Summer Placement

In

Sterling Hospital, Ahmedabad

(April 4 - May 30, 2011)

Discharge from hospital

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Post- graduate Programme in Hospital & Health Management,
New Delhi, 2010-12

IIHMR International Institute of Health Management Research

# FEEDBACK FORM

**Name of the Student:** Dr. MEGHA TRIVEDI

**Summer Training Institution:** STERLING HOSPITAL, A'BAD.

**Area of Summer Internship:** "Discharge of Patients from Hospital;

**Attendance:** Regular,

**Objectives met:**

**Deliverables:** Submitted her Project's hard copy which is very useful for us in the Patient services area.

**Strengths:** Good Communication, learning attitude

**Suggestions for Improvement:** —— Nothing ——

**Signature of the Officer-in-Charge (Training)**

for

**Date** 14/06/2011

**Place** Sterling Hospital, Ahmedabad.

## ACKNOWLEDGEMENT

It gives me immense pleasure, having done a project on an interesting and knowledgeable topic like “discharge from hospital.”

This project has not only widened my horizon as far as academics are concerned but also helped me to enlarge my knowledge bank. Operations Management and Human resources are not topics, which could be handled with certain amount of casualty. It requires a deep study and hard work, which is key to success. There are many people associated with this project without which this project would not have been possible.

I am deeply grateful to Dr. Chandramauli Raval, CMA for his ever willing help and guidance to complete my project successfully.

I would like to thank Mr. Dev Vyas, Training and Development Head who allowed me to do this project in Sterling Hospitals successfully.

I would like to thank to other office members of Sterling hospitals for their noble inspiration, keen interest, constant supervision and ever willing help throughout the course of this study.

Above all I would like to thank all contacted persons of the firm who took out valuable time to answer my queries and gave me full information about Sterling Hospitals.

I am grateful to my course coordinator Dr. Rajesh Bhalla –Dean IIHMR who has shared their experience and provided their guidance for this project.

Above all it gives me immense pleasure to thank authors of various books who indirectly helped me in gaining knowledge of Hospital industry.

Index

Abbreviations:-

1- ICU- Intensive Care Unit

2- HOD- Head Of Department

3- OJT- On the Job Training

4- MLC- Medico Legal Case

5- PACU- Post Acute Care Unit

6- CPOE- Computerized Physician Order Unit

7- EPR- Electronic Patient Record

8- PCP- Primary Care Physician

Introduction:-

Objective: To assess the completeness of hospital discharge summaries and the efficiency of the discharge summary.

Hospitals recognize that moving discharge times toward the earlier hours of the day can pay large dividends in patient flow throughout the hospital. The patient who leaves a medical-surgical bed allows transfer of a patient out of ICU, which allows the operating room (OR) to place the complex case in the ICU.

Arguably, the discharge process begins the day of admission, and a robust care management program can set expectations for discharge with the patient and family at the time of admission. Even with care management, however, there are at least two general approaches to the actual hour-by-hour timing of discharges.

The first approach is to attempt to move the time of discharge for all patients to an earlier time in the day. This approach has met with mixed results and can generate considerable frustration for patient and staff. It can also require a disproportionate investment in time with staff attempting to move immovable patients, while patients requiring minimal assistance to be discharged languish.

The second approach focuses on establishing a realistic time for discharge for each patient– an appointment for discharge. All relevant services and the family are aware of this appointment and efforts are focused on making the appointment. If the patient is scheduled for a 9:00 a.m. discharge, then physical therapy would make every effort to slot that patient for an early appointment and give the patient with a discharge appointment of 11:00 a.m. a later session. A similar practice is followed in other areas such as imaging and the lab.

As the final step in the hospital experience, the discharge process is likely to be well remembered by the patient. Even if everything else went satisfactorily, a slow, frustrating discharge process can result in low patient satisfaction.

The discharge process is a critical bottleneck for efficient patient flow. Slow or unpredictable discharge translates into a reduction in effective bed capacity and admission process delays. In fact, the discharge process and scheduling in-patient surgery rank as the two biggest factors

impacting wait times for in-patient beds. Implementing the required changes for more efficient patient discharge can be greatly enhanced with the application of Lean Flow principles, as well as with a supporting Change Management Framework.

