Summer Internship Report at

22nd April- 22nd June 2024

A Report on Discharge Process in In-Patient Admissions at

MaxSuperSpecialityHealthcare

By:

Priyanka Barik (PG/23/084)

PGDM (HEALTH AND HOSPITAL MANAGEMENT)
2023-2025

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ACKNOWLEDGEMENT

Completion of this work would not have been possible above all without the blessings and support from few significant people. It required a lot of effort from everyone involved in this project, as well as with me, and I would like to thank them.

Firstly, I would like to thank my mentor **Dr. Preetha G S**, Professor & Dean (Research), IIHMR Delhi, for providing constant support and guidance throughout my journey.

I would like to express my gratitude to **Mrs. Neeru** (Operations Head) who provided me with valuable guidance regarding the project. She encouraged me to work on this project with her valuable and intriguing, detail-oriented advice as well as attention, encouragement, and engagement towards the project. Her collaboration has been essential in the completion of this project.

I would also want to thank **Mrs. Sujata** (IP Admissions Duty Manager), **Mr. Japjeet Soni** (Training Champion), **Mrs. Preeti** & **Mr. Sunil Nehra** (Bed Manager) for sharing their direction, perspectives and continual monitoring and support, as well as for giving a great chance to work in their organization.

Last but not the least, I would like to thank my beloved parents, for their constant support and encouragement throughout my internship journey

Certificate of Approval

The Summer Internship Report on **TAT observed at Discharge Process in In-Patient Admissions** at **Max Super Speciality Healthcare** 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 – Dr. Preetha G.S.
Designation – Professor & Dean (Research)
IIHMR, Delhi

MAX Healthcare

FEEDBACK FORM

(Organization Supervisor)

Name of the Student: Priyanka Barik

Summer Internship Institution: Max super speciality Hospital

Area of Summer Internship: IPD Admissions

Attendance: 94%

Objectives met: Yes

Deliverables: Radiological conversion, patient dealing, Data management, Document Audit

Strengths: Responsible, easy learner, curious, creative, punctual

Suggestions for Improvement: Financial skill can be improved

Signature of the Officer-in-Charge (Internship)

Date: 22/06/2024
Place: Vaishali, Ghaziabad

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Signature of the Officer-in-Charge (Internship)

Date: 27/06/2024
Place: IIHMR Delhi

Certificate No – 2024/16798

CERTIFICATE
OF ACHIEVEMENT

MAX Healthcare

Max Institute of Medical Education

Certifies that

Priyanka Barik

has completed Internship in the department of

Hospital Operation

at Max Super Speciality Hospital, Vaishali, Uttar Pradesh

from 22nd April 2024 to 21st June 2024

Dr Vinitaa Jha
Director - Research & Academics
Max Healthcare Institute Ltd

Table of Content

Abbreviations

NABH : National Accreditation Board for Hospital

TAT : Turn Around Time

TPA : Third Party Administrator

CGHS : Central Government Health Scheme

ECHS : Ex-Serviceman Contributory Health Scheme

ESI : Employee State Insurance

LAMA: Left against Medical Advice

MLC : Medico Legal Cases

HIS : Hospital Information System

OPD : Out Patient Department

IPD : In Patient Department

DGHS : Directorate General of Health Services

MCD : Municipal Corporation Department

ONGC : Oil and Natural Gas Corporation Limited

NDRF : National Disaster Response Force

NCR : Northern Central Railway

SPSS : Statistical Package for Social Sciences

DAMA: Discharge against Medical Advice

GDP : Gross Domestic Product

AAC : Access, Assessment and Continuity of Care

SOP : Standard Operating Procedures

DMS : Database Management System

Overview

Patient discharge is a multi-step process involving multiple people and departments whose processes influence and impact each hospital's patient discharge process. Redundancies must be planned in coordination with all departments and disciplines involved and timed in conjunction with other activities.

Discharge planning creates a personalized discharge plan for a patient before they leave the hospital to ensure that patients are discharged at a standard time and with the correct post-discharge services.

One way to standardize the event is to establish a universal discharge time. Thanks to this, employees will be easily informed. Key elements of such an approach include:

Consistency of structures and processes (follow NABH guidelines); Tactical and timely service planning (annual review, monthly feedback); Linked conventions and pathways (e.g. shared across primary and secondary care are based on international best practice so objective performance measures are readily available)

The content is an attempt to analyze the gaps in the discharge process at Max Super Specialty Healthcare Hospital and make it available in terms of time. This study was part of the PGDHM syllabus offered by IIHMR, Delhi under the purview of this programme.

This study was conducted to study the discharge process, focusing on the amount of time taken for receiving the file in the Billing section, preparing the discharge summary, verifying the discharge summary, preparing the final bill, followed in the hospital for three categories of patients i.e. Corporate, Cash & TPA Patients admitted to hospital, along with an understanding of hospital discharge process operations. This project also intends to find out the root cause of the delay in the process, find out the SOPs and thereby try to find possible solutions and operational improvements. This study was conducted in the IPD of Max Super Specialty Healthcare Hospital.

During the course of the study, a total of 108 patients were discharged from the hospital included in the study. Data were obtained using descriptive and quantitative research, where process mapping was carried out in direct observation. Out of 108 patients, 35 patients were Corporate patients, 38 patients were Cash patients and 35 patients were TPA patients.

Profile of the Organization

- Max Healthcare opened its first medical center in South Delhi's Panchsheel Park in 2000. The company opened two more secondary care centers in Pitampura in North West Delhi and Noida in 2002.
- In 2004, the company commissioned the East Block of its flagship tertiary care hospital named Max Hospital, Saket in South Delhi.
- In 2007, Max Healthcare ventured into Gurgaon with a secondary care hospital.
- In 2011, Max Healthcare entered into a Public Private Partnership (PPP) agreement with the Government of Punjab to set up two hospitals in Mohali and Bathinda. In the same year, Max Healthcare launched its tertiary care hospital at Shalimar Bagh in North West Delhi.

- In 2012, Life Healthcare Group acquired a 26% stake in Max Healthcare for ₹516 million (US$96.56 million).
- In 2014, Life Healthcare invested an additional ₹766 million (US$125.51 million) to increase its stake to 46.41% and become an equal partner in the joint venture with Max India.
- Nanavati Max Super Specialty Hospital in Mumbai BLK-Max Super Specialty Hospital in Delhi.
- In 2015, Max Healthcare acquired Pushpanjali Crosslay Hospital in Vaishali, Ghaziabad and Saket City Hospital in Saket. These hospitals were subsequently renamed as Max Hospital Vaishali and Max Smart Hospital, Saket.

- • In 2016, a standalone cancer center called Max Cancer Center was commissioned in Lajpat Nagar, South Delhi.
- In 2018, Life Healthcare announced that it would sell its entire 49.7% stake in Max Healthcare and exit its joint venture with Max India.
- In 2019, Radiant Lifecare acquired a 49.7% stake in Max Health Institute Limited for ₹2,136 million (US$303.32 million) and appointed Abhay Soi as Chairman.
- In 2020, Max Healthcare merged with Radiant Lifecare, which operated BLK Hospital in Central Delhi and Nanavati Hospital in Mumbai, becoming India's second largest healthcare company by revenue.
- Company listed on stock exchanges in August 2020.
- Between 2021 and 2022, the co-founder of KKR & Co. sold Inc. its entire stake in Max Healthcare. As a result, Abhay Soi became the sole promoter of the company with more than 23% stake.
- The company raised capital of ₹ 1,200 crore through a qualified institutional scheme and acquired exclusive rights to support the development of a 500-bed hospital in South Delhi. It has secured two plots in Gurgaon with the potential to add 1,000 beds. The company has also bagged an O&M contract for the first asset-light model at Dwarka for 300+ beds. It acquired a stake in Eqova Healthcare with the potential to add more than 400 beds in East Delhi.

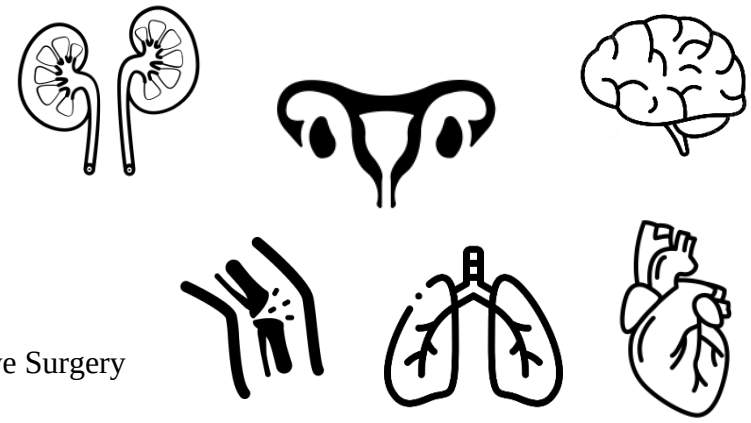
- In December 2023, Max Healthcare acquired Sahara Hospital in Lucknow for ₹940 million (US$120 million).
- Acquired Alexis Multi-Specialty Hospital in Nagpur for ₹412 million (US$52 million) in February 2024.

