SUMMER INTERNSHIP PROGRAM

At

SANTOKBA DURLABHJI MEMORIAL HOSPITAL (SDMH)

From 12/05/2025 to 21/07/2025

A REPORT BY

AKASH KUMAR

Master of Business Administration

Hospital and Health Management

1897

2024-26

under the Mentorship of

DR. MAHENDER KUMAR

Professor

IIHMR UNIVERSITY

Santokba Durlabhji Memorial Hospital
cum Medical Research Institute

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

No. 1525

21.07.2025

Our Ref. :

Date.....

TO WHOMSOEVER IT MAY CONCERN

This certificate is awarded to Mr. Akash Kumar in recognition of having successfully completed his Internship in the Quality Department of this hospital for the period from 12.05.2025 to 21.07.2025.

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

We wish him all the best for his future endeavors.

Dr. Kriti Tambi
Head-Quality

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

IIHMR UNIVERSITY

IIHMR University Faculty Mentor Approval

This is to certify that **MR. AKASH KUMAR** of academic year **2024-26** of

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: 28 July 2025

(Signature of Faculty Mentor)

Name: Dr. MAHENDER KUMAR

Designation: Professor

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur- 302029, Rajasthan, India.
Ph.: 0141-3924700, 2791431- 32, E-mail: iihmr@iihmr.edu.in, Web.: www.iihmr.edu.in

Audit and analysis of medication records in inpatient settings at SDMH

PRESENTED BY AKASH KUMAR- 1897
MBA-HM 29, IIHMR UNIVERSITY, JAIPUR
FACULTY MENTOR: DR. MAHENDER KUMAR
ORGANIZATION MENTOR: DR. KALPANA BINDAL

BRIEF HISTORY AND DESCRIPTION –

SDMH Is a Private, Trust-managed, Autonomous, Fee-for-services And Not-for-profit Hospital. It Is a Multidisciplinary, 525-bed, Tertiary Care Hospital. It Houses Several Wards, Operation Theatres, ICUs, Laboratories, Utility Services, Specialties and Super Specialties, Including One of The Best Blood Banks in The Country, Catering to The Entire State of Rajasthan and To Neighboring States as Well.

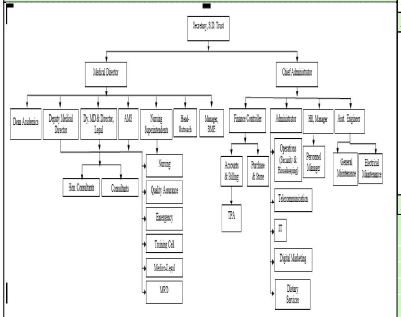
VISION –

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

MISSION–

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

ORGANIZATIONAL STRUCTURE –



SWOT ANALYSIS

Strengths

- Well-trained nursing staff.
- Well known for delivering quality patient care.
- Availability of well-established training programs.

Weaknesses

- More paperwork.
- Directional signages were not proper in some areas.
- Small waiting area in IPD.

Opportunities

- Spread use of EMR.
- Increase patient counselling.
- Convenient parking.

Threats:

- Rising competition from private hospitals.
- Rising patient expectations in terms of service quality and digital convenience.
- Limited online visibility or branding.

AIM–

To assess the medication records and identify medication errors in inpatient departments (wards, rooms, and ICUs).

OBJECTIVES–

1. To review medication records for identifying actual medication errors in inpatient departments.
2. To compare the frequency and type of medication errors between wards, rooms, and ICUs.
3. To suggest improvements for reducing medication errors and enhancing patient safety.

METHODOLOGY–

Study Setting: Santokba Durlabhji Memorial Hospital (SDMH), Jaipur.

Study Design: Descriptive cross-sectional study (audit-based).

Duration of study: 1 Month

Sample Size:

Wards – 80 patient files

Rooms – 40 patient files

ICUs – 40 patient files

Sampling Method: Random selection of files from each area.

Data Collection Method: Primary data collected through audit.

AUDIT PROCESS–

Randomly selected patient files

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In medication administration record checked all parameters of medication safety through checklist

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Fill the medication safety audit checklist

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Analysis and submitted to the quality department

ANALYSIS–

Parameters	% of Errors in Wards	% of Errors in Rooms	% of Errors in ICUs
No/ Wrong dose	1.25	5	2.5
No/Wrong frequency	3.75	7.5	5
No/Wrong concentration	1.25	5	2.5
No/Wrong rate of administration	2.5	2.5	7.5
Non-approved abbreviation used	5	10	12.5
Dose omission	1.25	2.5	2.5
Incomplete documentation by Nurse	10	7.5	10

CONCLUSION–

The checklist of Medication safety audit had 39 parameters.