Typical Emergency Department–Scenario

Symptoms

- Lengthy discharge and admission cycles
- Emergency room crowding due to lack of in-patient beds, leading to higher ambulance diversion as well as patients leaving without being seen
- Frustrated patients and staff

Achievable Results

- Smooth discharge process
- Reduced emergency room crowding
- Greater effective bed capacity
- Increased patient and staff satisfaction

Method and data:-

Completeness: Proportion of summaries in which the following information was reported: admission diagnosis, drug allergies, physical examination, significant laboratory tests and results, discharge diagnosis, discharge medications, discharge timings and medical follow-up.

Information in the charts and discharge summaries of each patient was reviewed with the use of a structured form developed previously for this project. (The form is available from the corresponding author upon request.) Information items on the form included those felt to be important for discharge summary content, modified from recommendations regarding content from the Joint Commission on Accreditation of Hospitals' to ensure relatively simple chart abstraction. All summaries were evaluated for the presence or absence of the following key items:

1. Admission diagnosis,
2. Drug allergy,
3. Physical examination,
4. Significant laboratory tests and results,
5. Discharge diagnosis,
6. Discharge medications (including dosage and duration, if pertinent [e.g., for antibiotics or anticoagulants])
7. Discharge timings and
8. Medical follow up

A patient was defined as having a drug allergy if the allergy was listed on the patient's admission write-up or if a "drug alert" was marked in the chart. The discharge medication list in the summary was compared with that in the discharge progress notes, discharge orders or the handwritten short report to the family physician. Medical follow-up was considered absent if no mention of medical attention for the patient was listed but the patient had a discharge diagnosis that the chart reviewer felt was significant enough to merit follow-up. To assess the completeness of laboratory investigation reporting, all tests were divided into six categories:

1. Hematologic,
2. Biochemical,
3. Electrocardiographic,
4. Microbiologic,
5. Imaging and
6. Pathological

In each category extreme results were defined as **"Significant."**

## Hospital/ organization profile:-


**STERLING ADDLIFE INDIA LIMITED** came into existence with effect from 29.12.2000 as a Limited Company registered with the office of the Registrar of Companies; Gujarat. Sterling Addlife India Ltd. is a dominant player and premier healthcare service provider in Gujarat. It has become one of the leading regional healthcare companies in India. The philosophy of the company remains to be patient centric, follower of ethical medical practices, and a provider of world class healthcare to global clientele.

Sterling Hospital, owned and managed by Sterling AddLife India Ltd., is the leading hospital chain in Gujarat. It is engaged in providing high quality medical and surgical care in a host of critical specialties such as-

- Cardiology and CVTS surgeries,
- Neurology and Neuro- surgeries,
- Nephrology and Kidney Transplant,
- GI Medicine and Surgeries,
- Hematology,
- Oncology and Onco-surgery,
- Critical and Emergency Care,
- Trauma and Orthopedic,
- Neonatology as well as General Medicine and Surgeries.

Sterling has six multi-specialty tertiary care hospitals, one each at Ahmedabad, Baroda, Rajkot, Surat, Mundra and Bhavnagar and two satellite centers, one each at Kalol and Mehsana. The company has STERLING HOSPITAL, a multi-super speciality hospital in Ahmedabad – with 310 beds, 7 major operation theatres and 137 ICU beds. The company has also taken over Sterling Hospital, Vadodara which is having all multi-super-specialty facilities. Sterling\'s high quality services attract patients from Gujarat, Rajasthan, Madhya Pradesh, Maharashtra and even from outside the country. Sterling is also focused on clinical research and medical education through DNB programs. As a part of Sterling\'s ambitious growth plans, Actis, the well-known Private Equity Firm, has acquired a significant equity stake in Sterling AddLife India Ltd.

