DISCHARGE PROCESS MANAGEMENT

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	Discharge Process Analysis	**Prepared by: Shweta Singh**

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Acknowledgement

Nothing in this world happens single handed. It is the collective efforts of many people who put in together to set the things done, so does this project work.

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Abbreviation list

NHI : National heart Institute

PCC : Patient Care Coordinator

CGHS : Central Government Health Scheme

ESI : Employee State Insurance

ECHS : Employee Contributory Health Scheme

TPA : Third Party Administrator

UNICEF : The United Nations Children's Fund

WHO : World Health Organization

OPD : Out Patient Department

IPD : In Patient Department

ICCU : Intensive Coronary Care Unit

PTCA : Percutaneous Transluminal Coronary Angioplasty

AICD : Automated Implantable Cardioverter-Defibrillator

CT : Computed Tomography

MRI : Magnetic Resonance Imaging

PACU : Post Anesthesia Care Unit.

GDA : General Duty Assistant

INTERNSHIP REPORT

HOSPITAL PROFILE

National Heart Institute, established in 1981, is a land mark in the health care delivery in India. It was the first heart institute to be launched in India and the first private sector cardiac catheterisation laboratory to be established in the **'Southern Hemisphere'**. Towards the goal of transplanting health and happiness, National Heart Institute is staffed by a team of dedicated and value driven medical professionals, whose endeavor is to provide the ultimate in contemporary medical care for we believe in 'Together we care ... as no one has ever done before'. The National Heart Institute is the Research & Referral tertiary care Heart Hospital of the All India Heart Foundation, which acts as a nucleus for diagnosis and treatment of heart ailments and allied diseases and is equipped with state of the art equipments. Surgical services include all kinds of closed and open Heart Surgeries like Coronary Artery Bypass Surgery, off pump bypass surgery (beating heart surgery), valve repair & replacement surgeries, aortic / carotid surgeries, congenital heart surgeries including blue babies and minimally invasive (Key hole) surgeries. It has modern Cath lab facilities where procedures like Angiographies, Angioplasties, Stenting of the Coronary arteries, valvotomies correction of birth heart defects and closure of holes of the heart, Electrophysiological studies, Radio Frequency ablation, Rotablation, Intra-vascular ultrasound, pacemaker and internal defibrillator implantation are carried out. Highly qualified staff, trained in India & abroad, with extensive experience in Cardiology & Cardiac Surgery service these areas.

Apart from indoor treatment, the Institute also provides comprehensive medical check-up, i.e. Executive health check-ups, at nominal rates with a view to ensuring good physical conditioning and health of all individuals. Cardiac patients with other ailments

are also admitted to this hospital, as specialists for diseases other than heart are available round the clock for consultation and treatment.

The Institute has been recognised for open heart surgeries, coronary artery bypass surgery, angiography and angioplasties and other specialised cardiac treatment by the Central Govt. Health Scheme (CGHS), Employees State Insurance (ESI), Employee Contributory Health Scheme (ECHS), besides the Governments of Himachal Pradesh, Haryana, Madhya Pradesh, Mizoram and Govt of NCT of Delhi. Ministry of Defence, Office of the Director General of Armed Forces Medical Services and Directorate General of Medical Services Naval Headquarters have recognised NHI for treatment of their employees and their families. 122 Public sector bodies, almost all the TPAs and International Organisations like World Health Organisation & UNICEF are also empanelled with the National Heart Institute.

Keeping in tune with its ethos of service to the humanity, National Heart Institute carries out regular Community outreach programmes (heart camps) and also ‘Executive Health Checks’ and ‘Recruitment Checks’ to detect cardiac problems early and take remedial action.

National Heart Institute is recognized by National Boards for post doctoral training and runs an active teaching and training programme in the specialties of Cardiology & Cardiovascular & Thoracic Surgery. It also carries out research in all facets of Cardiology & Cardiac Surgery.

National Heart Institute is recognized as a Collaborative Centre of WHO in Preventive Cardiology since 1983. It is an affiliate of the World Hypertension League and Heart Beat International.

National Heart Institute lays special emphasis on "Lifestyle Disorders" and caters to outdoor consultation, education and counseling on Diabetes, obesity, cholesterol related

diseases, thyroid disorders, alcohol and smoking. Indoor care for Diabetes & Lifestyle disorders are taken care of.

The hospital has a department of Pulmonology and Sleep Medicine which is equipped with sophisticated machines and is manned by dedicated Pulmonologists, Thoracic Surgeons and Physiotherapists.

10% indoor beds are earmarked for poor patients having monthly income of Rs.4000/- and below and the hospital regularly provides free treatment to such patients and lots many at subsidized rates. The hospital also runs free OPDs for two hours on all working days.

In collaboration with Heartbeat International, the hospital provides free Cardiac Pacemakers for needy patients.

Services:

- **Cardiac Emergencies**
- **Ambulance Services**
- **ICCU**
- **Health & Cardiac Check**
- **Philanthropic Work**
- **Transfusion Medicine**
- **Laboratory Services**
- **Physiotherapy Prog.**
- **Cardiac Rehabilitation**
- **Dental Services**

CENTERS OF EXCELLENCE

CARDIOLOGY

The Department provides intensive cardiac care, diagnosis & treatment of cardiac ailments. It has latest technologies for cardiac catheterization and angiography, Angioplasty, Valvuloplasty, Pacemaker and Defibrillator implantation, 3 D Echo, Holter, Stress Testing, Electrophysiological Studies, etc. The hospital's warm ambience, dedicated & well qualified doctors, cheerful & pleasing support staff, modern outpatient facility and dedicated inpatient care ensures that the patient is in the best hands at National Heart Institute.

Interventional Cardiology

Interventional cardiology is a branch of the medical speciality of cardiology that deals specifically with the catheter based treatment of structural heart diseases.

A large number of procedures can be performed on the heart by catheterization. This most commonly involves the insertion of a sheath into the femoral artery (in practice, any large peripheral artery or vein) and cannulating the heart under X-ray visualization (fluoroscopy, a real-time x-ray).