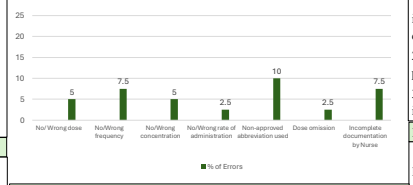
Seen in the table above are the parameters which found deficiencies.

The analysis of the audit was forwarded to the quality department.

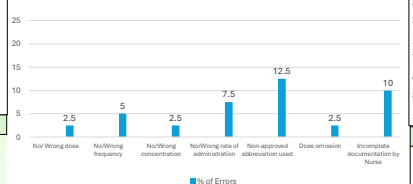
Training of nurses in all IPD wards was conducted.

MEDICATION RECORD AUDIT(WARDS)IN%–

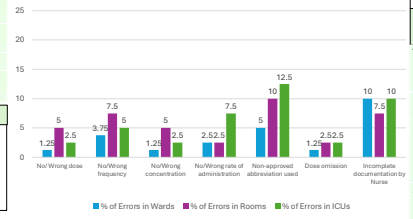
MEDICATION RECORD AUDIT(ROOMS)IN%–

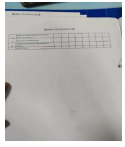


MEDICATION RECORD AUDIT(ICUs)IN%–



COMPARISON–





CHALLENGES FACED–

1. During shift changes, communication gaps sometimes led to inconsistencies in documentation or lack of accountability for missing entries.
2. Some nursing or support staff were newly recruited or untrained in proper documentation, leading to errors or incomplete records.
3. Use of non-standard or unclear abbreviations in patient records made it difficult to interpret clinical notes accurately.

MAJOR LEARNING DURING INTERNSHIP–

1. Learned about the importance of medication audits and their role in patient safety.
2. Understood how adherence to the Five Rights of medication administration (right patient, drug, dose, route, and time) plays a central role in preventing errors.
3. Understood that regular training sessions are essential to keep staff updated on drug protocols and safety measures.
4. I got familiar with NABH documentation practices and bedside auditing.
5. Improved skills in observation, analysis and team coordination.

SUGGESTION FOR IMPROVEMENT–

1. Display standard drug abbreviations to avoid misinterpretation.
2. Ensure all medication details are properly written and complete.
3. Cross-verify dose and timing before giving medicines.
4. Conduct training sessions on medication safety and error prevention.

DIFFERENCE BETWEEN THEORETICAL KNOWLEDGE AND PRACTICAL EXPOSURE–

Theoretical Understanding at IIHMR University:	Practical Exposure at SIP Organization (SDMH):
1. Learned about hospital through lectures and Focused on ideal hospital practices and policies.	1. Gained hands-on experience by working in real hospital settings and observed actual gaps in documentation, SOP adherence, and patient care.
2. Exposure to concept like EMR.	2. Limited use of EMR, much of the documentation and auditing was still manual.
3. Learned structured formats and complete documentation standards.	3. Applied quality checklists and audit tools in real-time and Saw practical issues like missing entries and non-approved abbreviations.
4. Learned different departments in hospital and infrastructure.	4. Experienced how different departments function in practice.

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream**: MBA (Hospital and Health Management)

Week no: 1st **From:……**12/05/2025……to……17/05/2025**…**

Activity Done	Orientation with Quality Assurance team. Guided tours of IPD and OPD blocks of hospital. Daily observation in different departments of safety protocols, documentation, energy preparedness and staff adherence. Observed various department and conducted ward audits using checklist in Gastroenterology, General Medical, Renal Wards. Analysed the discharge process of a patient and average discharge turnaround time (TAT) of a patient. Verified indicators related to the infection control (like-hand hygiene, sterilization, disinfection).
Linking theory (Classroom learning) with practice at your organisation	Application of quality management principles (NABH standards & KPI evaluation). Observation & analysis using tools like checklist. Patient safety, infection control, documentation setters & compliance monitoring, & biomedical waste management. Understood practical implementation of audit processes taught under Hospital Support Services.
Gaps identified on the working area.	Less digital records, more written documents. Inconsistent housekeeping and disinfection records. Delayed discharge procedures. Shortage of staff during duty shifts.
Suggestions for improvement	Ensure regulation and maintenance of cleaning and disinfection logs by housekeeping. Increase digitalization of patient & ward records. Increase staff to provide patient care more effectively. Monitoring discharge TAT and digitalizing discharge file processes.