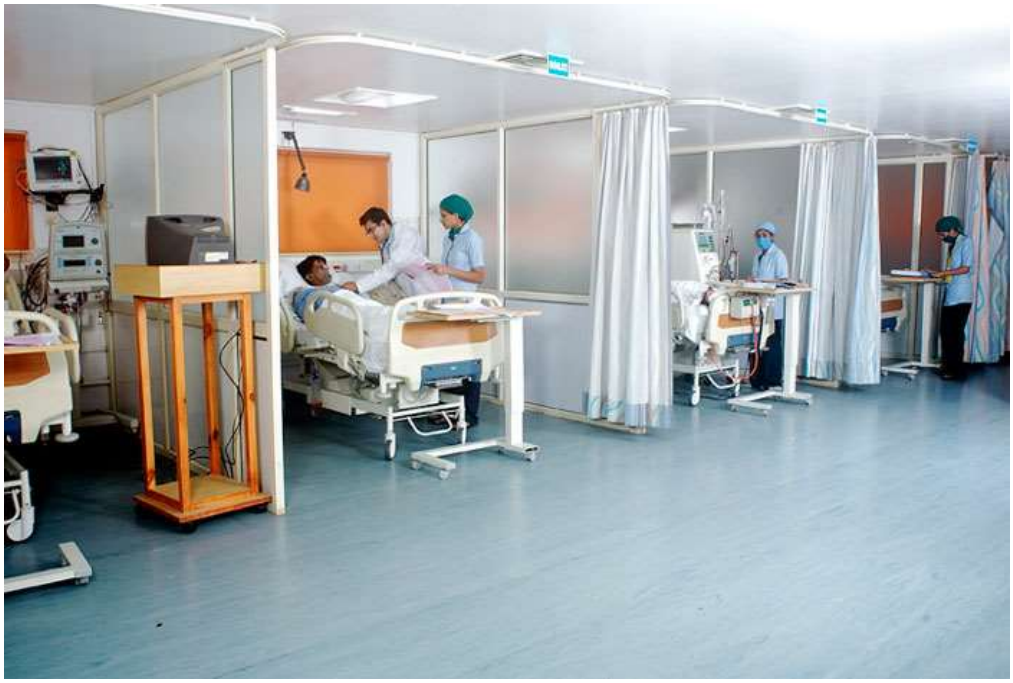
## About Sterling Hospital, Ahmedabad

In October 2001 The first hospital of the company, Sterling Hospital- Ahmedabad was opened to public.

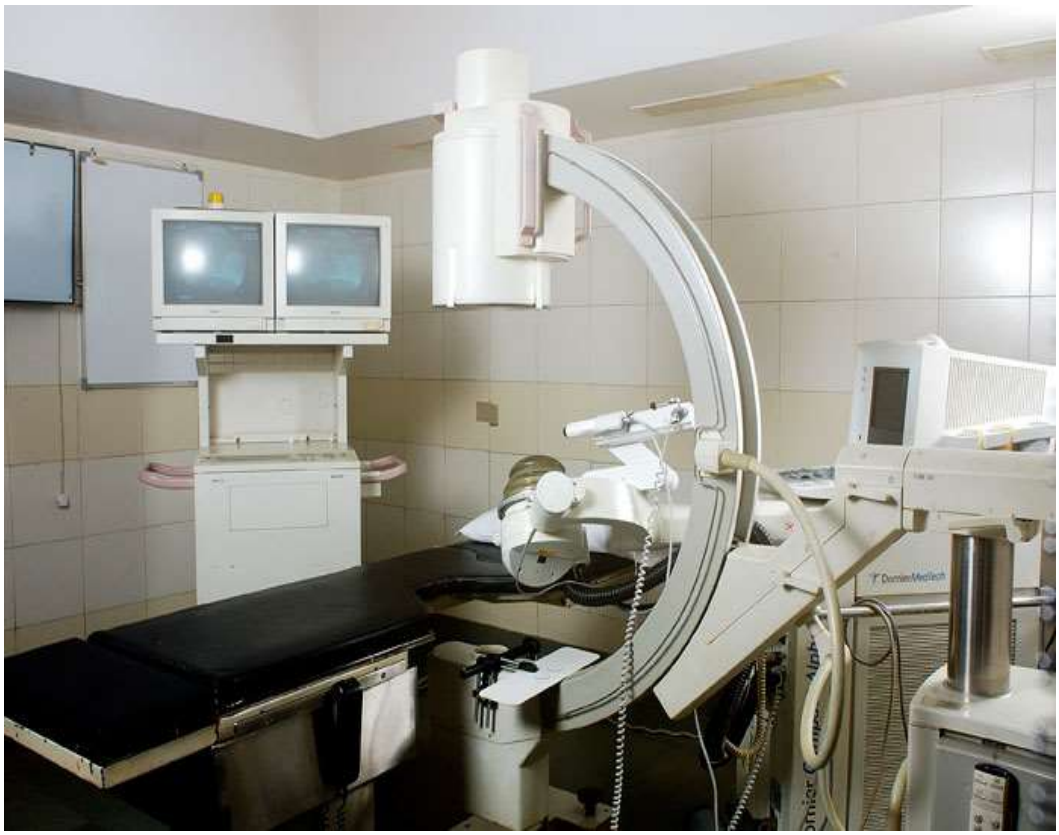
## Sterling specialties:-

1. Internal medicine
2. General surgery
3. Cardiology
4. Cardio- thoracic surgery
5. Gastroenterology
6. Obstetrics and gynecology
7. G.I. Surgery
8. Pediatric surgery