Procedures Performed by Specialists in Interventional Cardiology

- Angioplasty (PTCA, Percutaneous Transluminal Coronary Angioplasty) - for coronary atherosclerosis
- Valvuloplasty - dilation of narrowed cardiac valves (usually mitral, aortic or pulmonary)
- Procedures for congenital heart disease - insertion of occluders for ventricular or atrial septal defects, occlusion of patent ductus arteriosus, angioplasty of great vessels etc.
- Emergency angioplasty and stenting of occluded coronary vessels in the setting of acute heart attacks (Primary PTCA)
- Coronary Thrombectomy - a procedure performed to remove thrombus (blood clot) from blood vessels.
- Carotid angioplasty
- Insertion of temporary and permanent pacemaker including dual chamber pacing
- Insertion of AICD (Internal Defibrillator)
- Radio frequency ablation for irregular rhythms of the heart.

Invasive procedures of the heart to treat arrhythmias are performed by specialists in clinical cardiac electrophysiology.

Non- Invasive Cardiology :

- 3 D Echocardiography & Doppler Studies
- Foetal Echocardiography
- Transoesophageal Echocardiography
- Peripheral and Carotid Doppler Studies
- Stress Echocardiography
- 24 Hour Holter Monitoring
- Treadmill Stress Test
- Ambulatory Blood Pressure Monitoring
- Nuclear Cardiology (in Collaboration)
- Cardiac CT & MRI (In Collaboration)

NHI LOGO

NHI VISION

"To create long term relationships by caring as no one has done ever before"

NHI MISSION

"To provide superior, compassionate and innovative cardiac care to prevent and treat disease maintaining highest standards in safety and quality"

DEPARTMENTAL OVERVIEW

Inpatient" means that the procedure requires the patient to be admitted to the hospital, primarily so that he or she can be closely monitored during the procedure and afterwards, during recovery. An **inpatient** is "admitted" to the hospital and stays overnight or for an indeterminate time, usually several days or weeks (though some cases, like coma patients, have been in hospitals for years).

BED DISTRIBUTION IN THE IPD AREA AT NHI

- General bed (12)
- 4 Semi private rooms (8 beds)
- 6 Private rooms (6 beds)
- 12 Deluxe rooms (12)
- ICCU 1 (12 beds)
- ICCU 2 (8 beds)
- ICCU 3 (6 beds)
- ICCU 4 (4 beds)
- Recovery (8 beds)

All the patient occupancy areas are well lit and ventilated, and equipped with Pipe Line Oxygen, Central Suction etc. to minimize patient discomfort and for the immediate availability of the life saving systems. A quality service from the nurses is available round the clock.

- ❖ Basic services including breakfast, lunch, evening tea and dinner are provided. Provision of special diet for patients like diabetic etc is available. An attendant is allowed to stay only with private room patients, but in general wards the attendants are discouraged to stay except in case of pediatric patients. There is a visiting hour to in patient department. Every patient is given one attendant pass.
- ❖ Children below the age of 12 are not allowed to visit the patients.
- ❖ Visitors are allowed only at the notified Visiting Hours

- 01/ April to 30/ September (summers):
- 17:00 hrs - 19:00 hrs
- 01/ October to 31/ March (winters):
- 16:00 hrs – 18:00 hrs

Professional care is provided to the patients round the clock by the team of doctors, dedicated nursing staff and other supporting staff.

Patient Care Coordination (PCC) Department:

PCC addresses integration issues that cross providers, patient problems or time, with general clinical care aspects including document exchange, order processing, and coordination with other specialty domains.

- PCC addresses workflows that are common to multiple specialty areas and the integration needs of specialty areas that do not have a separate domain.

- PCC is focused on clinical content and workflows

- PCC profiles are championed by clinicians to support clinical integration

TASKS PERFORMED

1. Round of patient care (ICCUs / Wards) and related areas (patient kitchen) and make note of observations as regards to floor discipline, discrepancies and other aspects / issues need improvement.

2. Interaction with nursing In – charges as regards to patient discharge and monitor & record of the same on under – mentioned sub heads :-

- Discharge decision with timings.
- Discharge summary preparation, its timeliness and improvement if any.
- Adherence to benchmark / discharge timings
- Monitor of discharge timings from discharge decision to departure of patient.
- Co-ordination with Quality Cell to provide quality indicators and patient discharge timing analysis.

3.Scrutiny of patient feedback forms and information captured thereby. Coordination with Quality Cell as regards to capturing quality indicators pertaining to patient satisfaction. Presentation / circulation of gray areas brought out to the concerned Heads / In charges.

4.To monitor Housekeeping services in patient care including Biomedical Waste clearance from patient care areas. Direction to HK Supervisors on deficiencies notices / observed.

5. Monitor dietary services and related patient complaints

- Take round of Kitchen and observe functioning of the same.
- Turnout of serving boys.
- Round of patient pantry.

6. To look into staff discipline – personal tidiness & turnout etc. Of the operation staff.

7. Any other patient care and operation aspects so assigned.

REFLECTIVE LEARNING:

- Effective discharge management is when both individual and staff are satisfied knowing that adequate plans have been made for discharge, with the outcome of the individual's discharge taking place without unforeseen difficulties.
- Learning about Improving balance between bed supply and demand during peak demand hours
- Man power management
- Coordination between different departments (nursing, typing & Housekeeping etc.)
- Waste Management
- Analysis of the feedback forms & communicating the results to the respective departments.
- To streamline the Discharge process of hospitals through customer focus and optimum utilization of the resources.
- Customers' satisfaction is the main factor. A new and more effective method has to be adopted to ensure customers' satisfaction.
- Patient education must occur throughout the hospitalization, not only at the time of discharge.
- Information should be captured throughout the hospital stay, not only at the time of (or after) discharge.
- Waiting until the discharge order is written before beginning the discharge process is likely to increase the risk of errors.
- All patients should have access to their discharge information in their language and at their educational level.

PROJECT REPORT

Chapter 1

Introduction

Discharge

- **Discharge from the hospital is the point** at which the patient leaves the hospital and either returns home or is transferred to another facility such as one for rehabilitation or to a nursing home. Discharge involves the medical instructions that the patient will need to fully recover (Wikipedia).

- **Discharge from hospital is a process** and not an isolated event; it includes daily updation of discharge summary, collection of reports and the return of pharmacy beforehand. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting1.