Plan for the next week	Medication management in different wards in IPD.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream**: MBA (Hospital and Health Management)

Week no: 2nd **From:…** 19/05/2025**……to……**24/05/2025**…….**

Activity Done	Conducted medication safety audits in General Medicine, ICU, Neuro, Renal, Gastroenterology, RGHS, Maternity, LDR, Pulmonary, Twin sharing rooms and Cardiac wards using the Medication Safety Audit Checklist. Assessed drug charts of 8 patients per ward, focusing on prescription accuracy, nurse administration, and pharmacist dispensing practices. I interacted with nursing staff to understand their routine documentation procedures. I Observed dispensing activities in the pharmacy and the procedure of receiving medication orders into wards. I Recorded medication errors and near-miss events, categorizing them by type of errors and severity.
Linking theory (Classroom learning) with practice at your organisation	Applied principles of pharmacovigilance and medication error prevention studied during Pharmacology and Hospital Management lectures. Observed real-world applications of quality indicators in medication safety and related clinical governance standards. Understood the importance of Standard Operating Procedures (SOPs) in maintaining consistency in drug administration. Applied classroom training on ethical and legal aspects of medication errors in reviewing actual incidents.
Gaps identified on the working area.	Inconsistent use of capital letters for drug names and frequent use of unclear abbreviations in prescriptions. I observed lack of awareness among junior nursing staff regarding LASA (Look-Alike Sound-Alike) medications. Medication administration is not always followed by immediate documentation (medication administration record), leading to inconsistency. Inadequate communication between pharmacy and clinical staff during generic substitutions.

	Absence of a structured orientation for newly joined nurses on medication safety.
Suggestions for improvement	Develop a mandatory orientation/training program for new staff on hospital medication safety protocols. Introduce visual aids and posters in IPD wards to reinforce high-alert drug handling procedures. Conduct periodic refresher training on common medication errors and prevention strategies.
Plan for the next week	Conduct audit (medication management) for remaining IPD wards.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 3rd **From:……** 26/05/2025**……to……**31/05/2025**……..**

Activity Done	I conducted a medication safety audits in the following wards: Plastic Surgery Ward, Maternity Ward, Pulmonary Ward, Surgical ICU, Neuro ICU, SIDSS ICU, Chiranjeevi Ward, Royal Suites Room, Deluxe Room, LDR (Labor Delivery Room), Joint Replacement Ward. I reviewed medication administration records, prescription slips, nurse documentation, and pharmacy records for at least 6–8 patients per ward. I checked for errors related to drug dose, route, frequency, labelling, generic substitution, and documentation accuracy. I interacted with nursing and pharmacy staff for feedback on challenges they face in safe drug delivery.
Linking theory (Classroom learning) with practice at your organisation	Applied hospital pharmacy management concepts such as drug distribution systems and error classification. Utilized theoretical knowledge on medication reconciliation, especially in critical units like SICU, NICU, and SIDSS ICU. Concepts from maternal and neonatal care theory modules were applied in the LDR and Maternity wards. Learned the practical application of drug dosage calculations, particularly for paediatrics and elderly patients in Chiranjeevi and Neuro wards.
Gaps identified on the working area.	Plastic Surgery & Joint Replacement Ward: Occasional use of trade names instead of generic names; missing pre-op antibiotic documentation. Maternity & LDR: Incomplete documentation of oxytocin and magnesium sulphate doses; time of administration often not recorded. Pulmonary Ward: Delay in administration of bronchodilators and nebulization not documented consistently. Surgical ICU: Wrong time recorded for antibiotic prophylaxis; use of non-standard abbreviations (e.g., “OD” or “BD”). Neuro ICU: Complex regimens prone to transcription errors; illegible handwriting noticed.