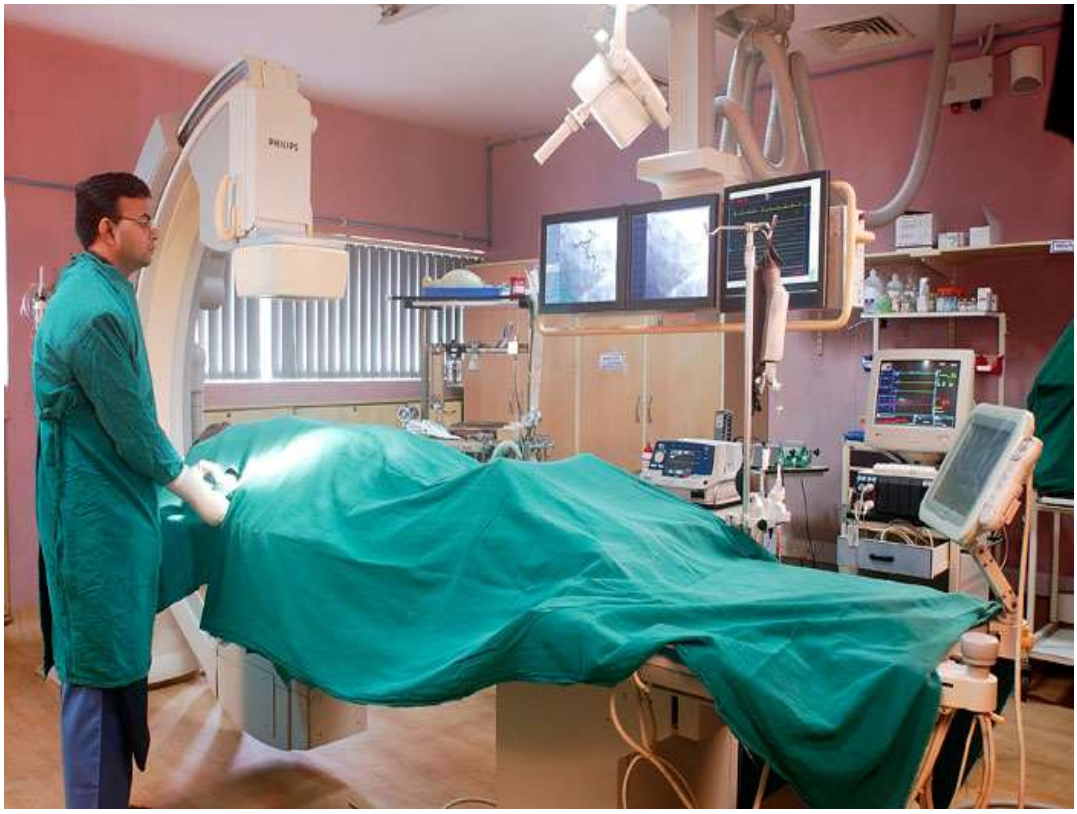
9. Bone and joint
10. Ear nose throat
11. Ophthalmology
12. Dermatology
13. Anesthesia services
14. Infectious diseases



15. Neurosurgery
16. Neurology
17. Nephrology
18. Urology
19. Plastic surgery
20. Pulmonology and critical care
21. Diabetology and endocrinology



22. Vascular surgery
23. Psychiatry
24. Oncology
25. Onco surgery
26. Dental sciences
27. Nutrition and diet
28. Pathology laboratory
29. Radiology
30. Pediatrics and neonatology.




## General findings:-

Discharge planning is critical to ensuring rapid, safe and smooth transition from hospital to another care environment; it involves the social work functions of high risk screening, social work assessment, counseling, locating and arranging resources, consultation/collaboration, patient and family education, patient advocacy and chart documentation; it is a complex activity requiring a wide range of clinical and organizational skills to address needs of patient, family and health care system and to promote the optimum functioning of patients, families and support systems. Delay factors may be internal (waiting for discharge summaries; waiting for declaration of chronicity ; transfer between nursing units; lack of documentation of discharge plan); external (lack/delay of access to rehabilitation, convalescence, palliative care, home care resources, long term care facility); and psychosocial (waiting for family adjustment, waiting for patient function to improve, unrealistic expectations of patient/family, social isolation of patient, inadequate support at home, lack of concrete medical aids, transportation for treatments, financial, family burden prevents discharge home)

In order to make the discharge appointment concept work, there are several critical success factors:

- Hospital staff, typically the Care Managers, must routinely identify those patients who are the best candidates for early discharge.
- With all the pieces in place, it is possible to achieve significant improvement in the balance between bed supply and demand during peak periods.