DISCHARGE PROCESS (IPD)

The discharge process is one of the most important functions of the inpatient department. It comes under the billing of the patient, which is the responsibility of IPD. Once the admission takes place of the patient he also needs to be discharged once he is in stable condition.

Types of discharges:-

1. Planned discharges
2. Unplanned discharges
3. Discharge on request
4. Discharge against medical advice

Sound admission and discharge processes are essential for quality health care delivery and are one of the important areas of practice that requires constant review, evaluation and development to keep abreast with the constantly changing demands of health care delivery. The discharge process can have an impact on numerous factors, such as patient satisfaction, bed availability, etc. No matter what type of patient is being discharged (cardiac, maternity, medicine, orthopedic, neurologic) numerous activities must be completed for each before the patient can be released.

Discharge of individual should not take place until the responsible clinician is satisfied, following consultation with the multi-disciplinary team, individual that the individual can be safely discharged.

Delayed discharges lead to : Bed control does not have enough bed options to meet incoming demand Critical care units become challenged with moving patients into step-down areas

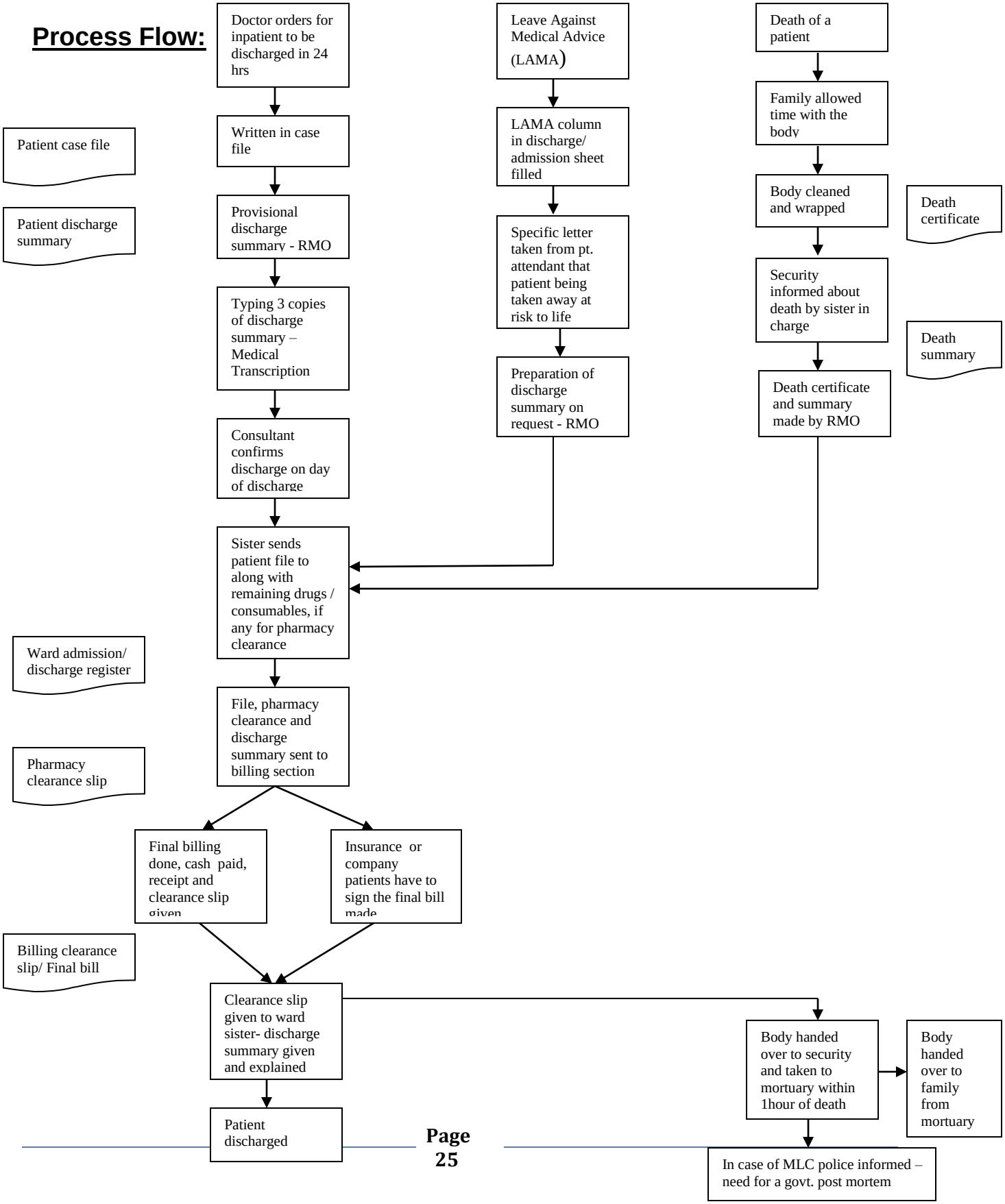
- Directly impacting inpatient admissions from the Emergency department

Delayed discharges are particularly problematic because of their significant impact on hospital admissions and patient throughput. As a result of delayed discharges, bed control does not have enough bed options to meet incoming demand. Critical care units become challenged with moving patients into step-down areas, which then directly impacts inpatient admissions from the Emergency department. Perioperative services also experiences back-ups in the PACU, waiting for beds to become available.

In effect, discharge delays create an upstream tidal wave of patient flow constraints which negatively impacts patient satisfaction, safety, hospital capacity, and financial performance.

Dissertation at National Heart Institute DELHI	IIHMR NEW DELHI Discharge Process Analysis	Duration 7th January to 7th April 2011 Prepared by: Shweta Singh

Process Flow:



Objectives:-

1. To identify process steps of discharge with special reference to time.

2. To identify the main reasons in the delay of discharge process.

3. Suggest ways to improve upon the discharge process so as to gradually match industry standards in terms of time taken and remove reasons of delay

Limitation Of the Study :-

- Time duration of the study was only 2 months i.e data collected and analysed here is of 2 month (20th January to 20th March)

NEED FOR THE STUDY:

The patients admitted in the hospital are already in grief and pain, they want to go home as early as possible and delayed discharges add to their grievances and also patient dissatisfaction. The aim any hospital should be to ensure a smooth discharge process. Reduction in the discharge process time will improve efficiency of the hospital as more number of patients would be treated in the same period of time and also reduce the wastage of hospital resources. Also, it will improve the patients' satisfaction, Quality of services and eventually revenue and profit of the hospital.