	SIDSS ICU: Paediatric dosing errors due to weight not being updated; verbal orders without written confirmation.
Suggestions for improvement	Display visual medication guides and LASA alert charts in all wards. Initiate real-time double-check systems for high-risk medication administration in ICUs. Conduct targeted training for staff in LDR and Maternity on timely documentation of maternal drugs. Introduce paediatric dose calculation tools in SIDSS ICU and Chiranjeevi wards to reduce manual errors.
Plan for the next week	Focused re-audit of Surgical ICU, Maternity Ward, and SIDSS ICU based on this week's error trends.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 4th **From:……**02/06/2025**……to……**07/06/2025**……..**

Activity Done	I conducted medication safety audits in: Pulmonary Ward, Surgical ICU, Neuro ICU, SIDSS ICU, Chiranjeevi Ward, Royal Suites Room, Deluxe Room, Labor Delivery Room (LDR), General Medical Ward I reviewed inpatient medication records and MARs for ~7–10 patients per ward. I evaluated compliance using the Medication Safety Audit Checklist (e.g., wrong dose, time, omission, abbreviation, duplication). I identified documentation issues, especially in drug administration timing and initials/signatures of nurses. I held informal interviews with nursing staff to understand workflow, challenges, and knowledge gaps. I designed and conducted on-the-spot training sessions (5–10 minutes) for nurses where errors were found.
Linking theory (Classroom learning) with practice at your organisation	Pharmacology knowledge applied in identifying drug interactions, high-risk medications, and dose adjustments. Practical implementation of Hospital Quality Assurance principles—error reporting, root cause analysis. Used knowledge of ICU medication protocols (like titration, infusion rate, and timing) in Surgical and Neuro ICUs. Recalled classroom sessions on LASA (Look-Alike, Sound-Alike) drugs, now seen in real case audits. Training modules from classroom learning on medication reconciliation and nurse empowerment used to train nursing staff.
Gaps identified on the working area.	Omitted nebulization documentation. Use of brand names over generic. Delayed entry of medication time. No double-check for high-alert drugs. Pre-op antibiotic time mismatches. Wrong use of abbreviations like “OD,” “BD”.

	Complex regimens written unclearly. Dosage units (mg/ml) often missing. Lack of clear start/stop orders for tapering drugs.
Suggestions for improvement	Immediate Training: Provide focused bedside 5–10 min “micro-training” sessions to nurses on: Correct documentation format. Use of capital letters for drug names. Signing and timing entries post-administration. Standardized Abbreviation List to be displayed on ward walls.
Plan for the next week	Monitor the wards where errors were observed—Surgical ICU, SIDSS ICU, and LDR—for improvement. Conduct a group training session for nurses in General Medical and Chiranjeevi Wards.

Signature of the Student

Akash Kumar

Approved by the IIHMR University’s Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 5th **From :…**09/06/2025**……to……**14/06/2025**……..**

Activity Done	I conducted Medication Safety Audit in the following ICU departments: MICU (Medical ICU), SICU (Surgical ICU), Neuro ICU, Neuro Surgical ICU, Gastro ICU, Pulmonary ICU I reviewed patient medication charts, MARs (Medication Administration Records), and doctors' prescriptions. I identified errors based on the Medication Safety Audit Checklist (wrong dose, wrong time, omissions, etc.). I compared written orders with administered medications and pharmacy supply records.
Linking theory (Classroom learning) with practice at your organisation	Applied Pharmacological and Clinical Therapeutics concepts to identify drug-related problems in ICU settings. Implemented principles from Hospital Quality Management and also NABH standards like medication safety audits. Practical experience of ICU medication protocols (e.g., IV infusions and schedule adherence). Used classroom learning about Medication Error Classifications (e.g., omission, wrong dose) during documentation review.
Gaps identified on the working area.	Use of non-approved abbreviations like "OD", "HS". Timing of administration not matching doctor's orders. Omitted doses of antibiotics not reported or documented. Infusion rate documentation missing or delayed. Lack of unit/mg clarity in prescription and transcription. Verbal orders not converted into written documentation timely. Use of brand names instead of generics in documentation.
Suggestions for improvement	Organize daily micro-training (5–10 min) for nurses in each ICU during shift changes covering: Correct use of generic names and capital letters. Standard abbreviation usage and timing of entries.

