly filled. • Sometimes, the initial assessment sheet and doctor progress notes lack proper signatures along with the employee ID. • Some files were missing important details like signatures, dates, or times on forms and consents. • I have identified gaps in staff awareness related complete documentation of procedure consent forms. • Sometimes different values or formats for the same data appear across various areas that causes inconsistency and confusion.
Suggestions for improvement	• Daily briefing at the start of the OPD, train staffs on how to triage patients for telemedicine, conducting random audits and cleanliness inspection. • To address the cleaning issue, I recommend to implement regular training sessions for the housekeeping team to emphasize the importance of thorough cleaning. To improve compliance of the consents I suggest creating a checklist to ensure all forms are filled out correctly. • Regular training and reminders for staff on the importance of hand hygiene should be conducted. Installing more visible hand sanitizer stations and putting up clear signages that encourage hand washing before and after patient contact. To reduce delays in initial assessments, setting clear timelines and monitoring completeness regularly can help.

	• Conducting regular, mandatory training sessions on the importance of PPE, proper usage and the risk associated with non-compliance. Regularly train staff on safe medication handling. • Providing clear guidelines to staff and doctors on how to fill out consent forms properly, conduct regular training sessions to reinforce the importance of accurate documentation. • Implement a mandatory checklist or electronic prompt to ensure that every initial assessment and doctor progress note is signed and includes the employee ID. • Conduct regular file audits to check for missing signatures, dates, and times. Train staff on the importance of complete documentation and make it mandatory to review forms before filing. • Conduct periodic training sessions on consent form requirements, emphasizing the importance of complete documentation. Develop and implement a checklist to ensure all mandatory fields. • Implement standardized data entry protocols and provide regular training for staff on proper data maintaining and conduct routine audits

	the Lab. I learned how to spot problems like missing documents, poor hygiene, improper use of PPE, and gaps in how biomedical waste is handled or how machines are maintained. • **Infection Control in Action** I saw how the hospital maintains cleanliness and reduces infection risks—through hand hygiene, using protective gear like gloves and masks, safe injection practices, and proper waste disposal. • **Importance of Good Documentation** I learned how important it is to have complete and timely documentation. Missing a signature or a date can create serious problems in patient care and legal compliance. I understood how important it is to document everything—right from admission to discharge. • **Understanding Digital Tools in Healthcare** I got to see how EMRs and EHRs help doctors and nurses work more efficiently by keeping all patient information in one place. It saves time and improves the overall quality of care. • **Understanding the importance of consent forms-** I now understand why it's so important to take proper consent from patients before procedures. I noticed that sometimes these forms are not filled out properly, and I suggested ways to improve that. • **Building a Culture of Quality and Safety** I saw how the hospital focuses on keeping patients safe by doing regular audits, mock drills (like Code Blue), and by following strict quality guidelines. This showed me how much effort goes into getting NABH accreditation.

Signature of the Student- Anupurva Nandi Anupurva Nandi

Approved by the IIHMR University's Mentor