Anand Kumar Internship report

by Anand Kumar

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Summer Internship Report

At

Max Hospital, Gurgaon

(April 22nd to 18th June, 2024)

Under the Supervision of

Eena Thakur

Medical Quality

Quality Department of Max Hospital

A Report by:

Anand Kumar

PGDM (Hospital and Health Management)

2023-2025

International Institute of Health Management Research, New Delhi

Acknowledgements

I would like to express my deepest gratitude to everyone who supported me throughout my summer internship, making it a valuable and enriching experience.

First and foremost, I extend my sincere thanks to my college mentor at **IIHMR Delhi**, **Dr. Pankaj Talreja**, for their unwavering support, guidance, and encouragement. Your insightful advice and constructive feedback have been instrumental in shaping my learning journey and enhancing my understanding and I am incredibly fortunate to have had the opportunity to learn from you.

I would also like to thank my supervisor at **Max Hospital**, **Eena Thakur** for their exceptional support and mentorship during my internship. Your practical insights, patient guidance, and willingness to share your expertise have significantly contributed to my professional growth. The hands-on experience and real-world exposure I gained under your supervision have been invaluable, and I am deeply grateful for your patience and willingness to help me navigate through challenges and learn from them.

Lastly, I am grateful to both IIHMR Delhi and Max Hospital for providing me with this opportunity and the resources necessary to succeed.

Thanking You

Anand Kumar

(Completion of Summer Internship from respective organization)

The certificate is awarded to

Name Anand Kumar

In recognition of having successfully completed his/her Internship in the department of

Title Quality

and has successfully completed her Project on

Title of the Project - Discrepancies in patient files for Quality Compliance

Date 18-6-21

Organisation Max Healthcare

He/She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him/her all the best for future endeavors

Organization Supervisor

Head-HR/Department Head

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: Anand Kumar

Summer Internship Institution: Max Hospital, Gurgaon

Area of Summer Internship: Quality department

Attendance: Regular

Objectives met: Yes.

Deliverables: Completed Project

Strengths: Adaptable. A quick learner

Suggestions for Improvement: —

Signature of the Officer-in-Charge (Internship)

Eram Thakur
Quality.

Date: 12/6/24
Place: Gurugram.

FEEDBACK FORM

(IIHMR MENTOR)

Name of the Student: Anand Kumar

Summer Internship Institution: Max Hospital, Gurgaon

Area of Summer Internship: Quality department

Attendance: Regular

Objectives met: Yes

Deliverables: Completed his Project

Strengths: Adaptable

Suggestions for Improvement:

Signature of the Officer-in-Charge (Internship)

Date: 17/09/24
Place:

Certificate of Approval

The Summer Internship Project of titled **"Identifying discrepancies in patient file for quality compliance"** at **Max Hospital, Gurgaon** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed, or conclusion drawn therein but approve the report only for the purpose it is submitted.

Name of the Mentor
Designation
IIHMR, Delhi

RE: Project Proposal for Summer Internship

DP

Dr. Pankaj Talreja
To You

13 Jun

Approved. Kindly proceed with poster presentation.

Best,
Dr. Pankaj Talreja

From: Anand Kumar <Anandk_2325@iihmrdelhi.edu.in>
Sent: Sunday, June 9, 2024 3:54 PM
To: Dr. Pankaj Talreja <pankajtalreja@iihmrdelhi.edu.in>
Subject: Project Proposal for Summer Internship

Good Afternoon Sir

I hope you're doing well.

I've attached my project proposal, titled "**Identifying Discrepancies in Patient Files for Quality Compliance**" for you to review. I'd really appreciate it if you could take a look and let me know what you think. Your feedback will be really helpful to ensure the project is well-prepared and comprehensive.

Thanks a lot for your time.