	Place red stickers on high-alert medications for double-checking before administration. Introduce Medication Safety Champions among senior nurses in each ICU to reinforce learning.
Plan for the next week	Re-audit 3 units (e.g., MICU, SICU, Neuro ICU) for improvements after training. Conduct a group training session (20–30 mins) on: LASA drugs. Error reporting process. NABH guidelines for medication safety.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba durlabhji memorial hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA(Hospital and health management)

Week no: 6th **From:……**16/06/2025**……to……**21/06/2025**……..**

Activity Done	I conducted medication record audits in: Pediatric ICU, Neuro ICU, SIDSS ICU, ONCO Ward, Chiranjeevi Ward, RGHS Ward, Cardiac Ward. I reviewed 8–10 medication records per ward. I checked compliance with safe medication practices: right drug, dose, frequency, route, and documentation. I assessed errors based on the Medication Safety Audit Checklist. I conducted on-the-spot micro-training (5–10 minutes) for nursing staff in case of observed medication-related errors. I engaged with staff to understand reasons for non-compliance and documentation challenges.
Linking theory (Classroom learning) with practice at your organisation	Applied concepts from pediatric especially weight-based dosing in SIDSS and Chiranjeevi wards. Reinforced lessons on documentation standards, medications, LASA drugs, and medication error types from academic modules. Understood practical challenges of polypharmacy in the Cardiac and RGHS wards, linking them to hospital QA and risk management learnings. Witnessed real-world use of emergency medications, and high-risk drug handling in Neuro and Pediatric ICUs.
Gaps identified on the working area.	Use of abbreviations like “SC”, “OD”, which are discouraged. Omitted doses not followed up with incident reports. Incomplete documentation of IV infusion start/stop times. Verbal orders not transcribed in time. Missed time of administration entries in night shifts.
Suggestions for improvement	Conduct daily micro-training (5–10 min) with nurses in high-risk wards (Pediatric ICU, ONCO, Cardiac).

	Display abbreviation alert posters in all nurse stations with Do's and Don'ts. Develop a ward-specific drug reference sheet including common high-alert medications and dose ranges. Encourage staff to use error reporting forms for missed or incorrect doses without fear of punishment. Training to Nursing Staff: When any error is detected: Explain the error type (e.g., omission, wrong timing, incomplete charting). Reinforce key safety protocols—5 Rights of Medication (Right Patient, Drug, Dose, Route, Time).
Plan for the next week	Conduct a follow-up audit in ONCO, Pediatric ICU, and RGHS Wards based on this week's findings.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 7th **From:…**23/06/2025**……to……**28/06/2025**……..**

Activity Done	I audited medication records in: Gastro Ward, General Medical Ward, Executive Rooms, Royal Suites, Deluxe Rooms. I reviewed 6–10 medication charts per ward using the Medication Safety Audit Checklist. I verified prescription clarity, documentation of time, dose, drug route, and nursing initials. I identified and recorded errors in transcription, omission, abbreviation use, and wrong strength/dose. OPD Front Desk Introduction: Patient registration process. Token generation and queue management. Coordination between reception, billing, and consultation areas.
Linking theory (Classroom learning) with practice at your organisation	Applied Hospital Management and Patient Handling concepts while observing OPD front desk operations. Understood the flow of outpatient services, patient queries, and real-time appointment management. Implemented theoretical knowledge of medication safety and nursing documentation standards during audits in IPD. Applied communication and quality assurance principles in addressing issues in both inpatient and outpatient settings. Reinforced knowledge of medical ethics and confidentiality in patient interactions at the OPD front desk.
Gaps identified on the working area.	High frequency of missed time entries and incomplete records, especially during night shifts. Inconsistent nurse signatures on MARs. Manual token system used in some areas causing delays. Occasional lack of coordination between patient file dispatch and doctor availability.

Suggestions for improvement	Train nurses to: Use only approved abbreviations. Record exact time of administration, not estimated times. Ensure double-checking of high-alert medications before administration. Train front desk staff on: Handling patient queries with empathy and clarity. Real-time HIS entry and cancellation handling.
Plan for the next week	Observe patient feedback desk in OPD for service quality tracking. Introduce other departments in hospital.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 8th **From:……**30/06/2025**……to……**05/07/2025**……..**

Activity Done	I observed Blood Bank operations and specialized machines like NAT for early detection in HIV. I observed OPD Floors – Token System, Vitals, and Admission Process. I observed real-time use of MIRACLE HIS (Hospital Information System).
Linking theory (Classroom learning) with practice at your organisation	Applied digital health and HIS concepts from health IT lectures in understanding MIRACLE HIS. Understood triage, vitals monitoring, and admission formalities, connecting theory with real-world OPD operations. Gained insights into quality assurance in blood banking and lab testing, as emphasized in QA management subjects.
Gaps identified on the working area.	Manual documentation still in practice in some areas of blood bank. Occasional delay in updating vitals into HIS due to rush hours. Some patients unaware of token flow or display system. OPD lifts are small and few causing long waits.
Suggestions for improvement	Display flowchart posters of blood collection-to-issue process for awareness. Regular training for staff on OPD digital workflows and updates. Regular tech check for number display systems.
Plan for the next week	Visit the Medical Records Department (MRD) to observe file handling, storage, and record compilation. Observe Endoscopy procedures, focusing on documentation, consent, and coordination with nursing and technical staff. Continue working on final report and presentation. Observe processes at TPA.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Reporting Format (Weekly)