Review Of Literature

Chang G (1988) had done a study to identify the distinguishing characteristics of patients with unplanned discharges from day hospital; the author reviewed 96% of all 1987 admissions. Unplanned discharges included precipitous in-patient hospitalization, discharge before 30-day program completion, and discharge against medical advice. Forty-three percent of reviewed admissions ended by unplanned discharge. Psychiatric patients with recent and/or remote substance abuse and patients with multiple day-hospital admissions were especially vulnerable to unplanned discharge. Use of a backup bed during admission and being referred from the general-hospital emergency room or parent mental-health facility were associated with high rates of unplanned discharge. Patients with multiple admissions were more likely than those with a single admission to have personality disorders and to be female and white. Using logistic regression analysis, the author found that when patients had several characteristics increasing their risk for unplanned discharge, the odds of leaving before program completion were considerable.

David Anthony et al (2005) The transfer of patient care from the hospital team to primary care and other providers in the community at the time of discharge is a high-risk process characterized by fi-agmented, nonstandardized, and haphazard cares that leads to errors and adverse events. The development of interventions to improve the discharge process requires a detailed evaluation of the process by a multidisciplinary team. Methods used are the resources of the Boston University- Morehouse College of Medicine AHRQ Developmental Center for Patient Safety Research (funded by the Agency for Healthcare Research and Quality), multidisciplinary teams have been assembled to identify and address the sources of error at discharge. To better understand the current hospital discharge process, the researchers have applied a

battery of epidemiologic and quality control methods taken from industry. These include probabilistic risk assessment, process mapping, qualitative analyses, failure mode and effects analysis, and root cause analysis. The researchers describe each of these methods and discuss their experience with them, displaying concrete tools that have arisen from their application. The conclusion of the study was a detailed, multifaceted process analysis has provided us with powerful insight into the many patient safety issues surrounding the discharge process. The generalizable methods described here have produced the re-engineering of the discharge process, allowing for the planning of a clinical trial and significant improvements in patient care.

PAUL PETERS et al (1997) A project employing a liaison none has been started in the Dutch Zaandam region. The liaison projects will discuss on the experience of problems in preparing for hospital discharge and on continuity between hospital and home care. This article discusses the effect of the liaison nurse on the quality of the discharge planning process. The Investigation included a pre-test and a main test for which data were collected using questionnaires. These were sent to patients who had received after-care on being discharged from hospital. To measure the quality of the discharge process and after-care continuity, use was made of explicit quality criteria, targeting discharge planning. The results show mat discharge planning in hospitals has improved. No significant improvement was detected with respect to continuity of care. It may be concluded that the discharge process requires more attention. The quality criteria used here could function as points of departure.

Sima Ajam et al (2006) The hospital discharge process is a basic bottleneck in hospital management. Improved discharge process is the main strategy that covers many

hospital activities. Discharge process is the last patient's contact with hospital system. Therefore, it is the most important stage affecting patient's satisfaction. If this process takes long, not only it makes patients dissatisfied but it also will not be beneficial for the hospital. The main objective was determining average waiting time of patient discharge process at Beheshti Hospital in Esfahan, Iran in the spring of 2006. This study was a case study in which data were collected by questionnaires, observation and forms. The statistical population was all personnel involved in discharge process and patients discharged throughout the spring of 2006. To analyze data SPSS and Win QSB (Windows Quantitative Systems for Business) were used. Results According to the personnel's views, the main factors affecting average waiting time were patients' financial problems and un-accessibility of interns to complete the summery sheets. The longest patient's waiting time for discharge was 345 minutes and the least was 35 minutes. Average time for patients in discharge process was 197 (±65) minutes. This study concluded that Discharge planning is a routine feature of health systems in many countries. Hospital information system should be implemented at least between wards, Para-clinics stations, accounting and cashier station. It causes many stages in manual patients' discharge process will be omitted.

Charity Mukotekwa et al (2007) had done a study aiming that the complexity of the discharge planning process is such that it is often difficult to achieve in a totally efficient and effective manner. In this paper a systems approach is adopted in analyzing the discharge planning process in a general surgical ward in order to understand better the nature of this complexity. Adopting a soft systems methodology it is shown that the major issues to be addressed relate to the need for a more seamless service provision and more effective utilization of resources. Conceptual models are formulated which

enable comparison to be made between current provision and the issues that need to be addressed. This in turn results in the creation of an agenda of items for change, from cultural, organizational and technological perspectives, which can be considered in terms of their feasibility and desirability. Key proposals highlighted, so as to improve discharge planning, include: the need for greater co-operation between the many healthcare professions involved; the adoption, particularly on the part of nursing staff, of a more holistic approach with regard to the needs of their patients; enhancing the utilization of nursing staff; and moving towards a greater adoption of information and communication technologies as a means of achieving more effective communication. More generally, the paper provides an example of the role that soft systems analysis can play as an aid in dealing with the complexities of healthcare processes and their management.

Chapter – 2

Data and Methods

METHODOLOGY

Area:

National Heart Hospital, Delhi

Study Design:

The study design is cross-sectional analysis in nature.

Research Methods:

The research method used was quantitative analysis.

Type of data collected:

- Primary data was collected by using a discharge monitoring tool

Sample size:

Sample size taken for the study is 405.

Duration of the Study:

2months (20th January to 20th February)

Tools and Techniques: Data was collected by designing a discharge monitoring tool. Data was collected on following variables:

- Bed No.

- Patients Name
- Consultants Name
- Category of the patient
- Discharge order time
- Bill Book sent for billing time noted
- Time when patient is finally discharged
- Time taken in the whole process
- Discharge summary given to the patient or not
- Reasons for delay if any

Data Analysis: Data was analyzed using excel.