Table Of Content

List of Abbreviations:

ICU	Intensive Care Unit
NICU	Neonatal Intensive Care Unit
PICU	Paediatric Intensive care unit
CCU	Critical Care unit
HDU	High Dependency Unit
WHO SSC	World Health Organization Surgical Safety Checklist
NABH	NATIONAL ACCREDITATION BOARD FOR HOSPITALS
NABL	National Accreditation Board for Testing and Calibration Laboratories
IVF	In vitro fertilization
ISO	International Organization for Standardization
COM	Clinical Outcome Measures
HIRA	Hazard Identification and risk Analysis
CC-14D	Critical Care- 14 Days
EHR	Electronic Health Record
CPRS	Computerized Patient Record System

Introduction to MAX Hospital

Max Hospital commenced its operations in the year of 2001. It was founded in the year 2007 and has bagged Express Healthcare for Excellence Awards in the department of healthcare. This hospital presents excellent centres for Reconstructive and Aesthetic surgery, Cardiac Surgery, Pulmonology, Gastroenterology (surgical & medical), Gynaecology, Obstetrics, Internal medicine, neurosciences, nephrology, IVF, Endocrine Surgery and Endocrinology. The laboratories here are NABL and NABH certified. Furthermore, it has ISO 9001:2000 certification as well.

The 104 bed Max Hospital Gurugram has treated over 5 lakh patients, applying its expertise across 35 specialized fields including Cardiac Sciences, Minimal Access, and Laparoscopic Surgery, Neurosciences, Urology, Orthopaedics, Aesthetics, and Reconstructive Surgery, and Nephrology.

It is a modern healthcare facility, equipped with 12 ICU beds, 5 CCUs, 7 HDUs and Cardiac Care beds, making it one of the largest medical centres in North India.

Along with this, the hospital also has an endoscopy department, radiology and pathology diagnostics, and other support units.

Its team of 150 doctors and 155 nursing staff is focused solely on providing a world-class healthcare experience. To help them do this, they use state-of-the-art technology, four high-end modular Operation Theatres, and an NABL-accredited Max Lab and NABH accreditation.

Objective

I am enthusiastic about joining the Medical Quality Department of Max Hospital for my summer internship to gain specialized knowledge and practical experience in healthcare quality management. My primary objective is to understand and contribute to the continuous improvement of medical care quality, patient safety, and clinical outcomes in a leading healthcare institution.

By engaging with the Medical Quality Department, I aim to:

1. **Enhance my knowledge of patient safety practices**
2. **NABH STANDARDS**

VISION & VALUES

VISION

Our vision is to deliver world-class healthcare with a service focus by creating an institution committed to the highest standards of medical & service excellence, patient care, scientific knowledge and medical education. We have set ourselves the mission of creating unparalleled standards of medical & service outcomes.

VALUES

1. Compassion

We have a deeper level of patient understanding and are always empathetic to their needs. This encourages a culture of providing a higher standard of patient-centred care. We respect each other and our patients, and ensure that their needs are met with dignity.

2. Excellence

   We ask more of ourselves and are always passionate about achieving the highest standards of medical expertise and patient care. We understand that being the best is a continuous journey of becoming better versions of ourselves every day.

3. Efficiency

   We create a responsive healing environment, by being nimble to the needs of our patients and delivering what they need with precision and timing. We are focused yet fast, personal yet practical, and advanced yet seamless in delivering the exact care our patients need.

4. Consistency

   We always deliver on our commitment and ensure the highest level of patient care is met at every stage, every time. We believe that only through consistency can we achieve our patients' trust and fulfil our goals.

DEPARTMENTS

Specialties:	**Other Departments**
Heart and Vascular Sciences	Critical Care Medicine
Neurosciences	Emergency Medicine
Musculoskeletal Sciences & Orthopaedics	Pathology
Liver and Biliary Sciences	Radiology
Ear Nose Throat	Paediatrics
Aesthetic And Reconstructive Surgery	Obstetrics & Gynaecology

Internal Medicine	Plastic Surgery
Gastroenterology, Hepatology & Endoscopy	Physical Medicine & Rehabilitation
Dermatology	Psychiatry
Endocrinology & Diabetes	Pulmonology

General Findings-1

Project on Preparing a Draft of Wound Assessment Policy and Form for ICU

1. Introduction The project aimed to create a standardized wound assessment policy and corresponding form to enhance patient care at Max Hospital. This initiative was driven by the need for consistency in wound assessment practices to improve patient outcomes and documentation accuracy.