## Discharge instructions given by the Sterling Hospital:-

1. Once your consultant ordered your discharge, it will take normally 2-3 hours for discharge procedure which includes so many procedures like your medicine return, summary making, preparing treatment sheet, discharge instruction and making your final bill.
2. Dietician will come and gives diet instruction or diet list.

3. If it's a Mediclaim case, than discharge will take 4-5 hours, because it depends upon the Mediclaim Company. Mediclaim desk is readily available for solving any query.
4. If the discharge is planned before a day, it is informed to the in charge nurse, and further arrangements are made before day.
5. The unused medicine is to be returned back to central medical store. This procedure takes time.
6. Once the refund of the medicines is done and the unit nurse informs to the patient's relatives, patients relatives have to make the final payment by cash or credit card at the billing department ( no demand draft or cheques are acceptable )
7. After the completion of payment, the billing department gives authorization letter, which the patients' relatives, has to submit it to the unit nurse.
8. At the end of all the process for discharge has been completed the unit nurse gives instructions regarding medicine and care at home. The nurse will submit all the medical documents to the relatives of the Patient.
9. If the patient has to be transferred to the home or hospital through ambulance prior intimation has to be given to the in charge nurse by the relative a day before, so that prior arrangements are made regarding the same.
10. Relatives have to make sure that all the personal belongings are in place before they leave the hospital.
11. For further discharge related query the in charge nurse is readily available.

In addition to the above precautions, the hospital also implements the lean six sigma hospital discharge process.

Respondents to a survey of interdisciplinary staff at Sterling Hospitals, Ahmedabad identified the following discharge planning issues:-

- **Hospital system issues are:-**

➢ Discharge date not known in advance and planning for discharge at the last minute
➢ Lack of communication and coordination between disciplines and various departments
➢ Lack of clear documentation of the discharge plans in the patient's medical chart
➢ Lack of clarity on likely long stay and patient's policy

- **Patient/family issues are:-**

- Patient and family not adequately informed about the long stay care fees
- Failure to include the patient and family in the discharge planning process
- Families lack support and interaction with community resources

**Case study on training and development at Sterling Hospital:-**

1: Training & Development Policy at Sterling Hospitals

2: Training & Development Process Flow Chart

3: Training & Development Practices

## 1: Training Need Analysis

Nothing occurs unless and until there is a need for it and therefore training is not an exception. No training can be done without its need. There are many ways to find out the need for training and the same steps are followed by Sterling Hospitals.

The need for training can be derived from:

1. **Requisition from the Departments:**

   A requisition from the Departments is issued by the HOD for providing the Training Session to the employees of that department. HOD comes to know the need for training by his/ her observation or sometimes the employee himself/ herself asks for training for the subject he / she wants to.

Performance Appraisal: As per the policy of the Hospital, Performance Appraisal of each and every employee is done. After the appraisal, feedback of each employee is given and from this feedback the need for training is recognized.

2. **Patients Feedback:**

Patients' feedback also tells us the need for training. The patient gives the feedback for the particular staff member who takes care of that patient. From the feedback of the patient, if there is a requirement of training, the same is given.

3. **General Observation:**

The HODs observe their particular department and analyze the need for training.

## 2: Training Calendar

The schedules of training programmes are maintained in training and development calendar.

Training and Development calendar format includes:

Refer annexure I

## 3: Process of Module Development

Training & Development modules are developed for each and every functional training subject by the Training Function at Sterling Hospitals. The process starts, once the training need is analyzed for any particular topic and ends with the final delivery to the employees concerned. Modules are generally developed based on the information received from various sources e.g. Subject matter available with Head of the Departments, information available on internet,

theoretical information available at Sterling Library, Feedback received from the employees concerned based on the practical work experience etc. Once the module is developed, the same is attested by the Training In charge and the concerned Head of the Department.