Chapter – 4

Results and Findings

Table No. 4.1 Total No. of patients who got discharged & given Feedback in the month of January, February and March

Month	No. of Patients
January	122
February	123
March	160

Fig. 4.1. Total No. of patients in Jan, Feb and March

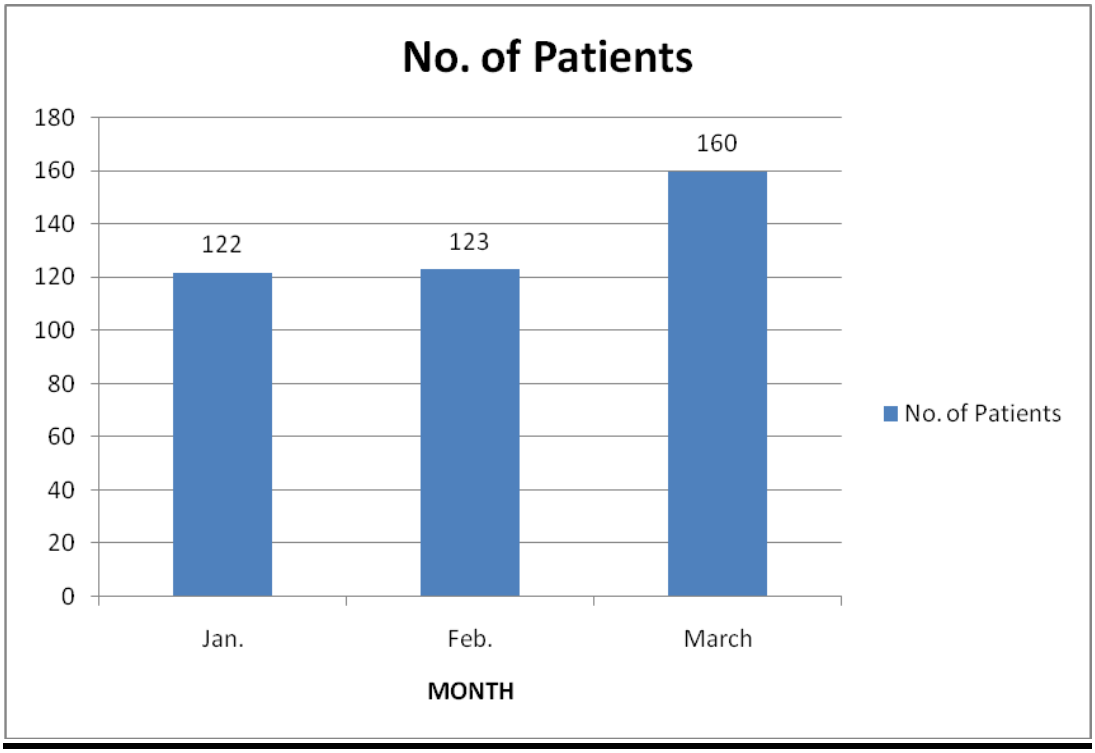
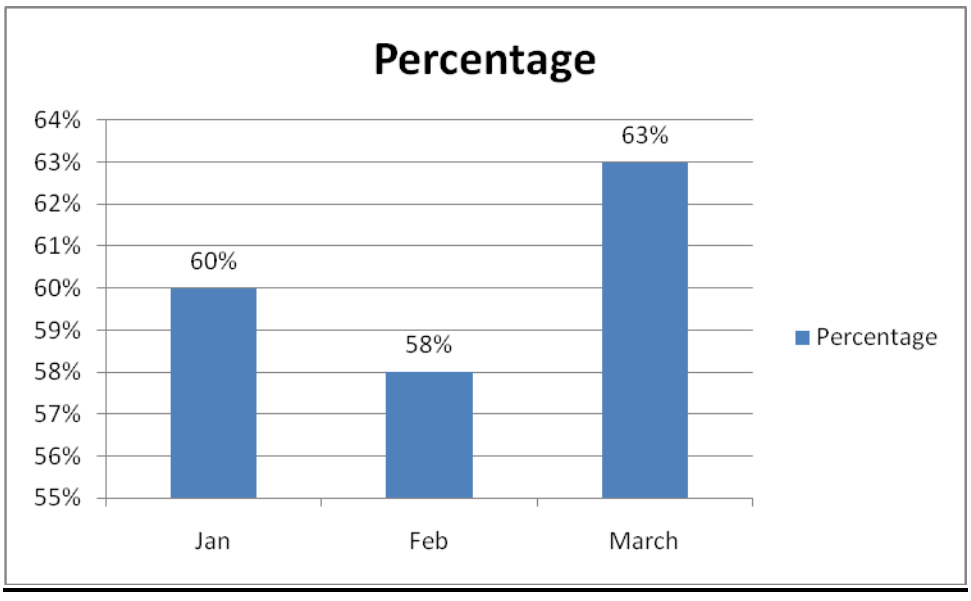


Table 4.2 Bed Occupancy Ratio

Month	Percentage
January 2011	60%
February	58%
March	63%

Figure 4.2 Bed Occupancy Ratio

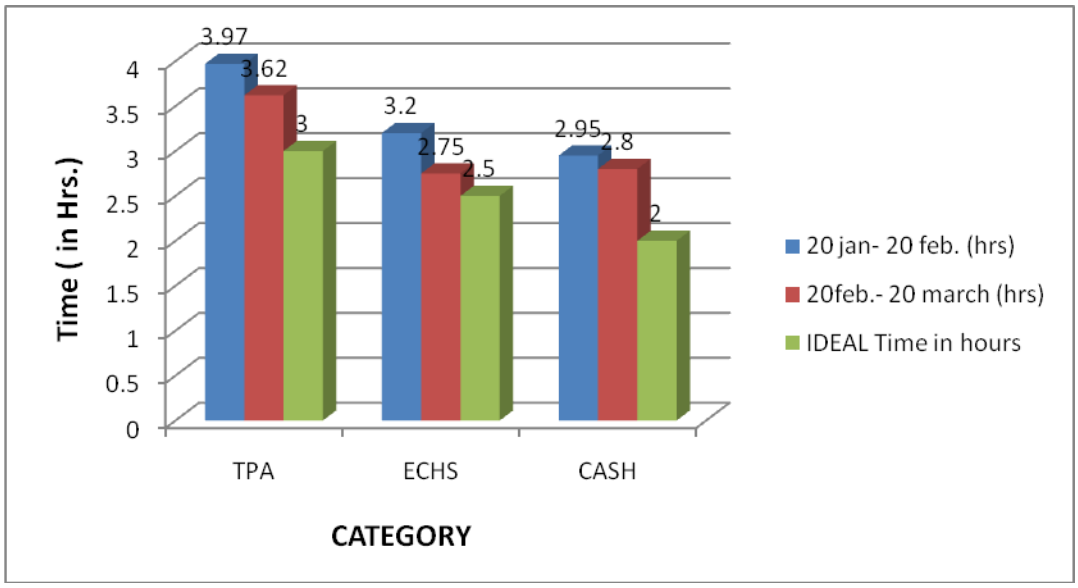


CATEGORY	20 Jan- 20 Feb. (Hours)	20Feb.- 20 March (Hours)	Benchmark set by the hospital*
TPA	3.97	3.62	3
ECHS	3.20	2.75	2.5
CASH	2.95	2.8	2

TABLE: 4.3 Discharge monitoring

*The benchmark time set for different categories is according to the hospital policy.