2. Wound Assessment Form: The Wound Assessment Form includes various sections to capture comprehensive details about the patient's wound. Key components of the form are:

- **Patient Information**: Name, Nurse Initials, Date.
- **Wound Factors**: Type of wound (pressure, surgical, burn, etc.), location, dimensions, wound bed characteristics, exudate details, wound margin description, Odor, pain, and infection status.
- **Treatment Information**: Duration of the wound, patient factors delaying healing, allergies to wound care products, previous treatments and outcomes, and additional comments.

3. Wound Assessment Policy The policy provides a structured approach to wound assessment and management, ensuring standardized care across the hospital. Key elements include:

- **Aim**: To standardize wound assessment for optimal patient outcomes.
- **Objectives**: Provide holistic care, ensure systematic wound management, and maintain individual quality of life.
- **Protocol**: Detailed steps for wound assessment upon admission, regular wound checks, creation of individualized wound management care plans, and thorough documentation.
- **Monitoring and Quality Improvement**: Regular audits and quality improvement initiatives to ensure compliance and drive future protocol enhancements.

4. Implementation and Monitoring

- **Training**: Healthcare staff received training on the new form and policy.
- **Continuous Monitoring**: Regular evaluations and feedback collection to ensure ongoing effectiveness and compliance.

This project resulted in a comprehensive and standardized approach to wound assessment,

General Findings-2

NABH- The National Accreditation Board for Hospitals & Healthcare Providers (NABH) is an institution that provides accreditation to hospitals and healthcare organizations in India, ensuring adherence to high-quality standards in patient care and clinical practices.

Some of the standards that I worked on are: -

1. **COM**
2. **HIRA**

Clinical Outcome Measure

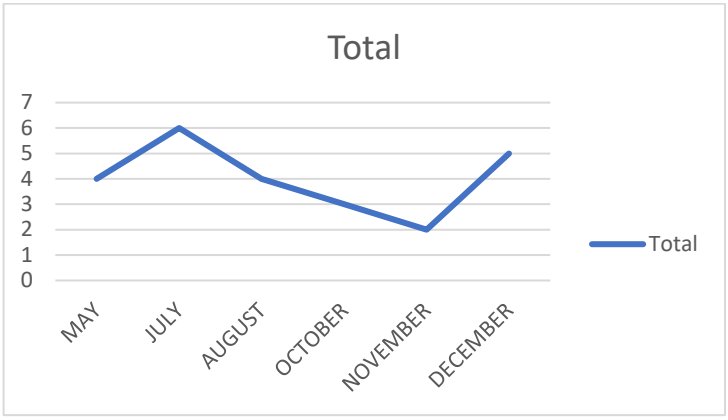
Clinical outcome measures are key indicators used to assess the results of healthcare services and interventions on patient health. These measures help in evaluating the effectiveness, safety, and quality of care provided by healthcare facilities. Clinical outcome measures include a variety of metrics, such as mortality rates, readmission rates. Some of these are mentioned below: -

1. **CC-14D Return Rate-** There exists the CC-14D return rate that is critical as outlined by NABH for monitoring clinical outcomes in hospitals. This rate measures the proportion of patients from hospital discharge who eventually require critical care services in a specified timeframe usually up to 14 days. It therefore gives insight into whether the hospitals discharge process takes care of the needs of its clients or not. If many patients come back, it may mean poor initial patient assessment during admission processes and their effectiveness, discharge planning, or follow-up care.

   In this project, we analyzed the readmission data of 24 patients who were readmitted to critical care within 14 days post-discharge of 6 different months. The distribution of these readmissions by different month is as follows:

- May: 4 patients
- July: 6 patients

- August: 4 patients
- October: 3 patients
- November: 2 patients
- December: 5 patients



Mortality Tracker-The instrument of mortality tracking is an essential tool within healthcare organizations aimed at ascertaining the reasons for patients' demise. Some of the uses of health information include: informing you on what killed, how surgeries went and also disparities in death rates according to American Society of Anaesthesiologists (ASA) physical status classification was engaged in March when a total number of 17 deaths were recorded with no chance events and none were from healthy patients.