## 4: Attendance System

It is mandatory to record the attendance for all the types of training whether it is OJT or Class Room Training. The attendance is maintained in the format mentioned below.

Refer annexure II

## 5: Training Methods

### 5.1: Functional Training

It includes High Risk Medication, Care of Vulnerable Patient, Catheter Care, MLC & Triage, Infection Control and Hygiene, Bio Medical Equipment Audit, Disinfection, Radiation Safety, Patient R&R, Medical Records Policy, Medical Services and Terminologies, Lab Safety, Software Application Training etc.

### 5.2: On the Job Training

It is mainly based on the practical work done at job. In short some times when employees are on the job they are guided by their trainer on at the time of their duty. As for example: How to handle Bio Medical Equipment carefully?

Tough it does not have record or documentation parameters but still it plays a major role in Training and Development.

**5.3: Behavioral Training**

It includes Induction, Team building, Stress Management and HR Policies.

**Induction Programme at Sterling Baroda**

## 6: Training Feedback Analysis

After each training session there is a feedback form which is provided to all the participants in the session. There are two aspects of the feedback form:

1. The Positive
2. The Negative

In the positive aspect all the good things about the training session as well as the Trainer is to be written by the participants.

In the negative aspect any suggestion by the participant about the session is welcomed by Sterling Hospitals.

Refer annexure III for the sample of the Feedback Form being used at Sterling.

**7: Re- Training**

Each and every participant of the training session undergoes a test. Minimum of 70% marks are to be obtained by the participants. If any of the participants gets less than 70%, he/ she have to get re- training.

**8: Measuring Training Effectiveness**

After each and every training session a test is conducted which helps in measuring the effectiveness of the training session. The effectiveness of training is also measured by the performance given by the employees after the training session.

Refer annexure IV for format of measuring Training effectiveness at Sterling Hospitals.

**9: Maintaining Training Records**

All the training sessions have to be recorded.

- The records contain-

- Training Program,
- Total No. of Workshops done,
- Total no. of Participants Covered,
- No. of weeks,
- Total Hours,
- Total man days and Cost.

MIS is maintained for different training programmes.

The format of MIS includes: Refer annexure V

**10: Mock Sessions by Interns at Sterling**

Trainees are also trained to take the practical sessions at the Sterling Hospitals. As a part of on-the-job training, I was asked to take the session for the new joiners, and I was happy to share General Information about the hospital with them.

## Conclusions:-

- **Hospital system issues:**
  - Physicians identify discharge date upon admission and in all orders
  - Daily, weekly or bi-weekly interdisciplinary rounds on all services/wards
  - Summary sheet in the patient's medical chart to document discharge planning events
  - Inform staff, patient and family of clear chronic care policies and placement options

- **Patient/family issues:**
  - Improve communication with patient and family concerning discharge date and planning
  - Provide patient and family with accurate information on chronic care status and fees
  - Hold family meetings of high-risk patients within 24-48 hours of admission
  - Provide patient and family with information concerning community resources and encourage contact

Patient flow problems arising from delayed discharge tend to occur in four stages:

(1) Delayed discharges on medical/surgical floors increase bed occupancy to full capacity on these floors;

(2) ICU units become backed up as new patients are admitted and beds are not available for step-down on the medical/surgical floors;

(3) The ED, trauma centre and PACU become full as new patients arrive and existing patients cannot be transferred to the ICU or medical/surgical floors;

(4) The ED and trauma centre are forced to go on divert, direct physician admissions and interfacility/intrafacility transfers are denied; surgeries are cancelled.

A process improvement initiative was done at the Sterling Hospitals and it began with an analysis of the causes of discharge delay. Non-medical and medical barriers to timely discharge were identified. Unavailability of staff accounted for maximum number of occurrences and was the largest barrier. Other barriers were transportation and late discharge order, while family delay accounted for very less number of discharge delay.

Several root causes were identified:

- Lack of awareness of 2 pm discharge time among staff and physicians;
- Lack of notification of pending discharge given to discharge planning staff, nurses and patients by physicians;
- Discharge tasks and responsibilities not well defined and delineated among case managers, floor nurses, discharge planners and social workers;
- Discharging patients not a priority for attending physicians, house staff, floor nurses, physician consults, and staff in radiology, lab, physical therapy, inpatient rehabilitation and messenger service areas;
- Transportation delays;
- Manual and cumbersome processes such as writing discharge orders, preparing discharge paperwork and filling discharge pharmacy scripts; and medical patients being much more difficult to prepare for discharge than surgical patients.