Name of the Organisation: Santokba durlabhji memorial hospital

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and health management)

Week no: 9th **From:……**07/07/2025**……to…**12/07/2025**……..**

Activity Done	I visited and observed the TPA Department: Understood workflows: pre-authorization → admission → billing → final claim submission I reviewed how errors in medication charts affect TPA claim approval. I interacted with TPA staff to understand common claim rejections. I conducted training sessions in IPD wards: Based on common documentation errors observed during audit.
Linking theory (Classroom learning) with practice at your organisation	Applied theoretical knowledge from: Hospital Quality Assurance and TPA Billing Processes Clinical Documentation Standards Digital Health (HIS integration) Reinforced classroom concepts of: Medication error types (omission, wrong dose, wrong time, transcription errors). Importance of accurate documentation for insurance processing.
Gaps identified on the working area.	In TPA Documentation: Drug charts attached with discharge summaries were: Incomplete or unclear Missing critical information (e.g., timing, frequency) Containing non-approved abbreviations In IPD Wards: Nurses unaware of how medication charting affects TPA claims Use of shortcuts/abbreviations still common. Some transcribed orders from doctors not entered into MAR.

Suggestions for improvement	Implement pre-discharge medication chart audit for TPA patients. Introduce medication safety champions in each wards.
Plan for the next week	Continue working on report. Take feedback from patients.

Signature of the Student

Akash Kumar

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Reporting Format (Weekly)

Name of the Organisation: Santokba Durlabhji memorial Hospital (SDMH)

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

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Week no: 10th **From:……**14/07/2025**……to……**19/07/2025**……..**

Activity Done	I conducted patient experience feedback survey across IPD wards. We collected data on CT and MRI scan waiting time (May–July). I analysed feedback on doctor behaviour, nursing, food, cleanliness. I identified issues in Gastro ward (AC not working). We compiled waiting time data for MRI (May–July) and CT (June).
Linking theory (Classroom learning) with practice at your organisation	Applied principles of Quality Management and Patient-Cantered Care in real-time by conducting patient satisfaction surveys. Used Operations & Hospital Workflow concepts to calculate waiting Time for radiology services. Practiced Service Quality Gap Model by mapping patient expectations vs actual experience.
Gaps identified on the working area.	Delay in CT & MRI procedures – indicating poor time management or resource allocation. Patients in Gastro Ward reported discomfort due to non-functional AC. Some patients experienced long discharge wait times. Food quality/taste dissatisfaction in select wards.
Suggestions for improvement	Optimize radiology scheduling systems to reduce MRI/CT delays and improve staff coordination. Immediate maintenance reporting and preventive facility checks (like ACs) in patient areas. Review and streamline discharge protocols to reduce patient wait time. Conduct monthly food taste surveys and coordinate with dieticians to improve patient food satisfaction.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Compiled Reporting

Name of the Organization: Santokba durlabhji memorial hospital (SDMH)

Area/ Department/ Project of Summer Internship Program:

Quality Assurance

Name of the Student: Akash Kumar

Roll no: 1897 **Stream:** MBA (Hospital and Health Management)

Activity Done	• Orientation with Quality Assurance team. • Guided tours of IPD and OPD blocks of hospital. • Daily observation in different departments of safety protocols and documentation. • I conducted medication safety audits using the Medication Safety Audit Checklist in the following wards: - General Medical ward, Neuro ward, Renal science ward, Gastroenterology ward, Cardiac ward, Plastic Surgery Ward, Maternity Ward, Pulmonary Ward, Chiranjeevi Ward, Joint Replacement Ward, ONCO Ward, RGHS Ward, SIDSS ward. MICU (Medical ICU), SICU (Surgical ICU), Neuro ICU, Neuro Surgical ICU, Gastro ICU, Pulmonary ICU Pediatric ICU, SIDSS (Santokba institute of digestive surgical sciences) ICU. Executive Rooms, Deluxe Rooms, Twin sharing rooms, Royal Suites Room, Semi-deluxe Room, LDR (Labor Delivery Room). • I reviewed medication administration records, prescription slips, nurse documentation, and pharmacy records for at least 6–8 patients per ward. • I evaluated compliance using the Medication Safety Audit Checklist (e.g., wrong dose, time, omission,