Observational Learnings

Specialization of Hospital

Max Super Specialty Hospital, Vaishali, Ghaziabad is a **370+** bed facility offering an unparalleled spectrum of preventive and diagnostic treatment options across specialities like:

- Oncology
- Neuro Sciences
- Cardiac Sciences
- Orthopaedics
- Nephrology
- Kidney Transplant
- Liver Transplant
- Urology
- Gastroenterology
- Pulmonology
- Aesthetic & Reconstructive Surgery
- Endocrinology
- Diabetes.



With 128 intensive care beds, 16 HDU beds and 14 state-of-the-art modular operating theatres, Max Super Specialty Hospital in Vaishali is home to the latest medical technology. And led by more than 259 leading physicians and medical experts and a nursing staff of more than 610 nurses, the entire hospital is committed to providing the highest standard of medical care to every patient who walks through our doors.

With more than 28 clinical specialties, Max Super Specialty Hospital, Vaishali offers the advantage of integrated medical care in a multidisciplinary environment provided by a faculty of highly qualified doctors, nurses and paramedics.

One aspect that sets us apart as the best hospital in India is that our hospital is accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and the National Accreditation Board for Testing and Calibration Laboratories (NABL).

VISION

To be India's most recognized healthcare provider committed to the highest standards of clinical excellence and patient care, backed by the latest technology and cutting-edge research.

VALUES

- Compassion
- Efficiency
- Perfection
- Consistency

Department Wise Observation

1. **OPERATIONS DEPARTMENT**

   This department oversees operational procedures to ensure the efficient functioning of the hospital's clinical and non-clinical departments. This department oversees compliance with all hospital rules and procedures and addresses any situations where the hospital deviates from these standards. All aspects of the overall functioning of health systems and patient care are important, including clinical and administrative duties.

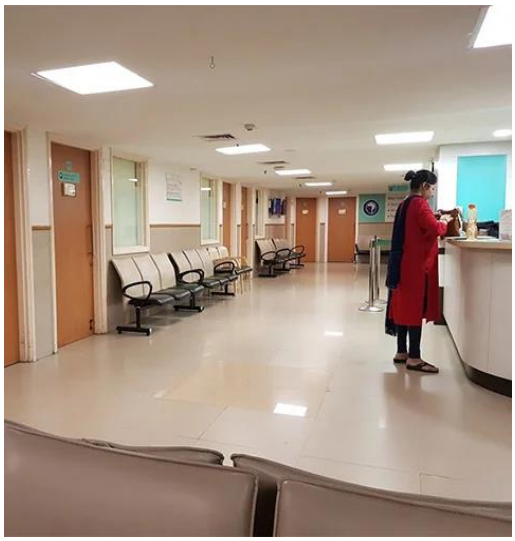
2. **FRONT DESK**

   In the main office, the receptionist we welcome clients and visitors. In addition to answering calls and answering questions, they help patients fill out paperwork. Patients check in at this desk before treatment, where staff store and retrieve patient information and determine if the service they need is available.

3. **IPD DEPARTMENT**

   When a patient requires specialist/hospital care due to a medical condition, they are admitted to an IPD or inpatient ward. Beds, medical supplies and qualified medical personnel are always available in this hospital. MAX Hospital Software, IPD Management The following features and such features certainly characterize a good IPD management software:

   • Intake of patients
   • Management of beds
   • OT schedule and consent form
   • Doctor's circular notes
   • Operational notes



4. **OPD DEPARTMENT**

The main point of interaction between patients and medical staff in a medical department is the OPD (Outpatient Department). The patient is brought to the OPD on first arrival at the hospital, where the medical team decides which unit they will be referred to.

MAX SUPER SPECIALTY HEALTHCARE OPD is located on ground floor, first, third, fifth and seventh level.

Robust OPD Features of MAX SUPER SPECIALTY HEALTHCARE:

- Patient registration
- Meeting scheduler
- Visit patient details

- Quick access to input
- Prescription details
- Billing data
- Certificates

5. BILLING DEPARTMENT

The billing department is essential because it serves as a direct line of communication between customers and the company's senior management. Hospitals submit medical claims to our billing department via scanned paperwork that includes all of the above records and information as well as information from the patient's insurance company. The primary goal of a hospital's billing process is to collect payment for services and supplies that the hospital has provided to its patients.

6. DAYCARE SERVICES

Total number of beds in the DAYCARE -

The process starts after a general OPD consultation where the doctor prescribes chemotherapy for treatment. The nurse will then receive the chemotherapy protocol via the online system. Day care doctors advise the right day to start chemotherapy, taking into account the patient's vitals and health. If the patient's vital signs are ready for chemotherapy, the nurse receives a chemo protocol that contains all the information about the drugs and their respective dose. Then the operations manager prepares the bill and the manager assigns a bed with an assigned time period (2 hours, 4 or 6, etc.). The patient now buys chemotherapy drugs at the pharmacy and hands them over to the Cytotoxic Admixture Unit (CAU), where the chemotherapy drugs are mixed. The patient then collects the mixed medication after about 30 minutes. Until then, the nurse prepares the patient with a pre-infusion and starts chemotherapy immediately after administering the mixed drugs. The patient is given chemotherapy and then discharged the same day.

7. THIRD-PARTY ASSURANCE (TPA)

This is an entity that processes Mediclaim insurance claims called the Mediclaim Claims Processing Centre. These trustees are usually independent, although they may also be owned by an insurance company. Insurance IRDAI grants licenses to these organizations. TPAs serve as intermediaries for policyholders and their insurance providers, mostly taking care of the back-end work associated with processing claims.

Before receiving cashless hospital services, the insured must present their TPA ID cards to the hospital authorities.

Below are some of the steps involved in processing and settling a claim:

- Receiving signals
- Acceptance of non-cash claims
- Payment of receivables
- Usage analysis
- Supplier network
- Registration
- Excellent selection
- Cashless transactions (if and when the policyholder is admitted to the insurance company's listed hospital, the insurance company pays the bill)
- Value-added services such as:

❖ Medical services

❖ Consultation with an expert

- ❖ Beds are available
- ❖ 24/7 free helpline
- ❖ Lifestyle management
- ❖ Wellness initiatives
- ❖ Prescription drugs
- ❖ Medical facilities
- ❖ Database maintenance

IPD AND OPD PHARMACY:

PNEUMATIC SHOOT SYSTEM - The pneumatic nailing system aims to reduce the waiting time for the delivery of the medicine. The system consists of a network of tubes that carry drugs, injections and consumables in small capsules made of glass and plastic. The pharmacy has a control panel. Through this control panel, pharmacists select the desired location (nursing station A) to shoot the capsule. They then contact the same nursing station (say nursing station A) by phone and inform them of the incoming capsule. The nurses receive the capsule, remove the medication and then send the capsule back to the pharmacy. This reduces manpower (discourages the use of ward boys to carry medicines from the pharmacy to the respective nursing stations) and aims to reduce waiting times.

8. MEDICAL RECORD DEPARTMENT

Patient health records include documentation of the patient's personal and social information, history of illness, clinical findings, examination, diagnosis, treatment received, description of follow-up and outcome. In addition, the patient's medical records contain a patient follow-up record. These records are kept in an organized and methodical manner.

9. INFORMATION TECHNOLOGY DEPARTMENT

By managing clinical software and other processes that help administrative staff members keep patient records and admissions systems up to date, this hospital's IT department plays a key role in the efficient operation of medical departments, operating rooms and emergency departments.

Managing health information and ordering and receiving test results are just two of the many tasks performed by a hospital's IT department.

This is in addition to the typical responsibilities of a hospital IT department, such as setting up and maintaining the network, ensuring IT security, managing cloud servers, and so on.

This division is also responsible for the help desk and desktop support.

Currently, the P4 PARAS version is practiced in MAX SUPER SPECIALTY HEALTHCARE, which deals with:

- ▪ Health care delivery platform
- ▪ Emergency care solution
- ▪ Super special solution
- ▪ Laboratory information system
- ▪ MMR with disease register
- ▪ E-Healthcare framework
- ▪ E-Claim Management
- ▪ Tele MediCare/ Tele Radiology solution

Discharge Process

Hospital services can be categorized into IPD and OPD services. An outpatient department is a facility that cares for outpatients who come for diagnosis, treatment, or follow-up care. The unit applies to health care services provided on the same day. The patient is examined and treated in the OPD until such time as hospitalization may be necessary. Bed services or part of the ward is the most important and largest single component of the hospital, which makes up 35-50% of the entire hospital complex. The main goal of the bed space is to provide accommodation for patients at the moment of illness, when dependence on others is the highest. An inpatient care area, ward, or nursing unit would thus include the nursing station, the beds it serves, and the necessary services, work, storage, and public areas needed to provide nursing care to patients. Operating costs are very high, which directly affects hospital budgets. It is essential that all hospital administrators are fully aware of the cost burden and focus on effective planning and efficient use of inpatient services.

It is very important for hospitals that admitted patients are discharged from hospital care in a harmless and well-organized manner that is beneficial for both patients and the organization. Studies witnessing increasing disease trends and increasing numbers of geriatric population clearly show the need for frequent need of health services.