## Recommendations

Recommendations for improvement were, in order by greatest potential:

- Discharge policy (official 2 pm discharge policy)
- Discharge orders (official discharge order policy was created requiring physicians to write orders for discharge and discharge dependent lab work, tests and X-rays preferably the night before the day of discharge and no later than 8 am on the day of discharge)
- Discharge facilitator (two nursing discharge facilitator were hired to expedite orders, assist with patient teaching and discharge paperwork and coordinate among physicians, radiology, lab, pharmacy, case managers, discharge coordinators, and floor nurses, and to work with bed placement nurses and the house supervisor)
- Physician communications (physicians were required to communicate expected discharge dates and times as soon as possible; the standard was on the days of admission for routine
- patients and no later than 24 hours in advance for more acute patients)
- Other communication (communication to patients regarding discharge time that included request to arrange transportation by 10:30 am); census alerts (an official critical census plan and policy)
- Physician rounds (rounding times were changed to accommodate early discharges and physicians' patients were grouped on the same unit to enhance efficiency)
- Discharge waiting area (used for stable patients awaiting transportation during days of critical census)
- Order alerts (orders for lab work, tests and X-rays were marked 'discharge-dependent' to ensure priority; patient binders were visually flagged to notify unit secretaries that discharge orders had been written; pharmacy process for filling discharge prescription was streamlined)
- Order entry (use of CPOE)
- Discharge monitoring (intranet website monitoring discharge times [by physician, unit, service and the overall hospital], census and occupancy rates); goal was to discharge 30% of discharging patients by 2pm and attain an average discharge time of 4 pm

- Staff notification (new bed board showing pending discharge dates and times / entry on EPR)
- Paperwork consolidation (one form used for admission, discharge and transfer; goes directly to patient with discharge orders)
- Discharge coordination (social work used on referral basis for psychosocial issues; case management roles expanded to include discharge planning and coordination oversight; discharge coordinators assigned by floor rather than service to provide single
- point of contact for physicians and staff)
- Staff notification of completed discharges (entered into admission, discharge and transfer system within 30 minutes of discharge)
- For increasing the quality of care for patients during discharge, following recommendations are provided:-

**1) Inpatient–outpatient physician discontinuity** –

- When possible, involve the PCP in discharge planning and work together to develop a follow-up plan
- At minimum, communicate the following to the PCP on the day of discharge: diagnoses, medications, results of procedures, pending tests, follow-up arrangements, and suggested next steps.
- Provide the PCP with a detailed discharge summary within 1 week.
- In discharge summaries include: diagnoses, abnormal physical findings, important test results, discharge.
- Medications with rationale for new or changed medications, follow-up arrangements made, counseling provided to the patient and family, and tasks to be completed (eg, appointments that still need to be made and tests that require follow-up).
- Follow a structured template with subheadings in discharge communications.
- When possible, use health information technology to create and disseminate discharge summaries.

**2. Changes and discrepancies in medication regimen**

- Obtain a complete medication history by asking patients about: medications taken at different times of day; medications prescribed by different physicians; non oral medications; over-the-counter products; dosage, indication, length of therapy, and timing of last dose of all drugs; allergies; and adherence.
- Compare and reconcile medication information obtained from patient and caregiver reports, patient lists, prescription bottles, medical records, and pharmacy records.
- Display preadmission medication list prominently in the chart.
- Reconcile medications at all care transitions, including admission, intra hospital transfer, and discharge.
- Communicate complete and accurate medication information to the next provider at discharge, including indications for new medications and reasons for any changes
- When possible, partner with clinical pharmacists to manage medication information and reconciliation, especially for high-risk patients.

**3-Self care responsibilities and social support-**

- Use multidisciplinary discharge planning teams to assess the needs of patients and their families.
- Arrange a specific follow-up appointment prior to discharge.
- Contact patients by telephone a few days after discharge to assess questions, symptoms, and medication related issues.
- Order home health services when indicated.
- Consider home visits for frail elderly patients.

4- **Ineffective physician patient communication-**

- Focus discharge counseling on informing patients of major diagnoses, medication changes, dates of follow-up appointments, self-care instructions, and who to contact if problems develop.
- Ensure that staff members communicate consistent instructions
- For high-volume conditions, consider using audiovisual recordings for discharge education, combined with an opportunity for additional counseling and questions

- Use trained interpreters when a language gap exists
- Provide simply written materials that include illustrations when possible to reinforce verbal instructions
- Ensure patients and family members comprehend key points by asking them to teach back the information in their own words and demonstrate any self-care behaviors
- Encourage patients and family members to ask questions through an open-ended invitation like ,“What questions do you have?” instead of “Do you have any questions?”