	abbreviation, frequency etc.). • I compared written orders with administered medications and pharmacy supply records. • I identified documentation issues, especially in drug administration timing and initials/signatures of nurses. • I interacted with nursing and pharmacy staff for feedback on challenges they face in safe drug delivery. • I engaged with staff to understand reasons for non-compliance and documentation challenges. • I conducted on-the-spot micro-training (5–10 minutes) for nursing staff in case of observed medication-related errors. OPD Front Desk Introduction, like- Patient registration process. Token generation and queue management. • Coordination between reception, billing, and consultation areas. • I observed Blood Bank operations and specialized machines like NAT for early detection in HIV. • I observed OPD Floors – Token System, Vitals, and Admission Process. • I observed real-time use of MIRACLE HIS (Hospital Information System). • I visited and observed the TPA Department: Understood workflows: pre-authorization → admission → billing → final claim submission • I reviewed how errors in medication charts affect TPA claim approval. • I interacted with TPA staff to understand common claim rejections. • I conducted training sessions in IPD wards: Based on common documentation errors (Medication administration record) observed during audit like- Use of brand names over generic. Delayed entry of medication time. No double-check for high-alert drugs. Wrong use of abbreviations like “OD,” “BD”. Dosage units (mg/ml) are often missing. Lack of clear start/stop orders for tapering drugs. Timing of the administration does not match doctor's orders.

	Verbal orders are not converted into written documentation timely. Missed time of administration entries in night shifts. • I conducted patient experience feedback survey across IPD wards. • We collected data on CT and MRI scan waiting time (May–July). • I analyzed feedback on doctor behavior, nursing, food, cleanliness. • We compiled waiting time data for MRI (May–July) and CT (June).
Linking theory (Classroom learning) with practice at your organisation	• Application of quality management principles (NABH standards). • Observation & analysis using tools like checklist. • Understood practical implementation of audit processes taught under Hospital Support Services. • Applied principles of pharmacovigilance and medication error prevention studied during Pharmacology and Hospital Management lectures. • Observed real-world applications of quality indicators in medication safety and related clinical governance standards. • Understood the importance of Standard Operating Procedures (SOPs) in maintaining consistency in drug administration. • Applied hospital pharmacy management concepts such as drug distribution systems and error classification. • Applied Hospital Management and Patient Handling concepts while observing OPD front desk operations. • Understood the flow of outpatient services, patient queries, and real-time appointment management. • Implemented theoretical knowledge of medication safety and nursing documentation standards during audits in IPD. • Applied communication and quality assurance principles in addressing issues in both inpatient and outpatient settings. • Reinforced knowledge of medical ethics and confidentiality

	in patient interactions at the OPD front desk. • Applied digital health and HIS concepts from health lectures in understanding MIRACLE HIS. • Understood triage, vitals monitoring, and admission formalities, connecting theory with real-world OPD operations. • Gained insights into quality assurance in blood banking and lab testing, as emphasized in QA management subjects. • Applied theoretical knowledge from: Hospital Quality Assurance and TPA Billing Processes Clinical Documentation Standards Digital Health (HIS integration) • Reinforced classroom concepts of: Medication error types (omission, wrong dose, wrong time, transcription errors). Importance of accurate documentation for insurance processing. • Applied principles of Quality Management and Patient-Centered Care in real-time by conducting patient satisfaction surveys. • Used Operations & Hospital Workflow concepts to calculate waiting Time for radiology services. • Practiced Service Quality Gap Model by Mapping Patient expectations vs actual experience.
Gaps identified on the working area.	• Less digital records, more written documents. • Inconsistent housekeeping and disinfection records. • Delayed discharge procedures. • Shortage of staff during duty shifts. • I observed lack of awareness among junior nursing staff regarding LASA (Look-Alike Sound-Alike) medications. • Medication administration is not always followed by

	immediate documentation (medication administration record), leading to inconsistency. • Inadequate communication between pharmacy and clinical staff during generic substitutions. • Absence of a structured orientation for newly joined nurses on medication safety. • Use of brand names over generic. • Delayed entry of medication time. • No double-check for high-alert drugs. • Wrong use of abbreviations like “OD,” “BD”. • Dosage units (mg/ml) often missing. • Timing of administration not matching doctor's orders. • Omitted doses not reported or documented. • Lack of unit/mg clarity in prescription and transcription. • Verbal orders not converted into written documentation timely. • Missed time of administration entries in night shifts. • High frequency of missed time entries and incomplete records, especially during night shifts. • Inconsistent nurse signatures on MARs. • Manual token system used in some areas causing delays. • Manual documentation still in practice in some areas of blood bank. • Occasional delay in updating vitals into HIS due to rush hours. • Some patients unaware of token flow or display system. • OPD lifts are small and few causing long waits. • In TPA Documentation: Drug charts attached with discharge summaries were: Incomplete or unclear Missing critical information (e.g., timing, frequency)