The growing demand for healthcare comes with a lot of competition. Enduring customer trust is an integral part of an organization's success. Systems and processes are designed to consistently satisfy customers. Our customers, the patient and the caregiver, want not only satisfactory treatment but also psychological satisfaction, prompt service, availability and affordability of services, courteous behavior, privacy and dignity, informed treatment and treatment throughout their journey that starts from admission to leaving the hospital, i.e. patient discharge. Despite hospital efforts for timely and efficient discharge, research has shown that a series of events occur in the patient discharge process that affect everyone involved in the process. When discharging a patient, after the necessary interventions, it is necessary to carry out a series of procedures involving different staff and departments to make the process complex but efficient.

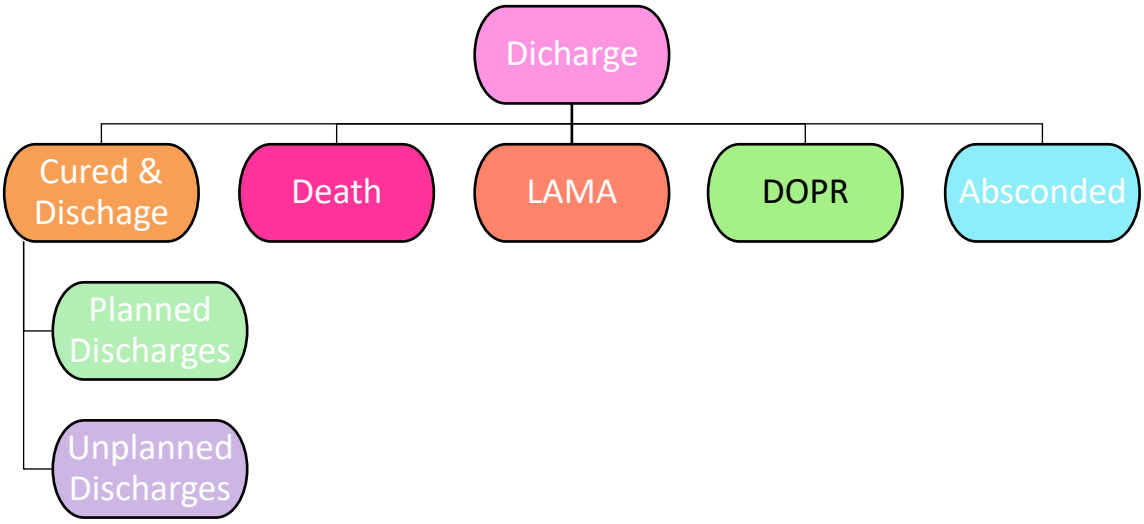
According to B.M. Sakharkar (Author of "Principles of Hospital Management and Planning"), "Discharge is the release of an admitted patient from a hospital".

According to the NABH, "Discharge is the process by which a patient is transferred from hospital with all appropriate medical summaries ensuring stability".

The discharge process begins when the consultant approves that the patient's health is good enough, the patient can continue with home care services or needs to be moved to the next category of facility (rehabilitation, psychiatric). Admission and discharge processes can act as bottlenecks in many hospitals, adversely affecting hospital efficiency.

Hospital costs are unpredictable and people usually avoid hospital admissions and seek treatment and continue with their normal lives after discharge from the hospital. Any undue delay in the discharge process is detrimental to both patients and the organization. For the patient, the lack of knowledge and communication leaves the patient unaware of the process and time consumption, often leading to irritation, discouragement and dissatisfaction. This also increases the patient's chances of exposure to hospital-acquired infections.

Types of Discharge



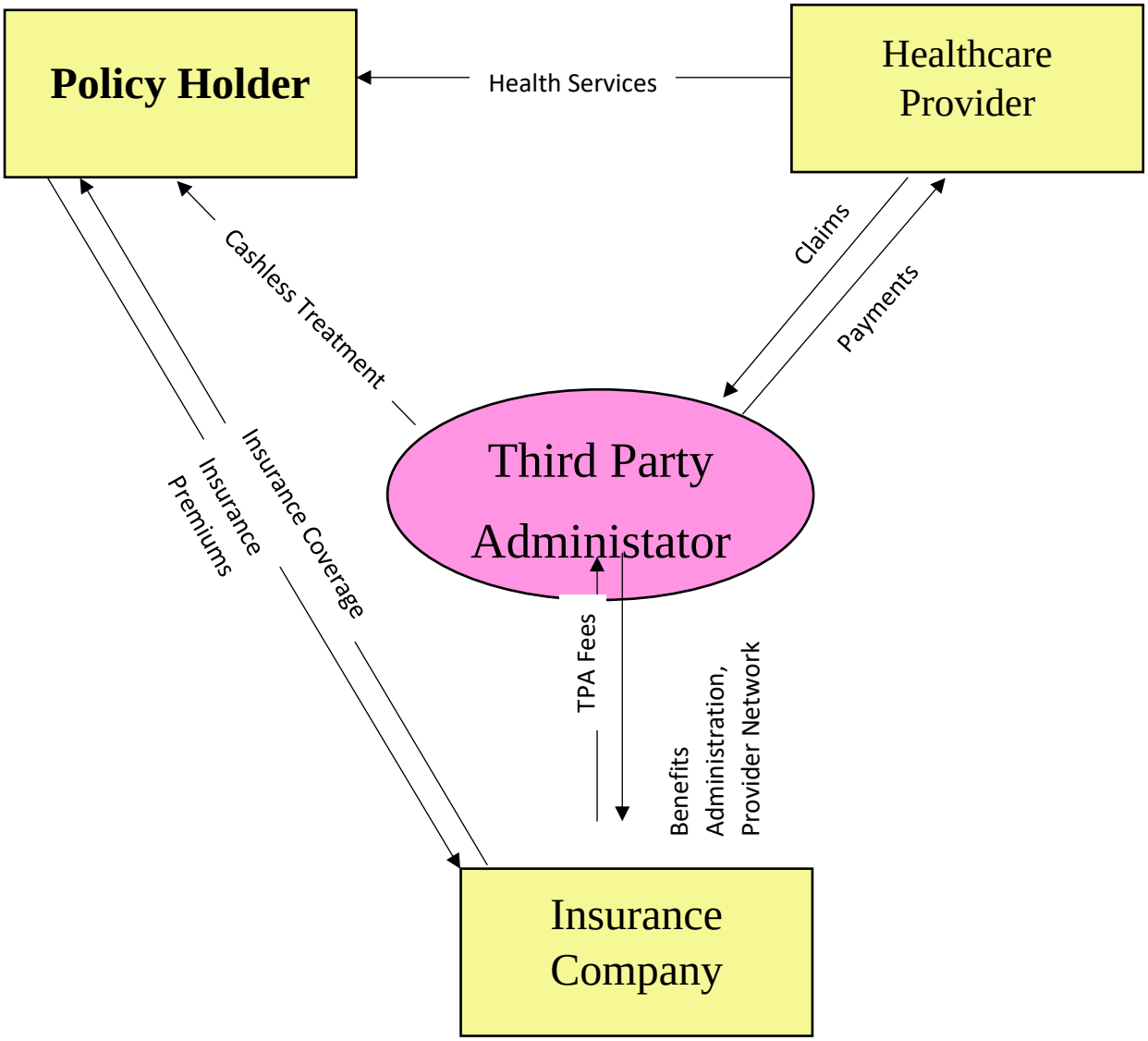
Discharge Planning

Planning provides the basic foundation from which the future management function is based. Discharge planning begins with determining a suitable day set for the end of hospital care and informing the patient and relatives to prepare to take the patient home. Planning for post-discharge services such as visitation care, physical therapy (physical therapy or occupational therapy), and home sampling is also part of the process. It is a goal-oriented continuous activity to reduce costs and improve patient outcomes. Ultimately, it serves to reduce unwanted longer hospital stays, unplanned readmissions, and to improve timeliness of services and coordination between departments. Discharge planning begins early in the patient's hospital stay. Hospitals should discharge patients to maintain accurate treatment statistics. It is important to track discharged patients for statistical reporting and to have an accurate view of our active client list.
Cash, panel and insurance/TPA
Categories of patients discharged from hospital:

- Corporate
- Cash
- TPA

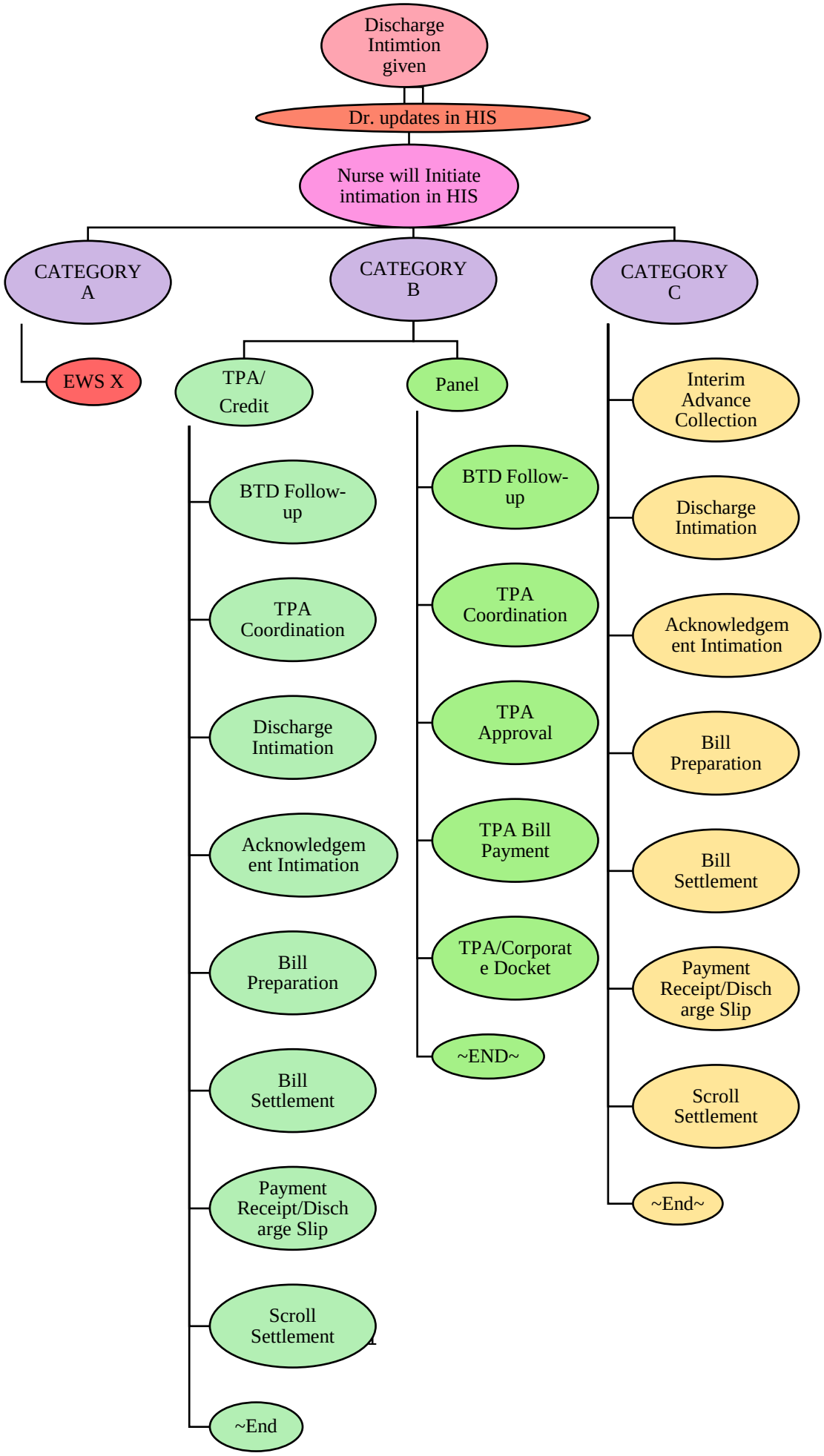
• **Corporate patients (Empanelled**) are those who pay for services at a discounted rate or are paid by the relevant panel, or the patient pays and is reimbursed. Few panels observed in the study were CGHS, ECHS, ESI, UP POLICE, DGHS, OFM, MCD, ONGC, NDRF, NCR etc.
• A **cash patient** is one who pays the final bill at the time of discharge either through credit/debit cards, UPI payments and currency.
• **Insurance** is a contract (policy) in which an individual or entity receives financial protection or compensation against losses from an insurance company. The company pools clients' risks to make payments more affordable for the insured and the insured pays a certain amount as premium. In return, the insurance company will indemnify the insured in respect of medical expenses under the following conditions: 18 - The insured should be admitted to a hospital/nursing home - The treatment of illness should not fall under any exclusion under the policy - The upper limit of indemnity limited to the sum insured as per fuses.

- TPA: Third-party administrators are intermediaries in the chain of an integrated delivery system that brings together all components of healthcare delivery, such as doctors, hospitals, insureds and insurers, into one entity. E.g. MAX BUPA, GIPSA, ICICI Lombard etc.



Process Mapping

Let's Understand Discharge process more clearly



Specific Findings

General Objective

To study the process of discharge and analyse the gaps and scope of operational improvement in the discharge process at MAX Super Speciality Hospital.

Specific Objectives

- To access the Discharge time for Corporate, Cash & TPA patients.
- To find the actual cause of delay for the discharge process
- To do an internal audit for NABH compliance to Discharge.

Purpose of the study

The purpose of the study is to understand the whole process and find out the problems in the discharge process so that improvements based on the recommendations can be worked upon during my further training and learning in the Hospital.

Scope of Study

The scope of this study is to analyse the steps, activities, manpower, departments involved in the Discharge process of In-patients at MAX Super Speciality Hospital & to improve the everyday functioning and the process as whole.

Methodology

Study Design

An Observational study based on process mapping and a Quantitative Research enumerating the percentage of discharges within time and enumerate analysis i.e. the time span of each of the steps for discharge as well as various elements leading to discharge on or off time

Study Area

In Patient Department of Max Super Speciality Hospital, Vaishali.

Sampling

All patients discharged from Different wards including

- Single
- Double
- Deluxe
- Suite
- Four bedded
- Economy (Male and Female General Wards)

are included (A sample of 108 Patients) within the time span of 22nd April-22nd June, 2024.

All patients were studied at each phase of discharge tracked (Discharge Intimation Date Time, Activity Sheet Date Time Update, Pharmacy clearance Date Time, Discharge Date Time, Time Bill Settled Date Time, Bed Release Date Time, Bill Prepared Date Time, Final Bill Prepared Date Time).

These patients are from variety of segments including:

Corporate/Government Panel: CGHS, ECHS, ESI, UP Police, ONGC, NDMC Etc.

Private: Cash patients

TPA: GIPSA, MAX BUPA, ICICI LOMBARD, STAR HEALTH Etc.

Resources used

• HIS (pharmacy discharge, final billing, admission, discharge)

• Hospital Staff (GDA's, Pharmacists, Nurses, Station Nurses, Billing Executive, TPA Executive, Medical Transcriptionist, TPA & Billing Head, DNS, Consultants, Medical Officer)

• Nursing station admission and discharge register

• Medical records (patient folder)

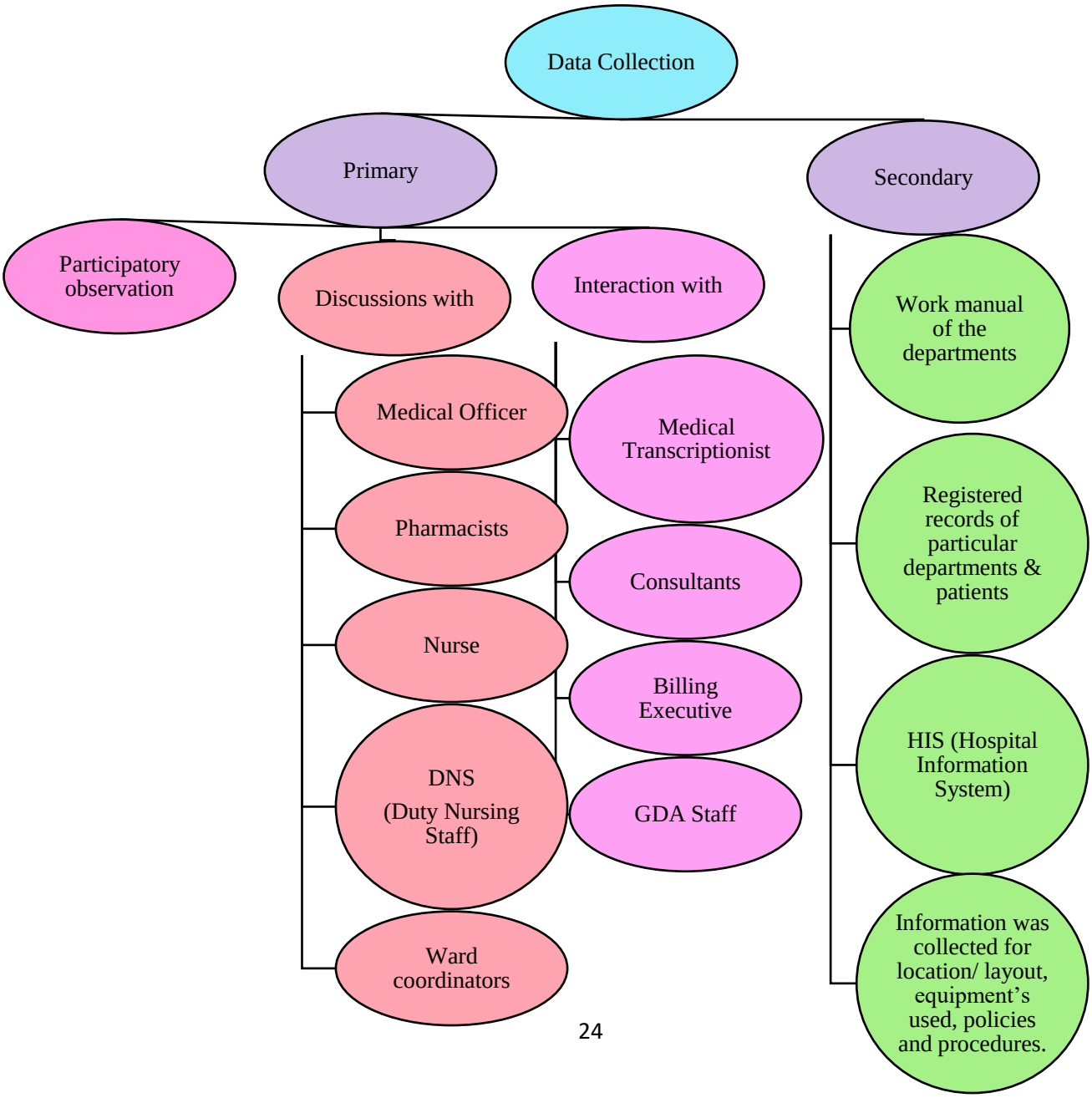
Procedure Adopted

• Information regarding the institution, establishment concept, location, area, history, planning, workforce, organizational hierarchy and other details were gathered from the hospital manual, records, policies, memorandums of understanding, licenses, relevant authorities and other sources.