ANNEXURE:

1- ANNEXURE I

| Date | Day | Subject | Group Name | Department | Min. No. of Participants | No. of Hours | Time | Week |
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2- ANNEXURE- 2

| Training Subject | | Date | | |
|---|---|---|---|---|
| Time Slot | | | | |
| Trainer's Name | | Venue | | |

| S. No | Name | Employee ID | Designation | Department | Attendance Signature Day | Attendance Status | Center | |
|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | Ahmedabad | |
| 2 | | | | | | | Ahmedabad | |
| 3 | | | | | | | Ahmedabad | |
| 4 | | | | | | | Ahmedabad | |
| 5 | | | | | | | Ahmedabad | |
| 6 | | | | | | | Ahmedabad | |
| 7 | | | | | | | Ahmedabad | |
| 8 | | | | | | | Ahmedabad | |
| 9 | | | | | | | Ahmedabad | |
| 10 | | | | | | | Ahmedabad | |
| 11 | | | | | | | Ahmedabad | Attendance Summary |
| 12 | | | | | | | Ahmedabad | CONSOLIDATED PATICIPANTS TURNOUT |
| 13 | | | | | | | Ahmedabad | Total no. of Participants listed = |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 14 | | | | | | | Ahmedabad | 100% Attendance = |
| 15 | | | | | | | Ahmedabad | Absentees = |
| 16 | | | | | | | Ahmedabad | Total No. of Participants = |
| 17 | | | | | | | Ahmedabad | |
| 18 | | | | | | | Ahmedabad | |
| 19 | | | | | | | Ahmedabad | |
| 20 | | | | | | | Ahmedabad | |
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| 34 | | | | | | | Ahmedabad | |
| 35 | | | | | | | Ahmedabad | |

3- ANNEXURE III

# Training Feedback form (functional)

Date:_____ Training/L&D subject:_____

Participant's Name: _____ (not mandatory, at your discretion).

Department: _____

Trainer's Name: _____

Time: _____

---



Trainer's Overall Job Knowledge ☐ ☐ ☐

Good Average Bad

(functionality, mechanism, protocols, knowledge)

Language of the Trainer was easily understood. ☐ ☐ ☐

| | Good | Average | Very Good |
|---|---|---|---|
| Trainer asked Questions/Discussed (Interacted) (where applicable). | | ☐ Yes | ☐ No |
| Trainer gave adequate, simple and on the job situations while explanations. | | ☐ Yes | ☐ No |
| Justified and Accurate information was given when asked a question to the trainer. | | Yes ☐ | No ☐ |
| The Presentation or Handout was accurate, with pictures and contents applicable to the subject. (where applicable). | ☐ Yes | ☐ No | ☐ N.A |

What are the areas of improvement for the functional training sessions?

_____

_____

_____

_____

In percentage, out of 100%, you rate the session as _____%

Your overall experience in the L&D/Training Session?

☐ ☐ ☐ ☐

Bad Average Good Very Good

_____
_____
_____

Thank You for your valuable participation and feedback.

4_ Annexure- iv

| TRAINING EFFECTIVENESS FORM | | | | | | |
|---|---|---|---|---|---|---|
| Training Subject - | | | | | | Training Date - |
| | | | | | | |
| List of Team Members | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| Areas of Improvement Noticed | | | | | | |
| | | | | | | |
| Areas where no Improvement has been noticed. | | | | | | |
| | | | | | | |
| Participants Name (No Improvement Seen) | | | | | | |
| | | | | | | |

| | | |
|---|---|---|
| Subject/Area where Re-Training is needed | | |
| | | |
| Signature, HOD | | |

5-ANNEXURE V

| Training Program | Total No. of Workshops Done | Total no. of Participants Covered | No of weeks | Total Hours | Total Man days | Cost |
|---|---|---|---|---|---|---|
| Induction | | | | | | |
| Service Excellence | | | | | | |
| Fire Prevention & Safety | | | | | | |
| Functional Training | | | | | | |
| Awareness Programme | | | | | | |
| Grooming & duties at work | | | | | | |
| Soft skills training | | | | | | |
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