	Containing non-approved abbreviations • In IPD Wards: Nurses unaware of how medication charting affects TPA claims. Use of shortcuts/abbreviations still common. Some transcribed orders from doctors not entered into MARs. Delay in CT & MRI procedures – indicating poor time management or resource allocation. Some patients experienced long discharge wait times. Food quality/taste dissatisfaction in select wards.
Suggestions for improvement	• Ensure regulation and maintenance of cleaning and disinfection logs by housekeeping. • Increase digitalization of patient & ward records. • Increase staff to provide patient care more effectively. • Monitoring discharge TAT and digitalizing discharge file processes. • Develop a mandatory orientation/training program for new staff on hospital medication safety protocols. • Introduce visual aids and posters in IPD wards to reinforce high-alert drug handling procedures. • Conduct periodic refresher training on common medication errors and prevention strategies. • Immediate Training: Provide focused bedside 5–10 min "micro-training" sessions to nurses on: • Correct documentation format. • Use of capital letters for drug names. • Signing and timing entries post-administration.

	• Standardized Abbreviation List to be displayed on ward walls. • Encourage staff to use error reporting forms for missed or incorrect doses without fear of punishment. • Training to Nursing Staff: • When any error is detected: Explain the error type (e.g., omission, wrong timing, incomplete charting). • Reinforce key safety protocols—5 Rights of Medication (Right Patient, Drug, Dose, Route, Time). • Train front desk staff on: Handling patient queries with empathy and clarity. Real-time HIS entry and cancellation handling. Display flowchart posters of blood collection-to-issue process for awareness. • Regular training for staff on OPD digital workflows and updates. • Regular tech check for number display systems. • Implement pre-discharge medication chart audit for TPA patients. • Introduce medication safety champions in each wards. • Optimize radiology scheduling systems to reduce MRI/CT delays and improve staff coordination. • Immediate maintenance reporting and preventive facility checks (like ACs) in patient areas. • Review and streamline discharge protocols to reduce patient wait time. • Conduct monthly food taste surveys and coordinate with dieticians to improve patient food satisfaction.
Key Learnings	• I gained in-depth understanding of how Medication Administration Records (MAR) are maintained across various IPD wards. • I identified common documentation errors: Missing drug strength, frequency, or route. non-approved abbreviations like OD, HS. Illegible handwriting and unsigned entries.

	• I understood how accurate documentation ensures patient safety, treatment continuity, and legal compliance. • I observed coordination between wards, pharmacy, lab, billing, and TPA units. • I learned how errors in one department (e.g., nursing documentation) impact others (e.g., TPA claims, discharge). • I gained familiarity with hospital admission and discharge workflows through OPD, IPD, and HIS. • I understood the role of Hospital Information Systems (HIS) in: Recording medication and nursing notes Uploading lab results (e.g., NAT in blood bank) Linking billing, TPA claims, and pharmacy orders • I identified gaps in real-time entry and digital literacy among staff. • I conducted hands-on training sessions for nurses based on error trends. • Strengthened skills in: Preparing standard training material Communicating documentation standards effectively Demonstrating with actual examples from patient files • I learned how to influence nursing practice through education and teamwork. • I conducted regular audits in over IPD areas including ICUs, special rooms, and general wards. • I developed skills in: Root cause analysis of documentation errors Presenting findings and trends Offering practical, low-cost improvement suggestions • I aligned audit processes with hospital quality and NABH guidelines. • I gained clarity on how insurance pre-approvals and

	claims are processed. • I understood how nursing documentation directly affects TPA outcomes. • I developed confidence in working with clinical teams, nurses, and admin staff. • I improved communication and observation skills through real-time feedback. • I enhanced ability to apply classroom knowledge to hospital systems.

Signature of the Student

Akash Kumar

Approved by the IIHMR University's Mentor

Dr. Mahender Kumar