• Different services of the department (clinical, support, auxiliary and administrative) of the hospital were studied through observation.

• Studying the identified involved departments also helped me to gather information and data. Personal observation and coordination and supervision of relevant workers, departments in the operational management of it.

Data Collection



Expected Outcome

The goal of a time motion study is to analyze the situation, examine the goals of the situation, and synthesize an improved, more effective method or system. Accurate observations and recording of existing work methods were carried out to identify critical activities and search for indicators from which new methods could emerge. Various work patterns were observed and time was recorded to determine the time it took skilled workers to complete a particular job to the current required level of performance.

Time Frame

22nd April 2024 to 22nd June 2024

Literature Review

According to a combined study by the industry body and Ernst & Young, India will need up to 17.5 million additional beds by the end of 2025. According to the World Bank, in 2017 the bed per population figure in India was found to be 0.53 beds per 1000 people. India is among the popular choices for medical tourism, which contributes to the burden on the health care system along with disease in the country.

The healthcare market in the country is growing at a tremendous rate with great opportunities. The government aims to increase healthcare spending to 3% of GDP by 2022. In the 2021 Union Budget, the government has allocated a huge amount for COVID and is supporting the health sector and hospitals by all means. India had an estimated 714,000 hospital beds spread across more than 69,000 hospitals in 2019, according to data released by Statista. Of these, about 1.1 million beds were in the private sector, outnumbering public hospitals. There is intense competition and the healthcare sector is a service sector driven by customer satisfaction, meeting and exceeding customer expectations. Patient discharge is one of the most important parts of a patient's hospital journey.

Various departments are involved in the process including Nursing, Billing, TPA, Pharmacy, Dietetics, Physiotherapy and a number of individuals including Consultants, Duty Doctors, Prescribers, Nurses, Billing Managers, General Assistants etc. As a hospital manager it is important to understand the overall process and its operations in order to effectively and efficiently manage operations.

I used the following keywords for my literature review:

1. Discharge process

2. Discharge of the patient

3. Discharge of the patient and the hospital

4. TAT for discharge and study

5. Average discharge time and delay

The following published works are reviewed: A study by Silva Ajami et al. (2007) to analyze release time. The means of data collection were questionnaires, checklists and observations made by the team and analysis was done on SPSS software. The researchers used a queuing model. An average time of 4.93 hours found and lack of guidance for staff involved, time to complete discharge summary, absence of HIS are the results made by the author.

In 2012, a study was conducted by Janita Vinaya Kumari et al. in the tertiary care organization after the end of the patient's hospitalization, i.e. the patient's discharge. The author says that the discharge and billing process are activities that the patient/caregiver is more likely to remember. The aim of the study was to calculate the average waiting time for patient discharge. Study registers were edited and designed by the research team and stored on the wards and in the billing department. In total, a sample of 2205 patients was analyzed. The findings were an average waiting time of 2 hours 22 minutes.

Swapnil Kumar et al. in 2013 conducted a time movement study in a hospital to observe the delay in discharge of all categories of patients i.e. insured patients, cash payment, DAMA etc. in the hospital. The standard time suggested by NABH was used to compare the average time it took a patient to leave the institution. The time required for the insured, self-payment, DAMA was found to be 5 hours 13 minutes, 6 hours 2 minutes and 5 hours 29 minutes. The author also conducted a satisfaction survey in his study and found that a total of 69.80% of patients claimed that the process was lengthy and the remaining 30.20% of patients felt that it took them a normal and expected time to leave the hospital. A total of 61.53% of patients voted to speed up the discharge process.

In 2014 Dr. Silva et al. conducted a study to determine the main reason for the delay in the discharge process of patients from two teaching hospitals with the aim of improving the relevant findings. The admission and discharge records of patients leaving the internal medicine department were reviewed. The author conducted a pilot study to determine the sample size. They found that between the two teaching hospitals, the delay was 60% in Hospital A and 50.7% in discharge delay in Hospital B. Investigation reports were not available in time, delayed decisions about the patient's clinical health and discharge & were found to be the main source of delay in of the discharge process is the provision of specialized consultations.

In 2014, a study was conducted at Apollo Hospitals, Bhilai for a period of three months to identify the delay in the discharge process against the standard time. The goal was a process review analyzing the entire process and identifying complicating challenges in the various steps of the process. And the purpose of the study was to strategize time reduction and process mapping. The author conducted a time-motion study involving all six units where patient records were monitored. This cross-sectional study was conducted with a sample of 300 patients randomly selected over 3 periods of three months. Respondents were interviewed during the study, including nurses, discharge pool staff, duty physicians and administrators. The researchers set out to follow at least 50% of the total number of patients discharged during the study period. The standard discharge time was 2 hours, which was two hours less than the average time of 4 hours. All patients including cash, credit, TPA, scheduled and unscheduled discharges were tracked. The finding was the time for Cash, Credit, unplanned and planned release was 3.6 hours. 4.2 hours, 4.1 and 3.4 hours, respectively.

The study was conducted at the Asian Heart Institute to determine the TAT of the discharge process and analyze gaps and standard operating procedures. It was a cross-sectional study conducted over a period of 45 days, where quantitative and qualitative analysis was performed. The sampling techniques used were non-probability purposive sampling. Primary sources such as observation, interactions with staff and departments and secondary sources such as HIS, patient file were used to collect data to find out the reasons for delay. The reasons were categorized into various categories such as delay caused by the patient, delay for which the hospital is responsible, delay due to approval of TPA, delay due to worsening clinical condition of the patient etc. The main reason found behind the delay in discharge by the process was gap in information flow and interdepartmental communication .

Mr. Khanna and co. (2016) conducted a study in a tertiary care hospital to determine the timeliness of the discharge process and its effect on shift and flow performance. The study was conducted to determine the optimal discharge time and target

read overcrowding and overcrowding along with improvisation of inpatient flow. Fifteen month patient records were used to understand and work on the patient journey, i.e. admission to hospital discharge. Discrete event stimulation was used to understand flow performance. They found that eighty percent of discharges were made before the afternoon, resulting in an additional nine beds being available for incoming inpatients. Average time to make a bed available for occupancy, length of stay and bed occupancy were targeted and reduced. The study showed that shocks performed before noon, i.e. before 11:00, lead to improvised patient flow and performance.

Dr. Soundara Raja (2017) published a study in a tertiary care hospital to find the reasons that contribute to the delay in patient admission to the ward. The objective of the study was to identify the root cause and provide recommendations for the same using valuable information and rectify the problem. Time-consuming preparation of the discharge summary, clearance from the pharmacy, delays by support services and nursing staff were reasons leading to patient dissatisfaction.

Hospital Recorded Time for Discharge of Private, Government Panel and TPA Patients

S.No.	Category	Avg. Time Taken	Criteria
1.	**Corporate**	10 Hrs 35 Mins	Discharge Intimation Date Time Activity Sheet Date Time Update Pharmacy clearance Date Time Discharge Date Time Time Bill Settled Date Time Bed Release Date Time Bill Prepared Date Time Final Bill Prepared Date Time
2.	**Cash Patients**	9 Hrs 21 Mins	
3.	**TPA**	12 Hrs 21 Mins	

Discharge process at Max Super Speciality Hospital

• The primary care consultant is primarily responsible for patient discharge decisions and completes these decisions during their pre-discharge visit and is informed to the carer/relative/nursing staff/physician.

• During the discharge day visit, the physician completes the patient's discharge based on the patient's clinical condition.

• Examination of the patient is done to see if he can be discharged or not on the scheduled day.

• Once the patient is found to be well, this is communicated to the ward nurse and the RMO service.

• The nursing staff reimburses the patient for excess medication, a discharge summary is drafted, and the patient is counseled regarding post-discharge care.

Preparation of Discharge Summary

• Once a final decision has been made, the consultant or doctor on duty, on the consultant's advice, prepares a summary containing the following information:

A. Reasons for Admission

b. Conducted investigations and summarizing information about the results

C. Diagnosis

d. Records of procedures performed

E. Patient Status at Discharge

F. Medical Orders

G. Follow-up Advice on When and How to Get Urgent Care

h. Hospital emergency number

i. Dietary advice

j. Date of return visit

• The prescribing physician enters the discharge summary from the patient file received at Billing and the discharge summary is sent to the consultant for correction and signature

• 3 copies of the final discharge summary maintained in the patient file by the nurse's department.