-

2. **HIRA**

   Ensuring safety in hospital wards is paramount to protecting both patients and healthcare professionals from potential harm.

   Hazard Identification & Risk Analysis (HIRA) plays a critical role in systematically identifying, assessing, and mitigating hazards that could compromise safety within healthcare environments. This project focuses on identifying various types of hazards present in hospital wards, assessing their potential impact, determining their probability of occurrence, and proposing effective risk management strategies.

- **Process of Hazard Identification & Risk Analysis**

  The HIRA process involves systematic steps to identify hazards, assess risks, and implement controls:

  Hazard Identification:

  i) Types of Hazards: Physical hazards (e.g., slips, trips, falls), chemical hazards (e.g., hazardous substances), biological hazards (e.g., infections), ergonomic hazards (e.g., lifting injuries), psychosocial hazards (e.g., workplace violence).

  ii) Description of Hazards: Detailed descriptions of each identified hazard, including how and where they occur in hospital wards.

  Risk Assessment:

  i) **Impact of Hazards:** Evaluating the potential consequences if a hazard manifests (e.g., patient falls leading to fractures, infections from inadequate sterilization).

  ii) Probability Assessment: Determining the likelihood of hazards occurring based on historical data, frequency of exposure, and environmental factors.

CHAPTER 2

Project

Title- Identifying Discrepancies in Patient Files for Quality Compliance at MAX Hospital Gurgaon

Introduction

- Ensuring the accuracy and completeness of patient files is crucial for maintaining high standards of healthcare quality and compliance. Discrepancies in patient files can lead to misdiagnoses, inappropriate treatments, and legal issues.
- This study aims to identify and analyse discrepancies in patient files, focusing on compliance with quality standards and guidelines, over two months.

Rationale

Focus Area	Important Rationale
1. **Patient Safety**	Reduced Errors - Misinformation can pose a risk to patient safety on a global scale. The ultimate goal is to prevent medication mistakes and have accurate diagnoses.
2. **Quality Improvement**	In healthcare, quality compliance implies that high standards are maintained. It is necessary to identify and correct any inconsistencies in patients' files so as ensure a uniform therapy and accurate matching of medical services according to their health condition.
3. **Regulatory Compliance**	The healthcare industry is subject to very strict legislative and audit requirements. Making sure administrative processes are consistent and patient files secure simulate compliance at the local, national, and international levels hence avoids hefty fines and continues to be accredited.

4. Operational Efficiency	Discrepancies in patient files can be a significant cause of inefficiencies in hospital operations, with treatment delays, repeated tests, and miscommunication among healthcare providers all occurring. Spotting these discrepancies and solving them helps up operations, which in turn lowers the cost and improves resource allocation.
5. Legal Protection	Correct registrations of the patient are important for legal protection. It is found that discrepancies in patient records can provoke legal disputes and malpractice claims. Making sure that personal data of the patient is comprehensive and accurate would serve as an additional protection of the hospital and its personnel from the legal implications.
6. Continuous Improvement	Frequent issue resolution regarding patient records within the hospital by way of recognizing the proper medical records made a good way of maintaining quality. This approach leads to finding out the actual causes of errors, applying the solutions, and thus, improvement of the delivery of healthcare services.

Research Question

1. What types of discrepancies are most commonly found in patient files?
2. In which department most discrepancies are found?
3. How these discrepancies can be corrected?

Aim

This project has the goal to enforce efficient auditing and monitoring tactics that lift the accuracy and sufficiency of patient records, offer a better quality of care and patient safety, ensure regulatory compliance, and make operational efficiency better.