Fig: 4.3 Discharge monitoring



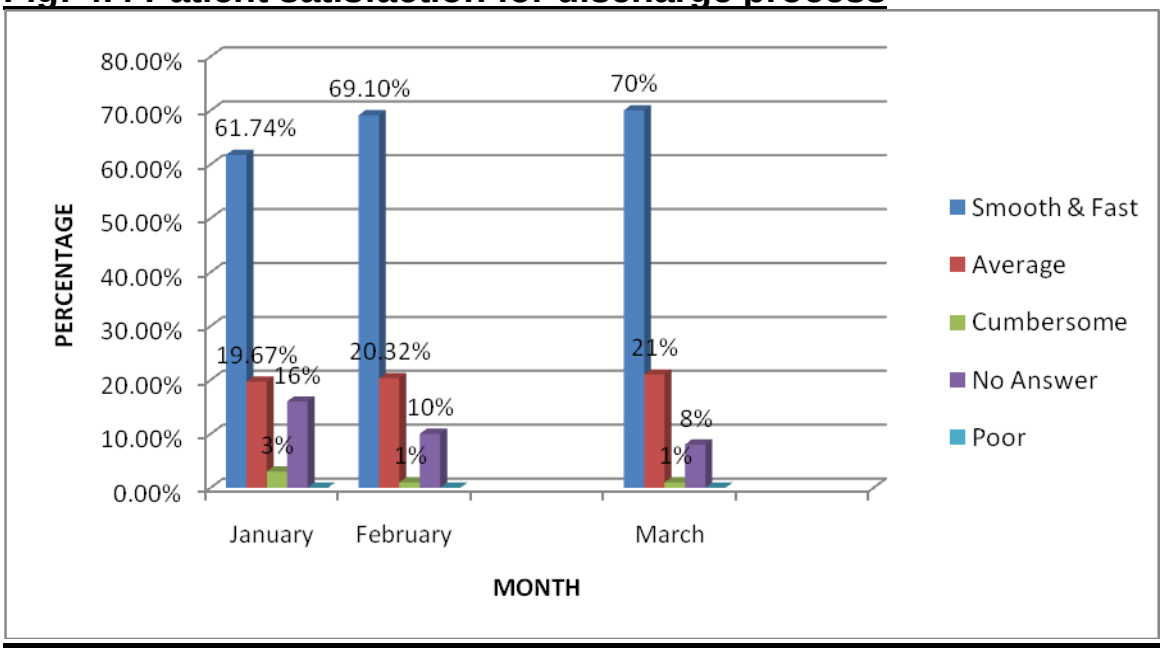
Analysis:

The time taken in discharge process is reported to be comparatively more in the first month i.e (20th Jan to 20th Feb) in all the three categories (TPA, ECHS, Cash).after steps were taken to reduce the discharge process time, consultants requested to finish their rounds before 12 and the circulation of the rough draft of discharge summary was stopped. As the graph depicts that the discharge process time was reduced in the following month (20th Feb to 20th March)

TABLE: 4.4 Patient satisfaction for discharge process

MONTH	DISCHARGE PROCESS GRADES (in %)				
	Smooth & Fast	Average	Cumbersome	No Answer	Poor
January	61.74%	19.67%	3%	16%	0.00%
February	69.10%	20.32%	1%	10%	0%
March	70%	21%	1%	8%	0%

Fig: 4.4 Patient satisfaction for discharge process



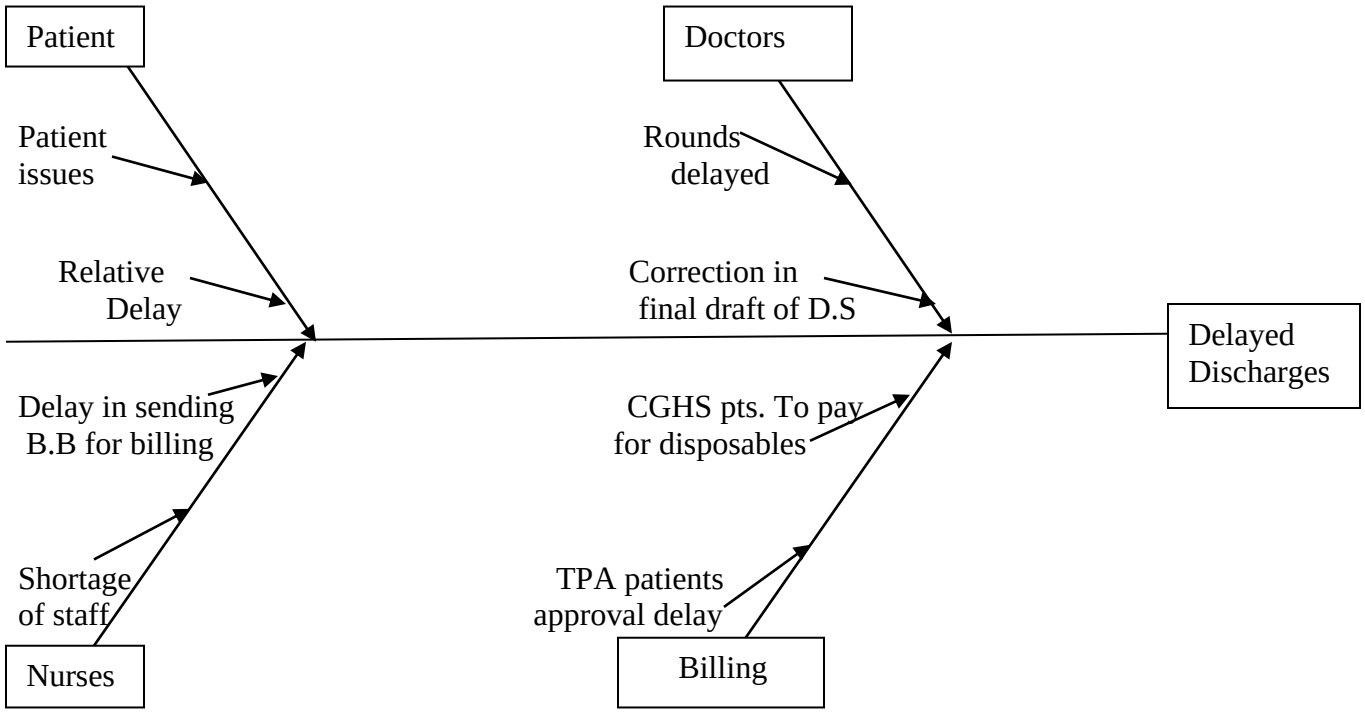
Analysis:

As the graph depicts the percentage for smooth and fast discharges has increased considerably from Jan to Feb and further more in March. Also the percentage for cumbersome discharges has reduced from Jan to Feb and March.

REASONS FOR DELAY IN DISCHARGE:

1. The morning rounds of Consultants are delayed upto 2pm
2. After the senior Resident checks a rough draft of discharge summary is given, which is then checked by the consultant and then the final draft is printed.(Paper wastage)
3. Corrections in final draft of discharge summary (By Consultants)
4. Even for planned discharges the bill book reaches the billing department by 10.30 am.
5. In case a patient is planned for discharge in afternoon, nurses are not informing the billing department about the same. They send the bill book at around 10 AM, so then patient is charged only till 11 AM where as patient gets discharged around 3PM (Revenue loss).
6. CGHS patients should be informed prior to arrange money for disposables.
7. If the outstanding bill is high, attendants should be informed a day in advance so that they are given time to arrange money.
8. Improper reporting of data by nursing staff.
9. Relative delay: at the time of discharge patient relative is not available which leads to delay in discharge.
10. Patient is not willing to go and wants to stay longer in the hospital (Counseling needed).

Fig.4.5 Cause and Effect Diagram



It was observed that maximum no. of delays in the discharge process were occurring in a particular area of the hospital i.e C- Wing 2nd Floor. The reasons for the delay are :-

- Attrition rate of nurses is high

- Untrained new nurses
- The nursing in charge of this particular wing is on leave for a long period.
- This area being general wards, the load of patients is much more on the nurses and also on GDAs

Table 4.5 Cause wise Percentage

S.No.	Causes	Percentage of occurrence
	PATIENTS	**21%**
1.	Patient not willing to go	11%
2.	Relatives delays	10%
	DOCTORS	**52%**
3.	Consultant rounds are delayed	33%
4.	Correction in final draft of discharge summary	19%
	NURSES	**10%**
5.	Shortage of staff	4%
6.	Delay in sending the bill book for billing	6%
	BILLING	**17%**
7.	CGHS patients should be informed prior to pay for disposables	5%
8.	TPA patients approval delay	12%

DISCUSSION

The study findings showed that the average discharge time for the TPA patients for the month of (20th Jan to 20th Feb) was 3.97 hours which reduced to 3.62 hours in the following month i.e (20th Feb to 20th March) much closer to the benchmark set by the hospital(Hospital policy) i.e 3 hours.

The results of the study showed that in the case of ECHS patients the discharge process time reduced from 3.20 hours (20th Jan to 20th Feb) to 2.75 hours(20th Feb to 20 March) whereas the bench mark set by the hospital is 2.5 hours for ECHS patients.

The results of the study showed that in case of CASH patients the discharge process time in the first month was 2.95 hours which reduced to 2.80 hours in the following month, The bench mark set by the hospital for this category of patients is 2 hours.

The study findings also showed that in January 61.74% rated the discharge process as smooth & Fast whereas the percentage further increased to 69.10% and in March it was 70%. The percentage for average rating of discharge process for the month of January was 19.67%,in February it increased to 20.32% and further to 21 % in March. Similarly the percentage for cumbersome rating of discharge process also reduced from 3% in January to 1% in February and March.

The RCA done for delayed discharges found out that consultant rounds and TPA approval delay are the main reasons for delayed discharges. The other reasons included Patient related issues (patient not willing to take discharge, relative arriving late for getting discharge process completed). Nurses related delays were also found that included delay from the nursing side to send the bill book for billing.

Implementation of the Discharge Plan:

Strategies to ensure continuity of care (the 4 C's)

- **C**ommunication
- **C**oordination
- **C**ollaboration
- **C**ontinual reassessment

1. Communication

- Should occur multi-directionally
- Should occur between the multi-disciplinary team and the individual
- Should occur at admission, ongoing, and prior to discharge
- Should eliminate all barriers
- Should be written in the individual's file
- Should be verbalized with individual and multi-disciplinary team, referring agencies

2. Coordination of services/case management

- Case manager or designated team member should coordinate the multi-disciplinary team in the discharge planning process.

- Case Manager will link the person with the most appropriate services post discharge.
- Case Manager should ascertain understanding of all communication with individual.

3. Collaboration

- Multi-disciplinary team members should be used for specialized assessments, recommendations, and case conferences.
- Individual should be involved at all levels of planning.

4. Continual reassessment

- The discharge planning process is dynamic, not static.

- Change in housing, placement, or other should be communicated to all team

Benefits of Implementing Discharge Plan for Individual

- Status will be maintained or improved; including physical, functional, and emotional.
- Individual confidence and self-perception will be improved.
- Individual will be able to re-iterate discharge plan and implement in home.
- Follow up appointments will be maintained, with transportation easily accessible.

Benefits of Implementing Discharge Plan for Providers

- Program staff can identify discharge assessment needs, intervention strategies, and follow up of clients.
- Program staff will increase knowledge base regarding unique learning needed of their target population.
- Program staff will accurately identify individuals at high risk for poor outcomes, who benefit most from which referrals and are referred most often.
- Multidisciplinary team members will collaborate on a regularly scheduled basis.
- Any change of status will be communicated among team members.