• One is given to the patient/caregiver and the second is attached to the case file and the 3rd copy is given to the accounting department.

• The nursing staff will recommend to the patient/caregiver the instructions for taking medication and instruction according to the communication of the nursing consultant.

• The patient/caregiver signs the report stored at the billing counter on receipt of the Discharge Summary.

Final Billing of Patient

• On the day of discharge, the attending physician or nurse in the ward will issue a confirmation of the patient's discharge.

• The patient file is sent to the billing section for final billing through the responsible floor or ward nurse.

Patient Counselling

• Before final discharge, the dietitian advises the patient about diet, instructs the nurse about prescriptions, revisions, etc., as indicated in the DS summary.

• The patient is informed about the return visit to the hospital.

• Discharge records are recorded in the discharge records maintained at the nursing station.

• The patient and relatives leave the hospital.

• In the case of old patients, delivery people, etc., the nurses of the department are taken in a wheelchair to the exit area of the hospital and dismissed.

Billing Section Formalities

• Account verified and three copies made – patient copy, record copy and bill copy

• Relative of the patient called from the billing section after the patient's file goes to the billing department

• The bill is settled (if the patient pays) and the cash receipt is received by signing all three copies of the bill; confirmation of approval then issued by the accountant / patient nurse

• Confirmation of approval together with a copy of the receipt given on the ward to the nurse in charge of the patient.

• Receipt No. with the amount entered in the department's income and discharge records and the discharge summary, examination reports and films handed over by the nurse to the patient's nurse

LAMA (Left Against Medical Advice)

• As part of the patient's rights, no patient may be held in hospital against their will.

• Nursing staff and the concerned physician should try to persuade the patient to stay, while also trying to find out why the patient wishes to leave, if possible to resolve the problem.

• It is the doctor's responsibility to explain to the patient that if the patient leaves the hospital against medical advice, the hospital ceases to be responsible for their care.

• However, if the patient still wishes to self-discharge, every possible step should be taken to ensure that the patient/authorized carer signs a form to that effect before leaving the hospital. In case the patient/relatives want to be discharged on medical advice; the treating primary care physician/physician states the same in the patient's record.

• Written consent in the form of LAMA is taken from the patient/relatives.

• If the patient refuses to sign the form, this is clearly documented in the Health Record.

• Risks and actions taken are recorded in records.

• The relative/servant is asked to pay all fees.

• A summary summary of layoffs is prepared and provided.

• One copy is attached to the patient file for record purposes

Discharge on Request

• DOPR (discharge at the patient's request) is given in the MAX hospital in case of imminent death of the patient. A summary of the discharge is prepared and provided. One copy is attached to the IPD file for record purposes

Medico Legal Cases

• All medico-legal and warrant cases are processed in the same manner as planned discharge, where information is sent to the appropriate authorities prior to such discharge.

• In case of MLC:

- Medico legal forms are completed and informing the police is done by the RMO / nurse. - All investigative reports and evidentiary materials are preserved; The nurse on duty is responsible for maintaining protection.

- MLC on admission, discharge home, transfer to another hospital or death is documented and the police are informed.

- A discharge summary is prepared and listed.

- A copy of the DS summary is attached on file for record purposes.

Pharmacy Clearance

• Unused medicine is returned to the pharmacy before billing and sending the file to the billing department.

• Pharmacy staff make the final deductions from the bill, if any, and grant a “pharmacy clearance” by the nurse in charge/nurse on the ward.

Patient Expiry

• In case of patient expiration, the primary treating consultant/doctors/nursing staff inform the patient's relatives. Relatives of the patient have time with the body.

• The nurse in the ward performs the necessary preparation for cleansing the body. The body is cleaned by designated personnel and wrapped in a clean sheet.

• The RMO formulates 3 replicas of the death certificate and the death summary.

• Death certificate and death summary are stamped.

• Body handed over to relatives or deposited in the mortuary within an hour of death.

• Body handed over to next of kin along with one copy of death summary and death certificate and second copy attached to patient records.

• In the case of medico-legal cases, the local police station is informed and they will decide whether an autopsy is necessary.

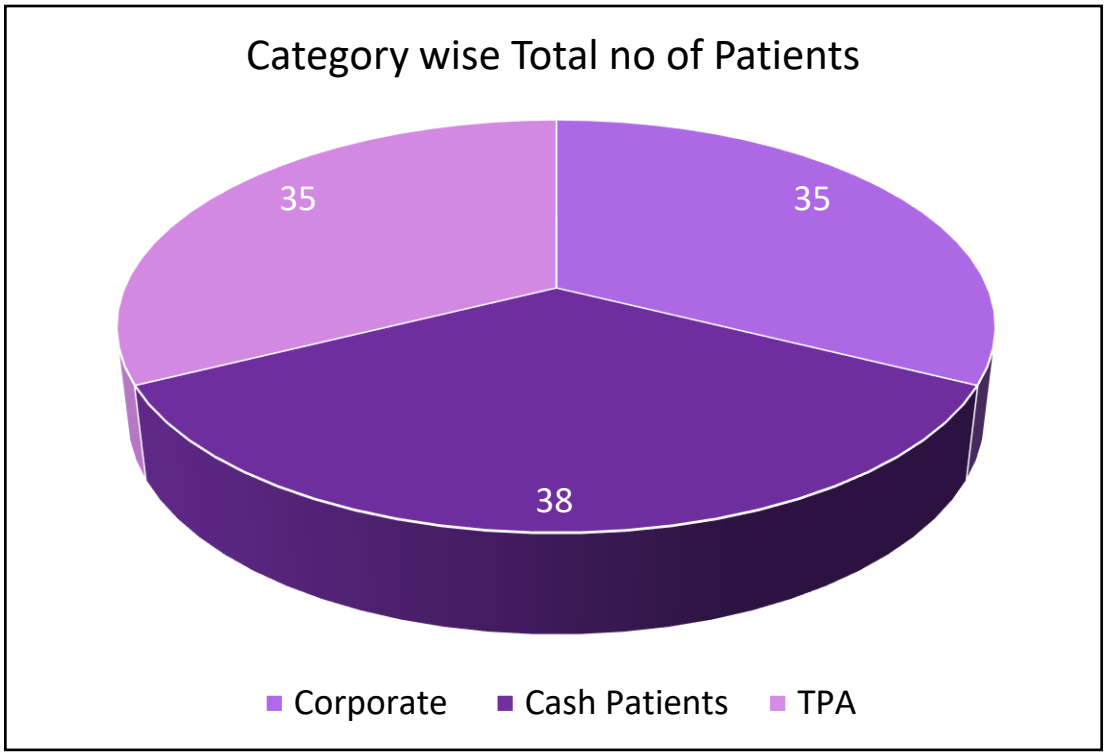
Records Generated

- Patients Case File
- Discharge Summary
- Death Certificate
- Death Summary
- LAMA form
- Admission Discharge Register
- Final Bill

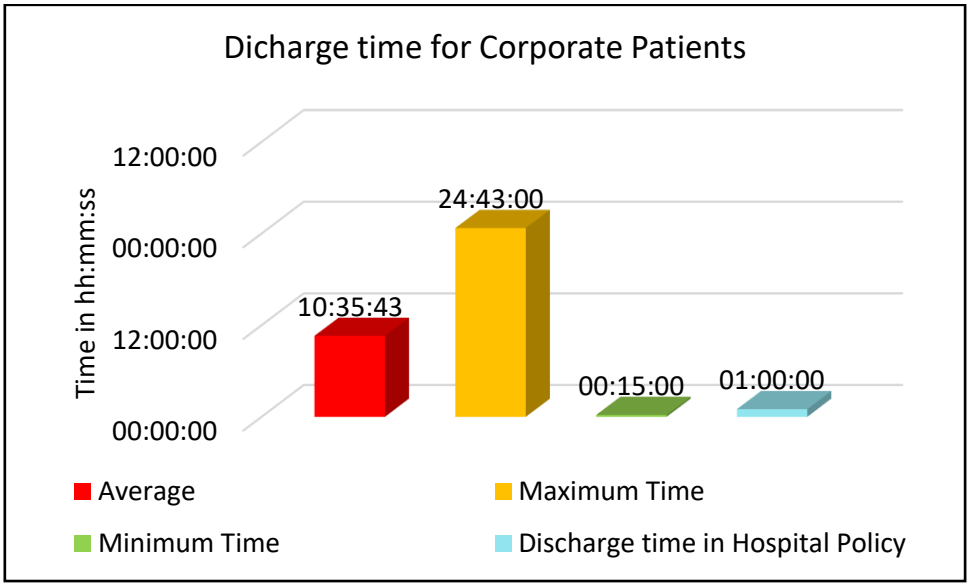
Data analysis

Category wise total number of patients (29th May-22nd June 2024)

S.No.	Category	Total number of Patients
1.	**Corporate**	35
2.	**Cash Patients**	38
3.	**TPA**	35
	Total=	108