Objective

1. Identify Common Discrepancies: To catalogue the types and frequencies of discrepancies found in patient files and electronic health records.
2. Determine Responsibility: To investigate the primary sources of discrepancies, including human errors, system limitations, and procedural flaws.
3. Enhance Compliance: To ensure compliance with national and international healthcare standards and regulations, patient records need to be kept with the intended high level of collection and proper filing.
4. Assist Decision-Making: To give information to hospital management based on data analysis to increase quality improvement initiatives

Method of Data Collection

1. **Passive Audits of Patient Files:**
    - **Source:** Physical and electronic patient files
    - **Process:** Conduct thorough passive audits of a representative sample of patient files, selected randomly or based on specific criteria such as patient files of a specific peri.
2. **Data Extraction from EHR Systems:**
    - **Source:** Electronic Health Records (EHR) systems at MAX Hospital Gurgaon which is **SANSYS EHR**
    - **Process:** Extract relevant patient file data using automated tools and scripts to ensure comprehensive and consistent data retrieval.

Methodology

4.1. Study Design

- A retrospective, observational study design will be utilized, involving passive audits of patient files to identify discrepancies.

4.2. Setting

- The study will be conducted in Max Hospital, Gurgaon, with a focus on both inpatient and outpatient departments.

4.3. Sample Size

- A sample of 200 patient files will be audited, dd and selected using a stratified random sampling method to ensure diverse representation across departments and patient demographics.

4.4. Data Collection

- Data Sources: We gather information from both Electronic Health Records (EHR) and good old-fashioned paper-based patient files.
- Audit Tool: A standardized audit tool will be developed, including key indicators such as:
  - Face Sheet and Discharge Summary
  - Medical history and physical examination records
  - Doctor and Nursing Notes
  - Treatment plans and medication orders
  - Follow-up care instructions
  - Consent forms and patient education documentation

4.5. Data Analysis

- Quantitative Analysis: Descriptive statistics will be used to summarize the data, highlighting the frequency and types of discrepancies.

5. Ethical Considerations

- Confidentiality: Patient anonymity will be maintained by de-identifying all patient data.

6. Timeline

- Activity Duration- 2 MONTHS
- Preparation and Training- 1 week
- Data Collection and Data Analysis- 6 weeks
- Reporting and Recommendations- 1 week

RESULTS

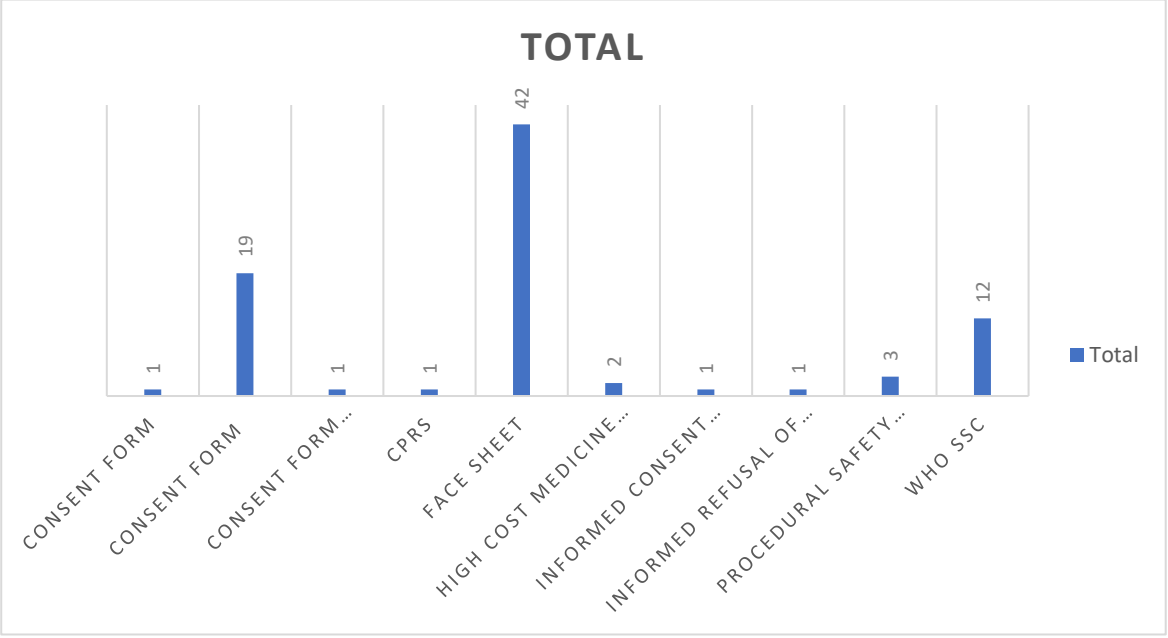
1. **Discrepancies Found**

Summary of Findings:

- **Total Patient Files Audited:** 200
- **Files with Discrepancies:** 83 (41.5% of total files)

Breakdown of Discrepancies (Total 83 discrepancies):

- **Face Sheet:** 42 discrepancies (50.6% of total discrepancies)
- **Procedural Safety Checklist:** 3 discrepancies (3.6% of total discrepancies)
- **WHO Surgical Safety Checklist:** 12 discrepancies (14.5% of total discrepancies)
- **High-Cost Medicine Consent Form:** 2 discrepancies (2.4% of total discrepancies)
- **Consent Forms:** 20 discrepancies (24.1% of total discrepancies)
- **CPRS (Computerized Patient Record System):** 1 discrepancy (1.2% of total discrepancies)
- **Informed Refusal of Recommended Treatment:** 1 discrepancy (1.2% of total discrepancies)
- **Informed Consent Form - Generic and Blood Transfusion:** 1 discrepancy (1.2% of total discrepancies)
- **Consent Form - Contrast Media:** 1 discrepancy (1.2% of total discrepancies)



Graph of Frequency of Various Discrepancies

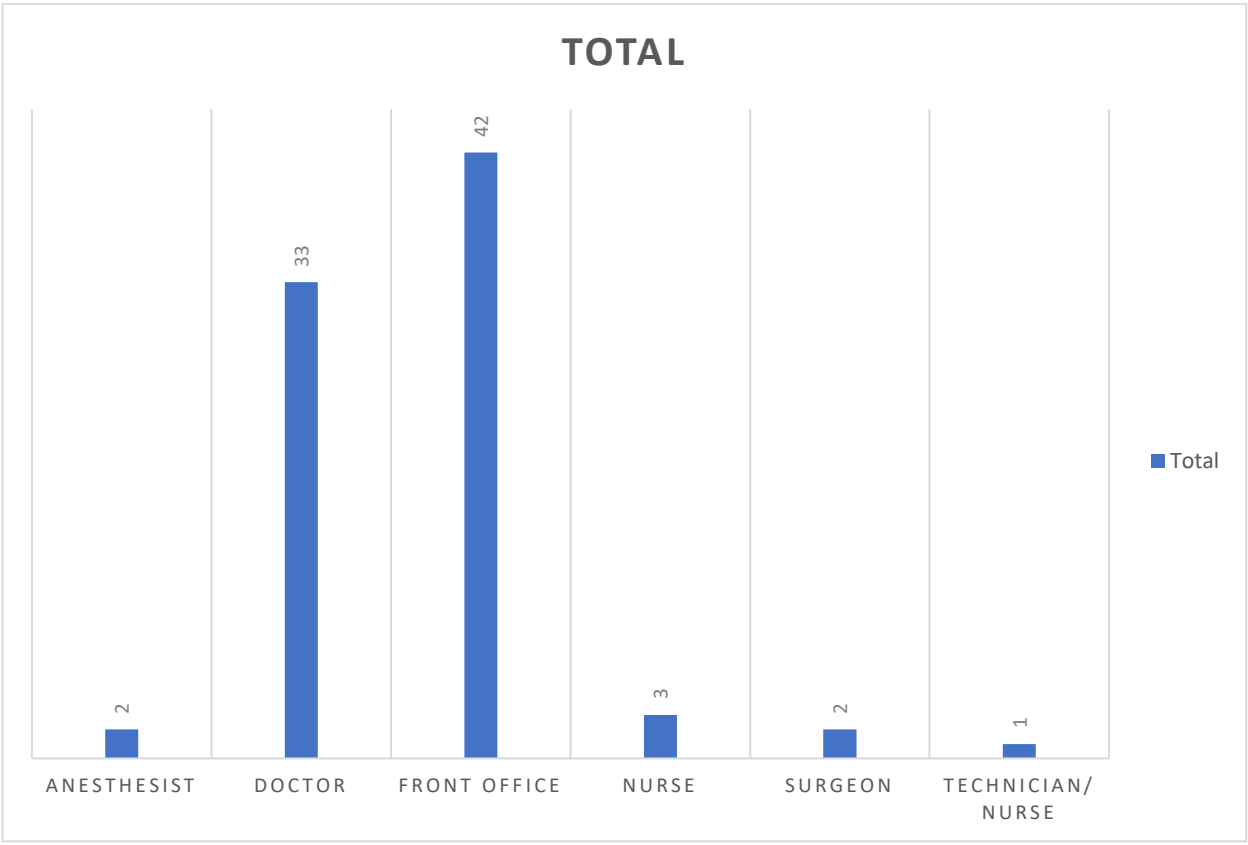
2. **Discrepancies by Responsibility**

Summary of Findings:

- **Total Patient Files Audited:** 200
- **Files with Discrepancies:** 83 (41.5% of total files)

Breakdown of Discrepancies by Responsible Party:

- **Front Office:** 42 discrepancies (50.6% of total discrepancies)
- **Doctors:** 33 discrepancies (39.8% of total discrepancies)
- **Nurses:** 3 discrepancies (3.6% of total discrepancies)
- **Surgeons:** 2 discrepancies (2.4% of total discrepancies)
- **Technician/Nurse:** 1 discrepancy (1.2% of total discrepancies)
- **Anaesthetist:** 2 discrepancies (2.4% of total discrepancies)



Graph of Frequency of Discrepancies by Responsibility

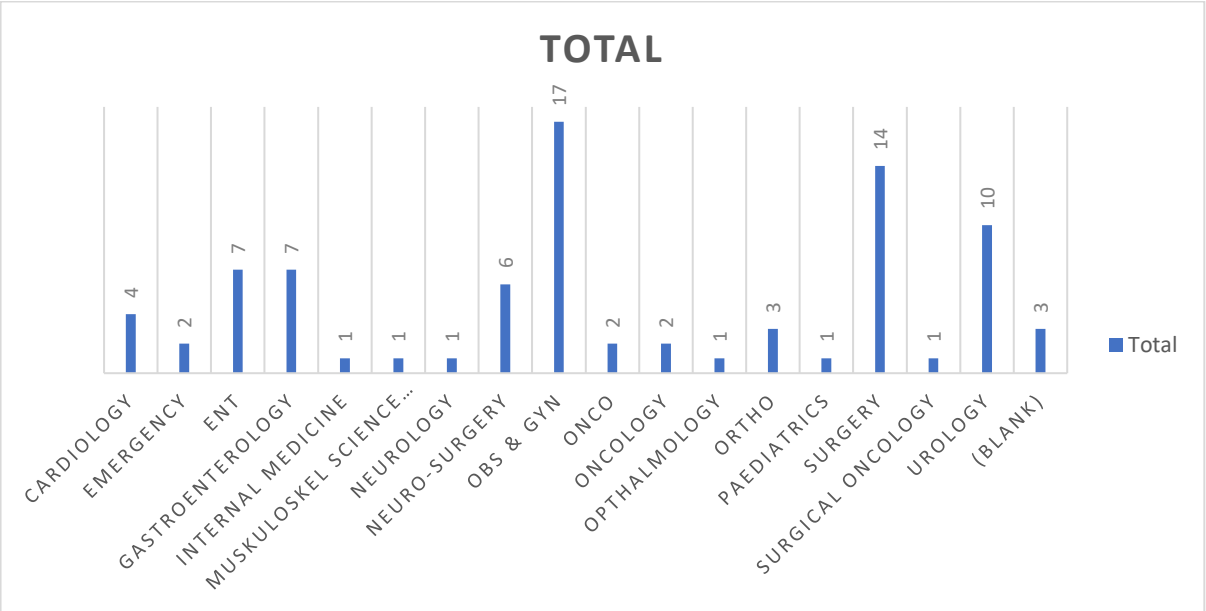
3. **Discrepancies by Department**

Summary of Findings:

- **Total Patient Files Audited:** 200
- **Files with Discrepancies:** 83 (41.5% of total files)

Breakdown of Discrepancies by Department (Total 83 discrepancies):

- **Cardiology:** 4 discrepancies (4.8%)
- **Emergency:** 2 discrepancies (2.4%)
- **ENT:** 7 discrepancies (8.4%)
- **Gastroenterology:** 7 discrepancies (8.4%)
- **Internal Medicine:** 1 discrepancy (1.2%)
- **Musculoskeletal Science and Orthopaedics:** 1 discrepancy (1.2%)
- **Neurology:** 1 discrepancy (1.2%)
- **Neurosurgery:** 1 discrepancy (1.2%)
- **Obstetrics & Gynaecology:** 17 discrepancies (20.5%)
- **Oncology:** 4 discrepancies (4.8%)
- **Ophthalmology:** 1 discrepancy (1.2%)
- **Orthopaedics:** 3 discrepancies (3.6%)
- **Paediatrics:** 1 discrepancy (1.2%)
- **Surgery:** 14 discrepancies (16.9%)
- **Surgical Oncology:** 1 discrepancy (1.2%)
- **Urology:** 10 discrepancies (12.0%)



Graph of Discrepancies by Departments

Discussion

During my time at Max Hospital, Gurgaon, a study was conducted to identify errors in patient records and enhance the precision of healthcare documentation. The analysis revealed that approximately 41.5% of the reviewed patient files contained discrepancies. The predominant mistakes were found in the face and consent forms, primarily attributed to the front office staff and occasionally doctors. These findings highlight specific areas necessitating modifications to ensure secure patient care and adherence to regulations.

Strengths and Limitations

Strengths:

1. In-depth Audit: The study employed a stratified random sampling technique, examining 200 patient files from various departments for representativeness.

2. Comprehensive Analysis: Both quantitative and qualitative methods were used to provide thorough information on existing discrepancies and their origins.

3. Emphasis on Compliance and Safety: The study emphasized adherence to national and international healthcare standards, linking findings directly to regulatory enhancements.

Limitations:

1. Retrospective Design: Being a retrospective observational study, it relies on preexisting records that may not capture all real-time documentation nuances.

2. Sample Size: While 200 files offer a considerable dataset, larger samples could yield more generalized results.

3. Limited Scope: The study focused on a single hospital, potentially restricting the generalizability of its findings to other healthcare environments.

Recommendations

1. Ongoing Training Programs: Continuous training sessions for front office staff and physicians are essential to reduce documentation errors.

2. Standardized Documentation Procedures: Establishing uniform procedures for completing face sheets and consent forms can minimize variability and mistakes.

3. Regular Audits: Conducting routine audits and feedback sessions ensures high documentation standards are upheld promptly addressed.

4. Interdisciplinary Collaboration: Promoting collaboration across departments is crucial for a comprehensive approach to managing patient files and minimizing errors.

Conclusion

The study conducted at Max Hospital Gurgaon underscores the significance of precise patient documentation in delivering top-quality healthcare services. By identifying and rectifying discrepancies in patient files, the hospital can significantly enhance patient safety, regulatory compliance, and operational effectiveness. Implementation of these suggested strategies will cultivate an environment of continuous improvement and excellence in healthcare delivery. These insights and recommendations are imperative for the hospital's quality department to enact measures that enhance overall healthcare documentation practices leading to improved patient outcomes.

ANNEXURE

IIHMR DELHI

JOINING REPORT ON INTERNSHIP

1. Student: Anand Kumar

2. Roll. No: PG/23/016

3. Contact Number: 8397836814

4. Email ID: Anandk_2325@iihmrdelhi.edu.in

5. Name of the Organization: Max Hospital, Gurgaon

6. Topic of Summer Training: Identifying Discrepancies in Patient Files for Quality Compliance at MAX Hospital Gurgaon

7. Address of the Company where student is posted: B Block, Sushant Lok 1, Near Huda City Centre MF Husain Marg Near Huda City Centre, Sector 43, Gurugram, Haryana 122001

8. Date of Joining the Company: 22th APRIL 2024

9. Name of the Company Supervisor: EENA THAKUR

10. Contact Number of Supervisor: 8729022623

References

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Anand Kumar Internship report

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