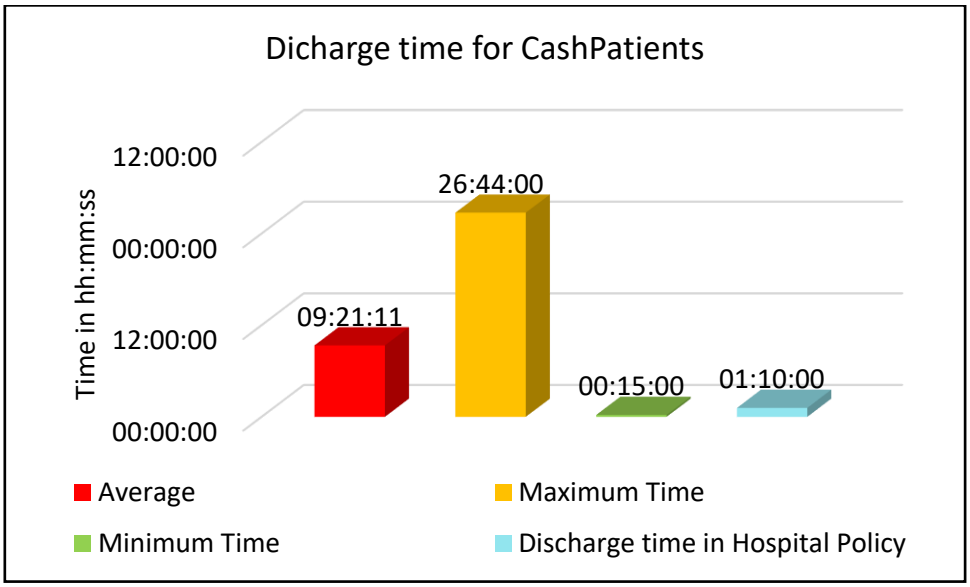
Discharge time for Corporate Patients



- The average time for Discharge of 35 Corporate Patients **is 10 Hours 35 minutes**.
- Out of **35 patients, 1 (2.85%)** were discharged under the Hospital policy time for
- Panel patients
- Rest **34 patients (97.14%)** took **more than 1 hour** for the completion of discharge process.
- The **maximum** recorded time is **24 Hour 43 Minutes**.
- The **Benchmark** for the patient discharge of Corporate category is **15 Minutes.**

Time	**No. of Patients**
< 1 Hr	**1**
1-2 Hrs	6
2-5 Hrs	4
5-10 Hrs	1
> 10 Hrs	23

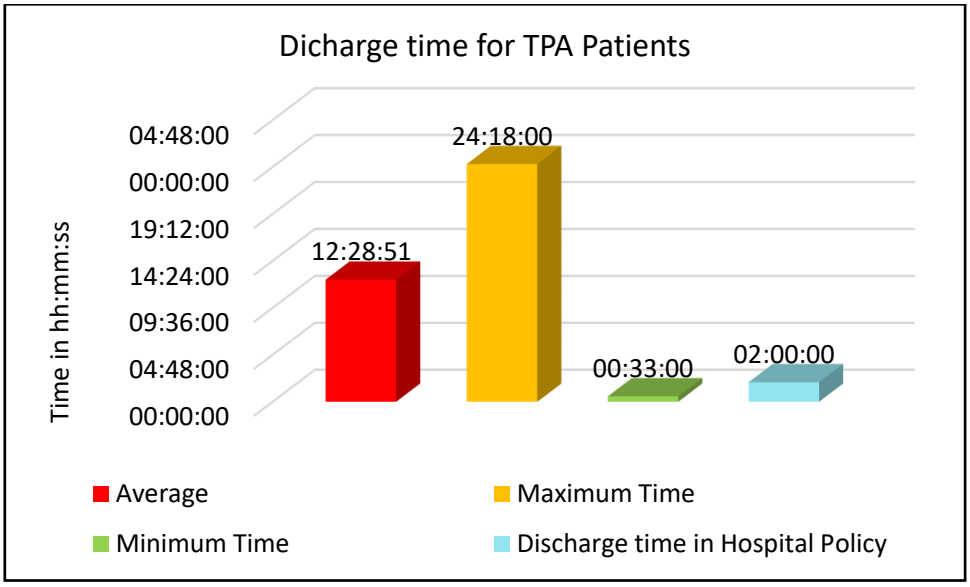
Discharge time for Cash Patients



- The **average time** for Discharge for 38 Cash Patients is **9 Hours 21 minutes.**
- Out of **38 patients**, **4 (10.5%)** were discharged under the Hospital policy time for
- Cash patients.
- Rest **34 (89.5%)** took **more than 1 hour 10 mins** for the completion of discharge process.
- The **maximum** recorded time is **26 Hour 44 Minutes**.
- The **Benchmark** for the patient discharge of **Cash category** is **15 minutes.**

Time	**No. of Patients**
< 1 Hr	4
1-2 Hrs	11
2-5 Hrs	2
5-10 Hrs	1
> 10 Hrs	20

Discharge time for TPA Patients



- The **average time** for Discharge for 19 TPA Patients is **12 Hours 28 minutes.**

- Out of 35 **patients**, **4 (11.4%)** patients were discharged under the Hospital policy time for TPA patients that is **2** hrs.
- Rest **34 (89.5%)** took **more than 2 hours** for the completion of discharge process.

- The **maximum** recorded time is **24 Hour 18 Minutes**.
- The **Benchmark** for the patient discharge of **TPA category** is **33 minutes.**

Time	**No. of Patients**
< 2 Hrs	6
2-5 Hrs	5
5-10 Hrs	1
> 10 Hrs	23

Internal Audit: NABH Compliance (AAC 13 & 14)

MAX Healthcare

DISCHARGE PROCESS INTERNAL AUDIT		
AAC.13: The Organisation has a documented discharge process		
a.	The Patient's discharge process is planned in consultation with the patient and/or family	No
b.	Documented procedures exist for coordination of various departments and agencies involved in the discharge process (including medico-legal and absconded cases)	Yes
c.	Documented policies and procedures are in place for patients leaving against medical advice and patients being discharged on request.	Yes
d.	A discharge summary is given to all the patients leaving the organisation (including patients leaving against medical advice and on request).	Yes
e.	The organisation defines the time taken for discharge and monitors the same.	Yes
AAC.14: Organisation defines the content of the discharge summary		
a.	Discharge summary is provided to patients at the time of discharge	Yes
b.	Discharge summary contains the name of Patient's, Unique Identification Number, Date of Admission and Date of Discharge.	Yes
c.	Discharge Summary contains the reasons for admission, significant findings and diagnosis and patient's condition at the time of discharge.	Yes
d.	Discharge summary contains information regarding investigation results, any procedure performed, medications administered and other treatment given.	Yes
e.	Discharge summary contains Follow-up Advice, medication and other instructions in an understandable manner.	Yes
f.	Discharge summary incorporable instructions about when and how to obtain urgent care.	No
g.	In case of death, the summary of the case also includes the cause of death.	Yes

• Discharge is not planned 24 hours before.

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AAC.13.a.

Discharge of patients is not planned.

Corrective Action: The physician was notified of the problem. And a meeting was held with the program to motivate doctors for planned discharges. The indication of the expected days of the patient's stay is mandatory in the patient's admission form, and the authorized nurses are entrusted with the responsibility of checking the form in the emergency department and communicating with the doctor for planning the patient's discharge in the wards.

AAC 14.f.

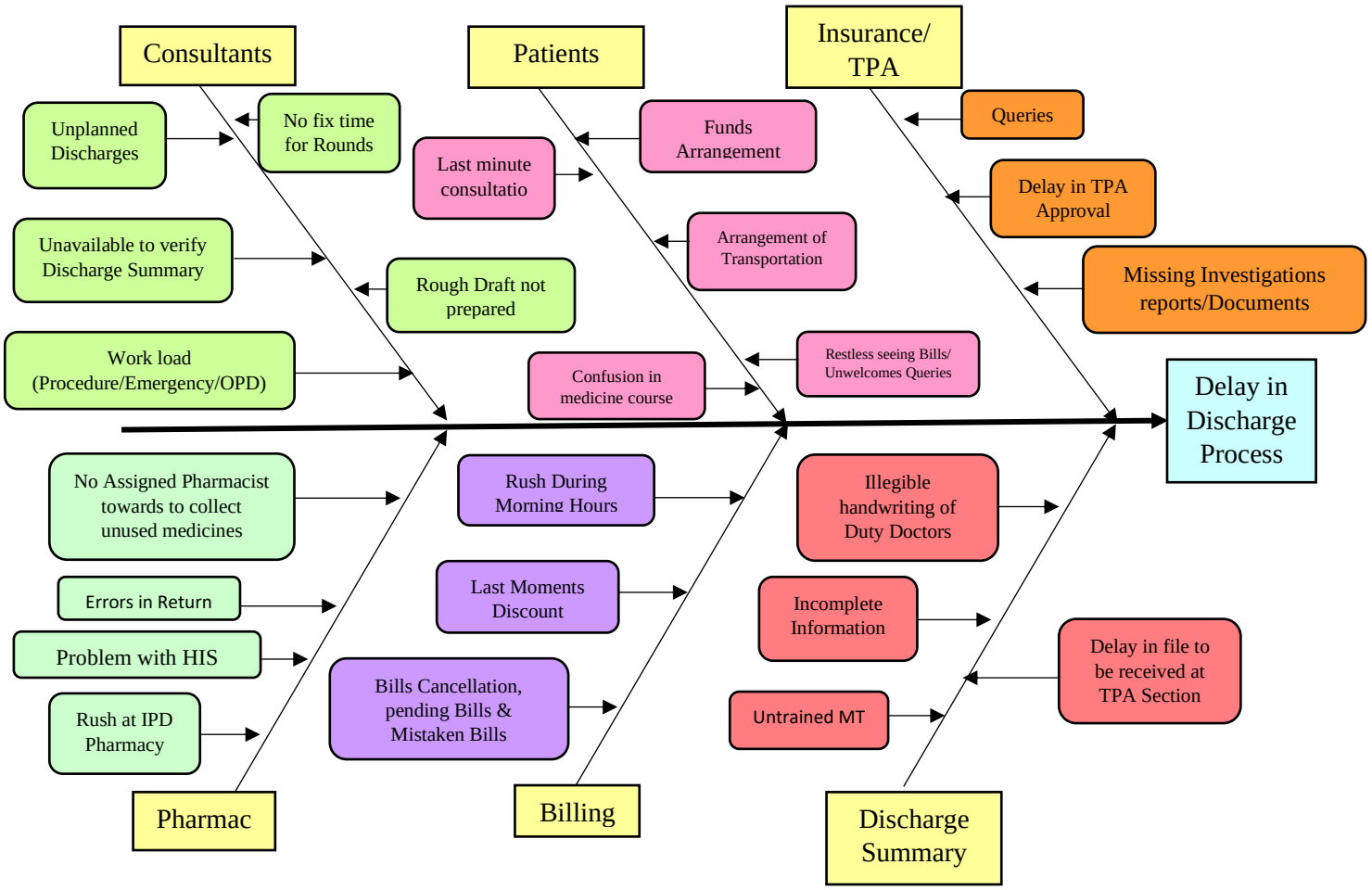
The discharge summary does not include information on when and how to obtain corrective action for emergency care: Prescribers are specifically trained in NABH

AAC 13 & 14.

The Billing Head will cross-check the billing summaries when signing the entry authorization for several days until the request is fully accepted.

Results

Cause and Effect Diagram



Other Reasons for the Delay in Discharge Process

• Lack of staff training and knowledge of the layoff process and criteria.

• Typos and errors in the Medical Transcriptionist discharge summary.

• Sometimes patients are really not in a position to pay the huge bill. The hospital seeks to provide discounts on a humanitarian basis, which includes certain approvals and consultations.

• Inter-departmental coordination lock as patient status is sometimes unknown (whether cash/panel/TPA)

• Sometimes the patient card does not work.

• Excessive amount of medication ordered by nurse: Longer return time.

• All messages are not available on HMS which is required to send TPA for Cashless.

• Photocopying and printing of discharge reports/summary takes some time.

• GDA shortage/unavailability: GDA staff will take unused medication from the IPD patient to the pharmacy and billing department for clearance. The GDA also has many other responsibilities that include caring for patients, doctors, nurses and administrative staff and assisting them in their activities. The morning hour has the maximum number of discharges, which requires a large number of GDAs going for discharge activities. The lack or absence of GDAs contributes to delays in the discharge process.

• Another important issue is the late preparation of the DS summary, as it involves many steps:

a) Physicians not involved in the treatment are asked to write a summary in the patient's file. They have to go through the entire notes, which causes delays.

b) Sometimes DS is ready late due to Medical Transcriptionist workload.

c) Sometimes everything is ready, but it still could not be delivered to the patient because the nursing staff is very busy and sends the file late to the billing department.

d) Sometimes the staff tends to try to accumulate 2 or 3 discharges at the same time, so there is a delay in filling out notes, approving the pharmacy, sending files.

Miscellaneous

There are various other reasons that slow down the discharge process. Some patients prefer to leave after lunch. Some patients have transportation and other issues that extend their stay. Few people have sudden questions that require a doctor's consultation before returning home, which takes time.

Conclusion

Discharging patients appropriately is complicated. Effective and well-timed discharge can be achieved through interdepartmental coordination and proper communication between all involved in the discharge process.

In this study, the time required for discharge of cash, TPA and panel patients at MAX Hospital was analyzed. The time required for the DS of cash patients was found to be delayed by 27 minutes compared to the time specified in the hospital policy. It is almost the same for panel patients. And in patients with TPA, a delay of 12 minutes was found. Various reasons associated with the delay in the process have been identified and will be worked on.

Unplanned discharges are the main reason for chaos in the discharge process. In NABH Chapter 1, AAC 13 clearly states that discharge should be planned in advance in consultation with the patient/family. As part of the internal audit, two cases of non-compliance were detected, for which the necessary measures were taken.

Recommendations

• Planned discharge: medication return, cross-consultation, report taking and summary preparation.

• The timing of the doctor's cycles can be tried to be set best in the morning.

• The nurse should know the expected date of discharge so that she can complete her notes, report withdrawals and return unused medications to the pharmacy.

• The patient should not be discharged immediately upon request. This could be scheduled for an evening strike so that it should also prove to be a suitable strike, otherwise not only will the case itself be delayed, but it will also fetter the power of other planned strikes.

• The Discharge Coordinator/Nurse should coordinate a parallel workflow that is missing in many cases, such as informing the Dietitian or Physiotherapy or should inform the wheelchair cleaning department, transport team for ambulatory services (if required) as initiated . by the attending physician at the time when he prepares the DS for a smooth course.

• For non-cash patients, documents should be collected in a timely manner so that the nurse does not have to rush to collect reports or background checks.

• The patient must be well informed about the time of the entire process and the steps involved in it.

• Prioritizing the TPA patient pool for discharge summary and bill preparation as claim approval takes the most time.

• Color coding of file folders.

• Interdepartmental coordination and communication (training, sensitization, meetings, communication channel)

• Timely collection of reports and department reviews.

• Nurse training to prepare a discharge summary.

• Separate IPD Billing counters.

Limitations of the Study

- Limited duration
- Includes only In Patient Department patients.
- TAT for TPA patients is accessed through email.

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ANNEXURE: DOPR FORM

Name	:	Age	:
Reg No.	:	Address:	
D.O.A	:	D.O.D	:
Consultant	:	Ward	:

Final Diagnosis:

Admissions complaints &
Brief History of
Presenting Illness:

Relevant past Medical/surgical history:

Relevant Family History:

Physical Examination			
	Temp	:	
	PR	:	/min
	BP	:	mmHg
	SPO_2	:	
	RBS	:	
	Chest	:	
	CVS	:	
	P/A	:	
	CNS	:	

यह दस्तावेज आपके उपचार हेतु महत्वपूर्ण है कृप्या कर इस कागज को हर बार अपने साथ अस्पताल लेकर आऐं
Please bring this paper with you on every visit to the hospital

ANNEXURE: MLC FORM

M.L.C. Form S.No. _____

GOVT ID:			
M.L.C NO.:	Name & Address:		
Indoor/OPD No.:			
Examination Date & Time:		Age:	Sex:
Brought /Referred by(Name & Address):	Identification Marks/L.H.T.I. of the Patient		
GOVT ID:			
Relationship:			
Time brought in:			
Signature:			

History and alleged cause of Injury: _____

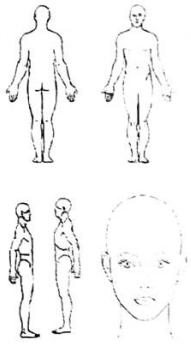
_____

Condition on Arrival: _____

_____

Details of injuries/Clinical Features (Nature, Exact Situation, Dimension, Fresh/Healing, Cause of Injury/Age of Injury)

Site of Injury



Radiological Investigations:

Summary Of Treatment:

Condition of Discharge & Diagnosis:

Attended by Drs.:

Date of Admission: / /	IP.No.:	Date of Discharge: / /	
Police Information on Admission		Police Information on Discharge	
Date & Time Informed:	Date & Time Arrived:	Date & Time Informed:	Date & Time Arrived:
Email sent to Police:		Police Station:	
Police Station:		Constable's Name:	
Constable's Name:		Buckle No.:	Signature:
Buckle No.:		Signature Of M.O:	
Name of Institution:			
Signature:		Name of M.O.:	
		Designation:	Reg.No.:

TO BE PRESERVED FOREVER

ANNEXURE: LAMA FORM

MAX Healthcare

Name of Patient.....Regn. no.....Age/Sex.....

W/O, S/O, D/O.....

Address.....

Provisional/Final Diagnosis.....

I, myself going out of Max Super Speciality Hospital.

I Mr./Mrs./Ms.....

Taking this patient Mr./Mrs./Ms.....

Out of the hospital against Medical Advice. All the consequences and complications have been explained to me by the doctor, in the language I understand and fully accept the inherent risk involved in such decision of mine.

Reason.....

.....

.....

.....

.....

.....

.....

Name and Signature of Patient/Attendant:

_____

Relation with Patient: _____

_____

Date:_____

Name and Signature of Duty Doctor:

_____

_____

Name and Signature of Witness:

_____

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