Benefits of Implementing Discharge Plan for Institutions

- The number of hospital readmissions and ER visits will decrease.
- Rating of caregiver and patient satisfaction with care will increase.
- Cost containment will improve.

IMPORTANCE OF QUICK DISCHARGE PROCESS

- When the patient is discharged quickly from the hospital it leads to a positive impression to the hospital.
- To satisfy patients who will work as spokes person for the hospital.
- Bed occupancy rate is increased.
- The staff will spend more quality time rather than doing crises management due to delay in discharges.
- If the patient is discharged after 12:00 pm the bed charge for next day is charged by the patient or is added as a cost to hospital.

Chapter 5

Conclusion and Recommendations

Conclusion

DISCHARGE is perhaps an important factor that adversely affects the performance and the image of hospitals. Delay in discharge prolongs the hospital stay of the patients, increases bed occupancy rate and thereby puts undue pressure on the already strained resources of the hospitals, community and the country. To the patient it means prolonged suffering and additional financial burden. To the hospital it may spell legal trouble.

Hence the report tries to capture Discharge monitoring parameters which would help to monitor and control the delay in discharges in the hospital. The report also shows that Smooth discharge process is directly related to increase in patient satisfaction and staff satisfaction.

Recommendations:

1. Medical dictionary in computer of the typing staff to avoid errors.
2. Final orders to be taken from Consultant in Evening rounds or over the phone
   - Investigations
   - Cross referrals
   - Medications
3. Shifts for typing staff (7AM to 3 PM,10 AM to 6PM)
4. Lunch timings for the typing staff to be divided.
5. Night Resident makes discharge summary after initiating final orders
6. Junior Resident calls Consultant to check/correct the summaries.
7. Shift In charge to complete patient discharge file
   - Assigned Nurse completes Pharmacy Returns
   - Assigned Nurse - Early morning pending investigations to be completed
8. Morning shift Assigned Nurse to send Final billing by 8 am
9. Morning Resident to ensure all orders are complete & reports received before rounds
10. Consultant Rounds & signing of discharge summary on time in the morning.
11. Time monitoring for each discharge summary typing/preparation in EDP.
12. Typing staff to be advised to recheck for any queries with RMO before printing.
13. No rough drafts to be given for discharge summaries, after the consultant checks only the final draft is printed (paper wastage reduced)
14. Discharges after 12pm should be charged for full day, this is to ensure that consultants finish their rounds before 12pm and help in timely discharges.
15. Rounds must be performed on a schedule that supports discharge appointments
16. Every discharge must have a written discharge plan that is comprehensive in scope and that addresses medications, therapies, dietary and other lifestyle

modifications, follow-up care, patient education, and instructions about what to do if the condition worsens.

17. This comprehensive discharge plan should be completed before the patient leaves the hospital.

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ANNEXURE

Discharge policy

To ensure smooth coordination of various departments and agencies involved in the discharge process, including patients connected with medico legal cases and those leaving against medical advice (LAMA)

1. Purpose :

- To provide criteria and procedures involved in patient discharge process with an aim to minimize the time involved in the process in order to increase patient's comfort and satisfaction.
- It encompasses accurate billing, proper handing over of reports and documents to the patient.

2. Scope :

The scope of discharge process is to provide timely discharge to all patients who are fir for the same.

3. Responsibility :

Treating consultant is the responsible person for timely discharge along with the

- Front office staff
- Sister In-charge

4. Quality Objectives :

S.No.	Quality Objectives	Performance Indicators	Measurement criteria
1.	Service level	Staff Availability (Doctors, Nurses & GDA)	Duty Roaster/ Attendance Record
		Discharge time (Two hours)	• Patient's medical record • Pharmacy clearance • Ward admission/discharge register
		Contents of discharge summary	Patient's discharge summary
2.	Customer satisfaction	Satisfaction level	Patient feedback form

5. Process :

5.1 Discharge Decision

Decision regarding discharging the patient rests with the primary Treating consultant of the patient who makes such decision during his rounds 12 hours prior to the discharge of patient and the same is communicated to the

- Patient
- Patients relatives
- The concerned ward nursing staff
- Duty medical officer

The discharge process is planned in consultation with the patient and family
However the final decision regarding discharge is made on the basis of the condition of the patient during next day morning rounds.
The discharge policies and procedures are documented to ensure coordination amongst various departments including accounts so that the discharge papers are completed within time.
For MLC cases the hospital shall ensure that the police is informed.

5.2 Preparation of Discharge Summary

After final decision to discharge the patient is taken, the **Treating consultant / Resident doctor** prepares the tentative discharge summary of the patient at least 12 hrs in advance. This discharge summary is made final, after the decision is made by the

consultant. Discharge summary is provided to all the patients treated in the hospital at the time of discharge. The contents of discharge summary will be as follows:

- Contents :
  - Reasons for admission
  - Clinical profile (salient features and present history and examination) or significant findings
  - Investigations performed and summarized information about the results of the investigations
  - Diagnosis
  - Record of procedures (operations etc) performed
  - Result of procedures/surgeries performed/ any other treatment given
  - Condition of the patient at the time of discharge
  - Further management and medication
  - Follow up advice
  - Emergency contact number of the hospital/ emergency department/ treating consultant, in order to obtain urgent care

- Discharge summary typed and signed by the **Treating consultant/ resident doctor**.
- 3 copies of final discharge summary kept in patient file by ward nurse and electronic record of discharge summary is also maintained.

- One copy of the discharge summary is handed over to the patient/relatives and the other copy is attached to the patient's case file. One copy sent to the TPA (Third Party Administrator) Desk in medi claim cases or the empanelled organization as per the norms.
- As per the instructions of the treating consultant in the discharge summary, patient relatives are advised by the ward nurse.

  Discharge summary is provided to all the patients at the time of discharge.

5.3 Final Billing

- On the day of discharge, confirmation of patient discharge is given by treating doctor or ward nurse.
- Patient file sent to billing section for final billing settlement by ward sister.
- All the investigations, bed charges, consultation charges, surgery charges, consumables and other expenses incurred on the patient his/ her stay in the hospital is entered in bill book the nursing staff assigned by the patient.
- Accordingly bill is prepared by the Front office/ Billing section.
- Bill is audited and 2 copies made – patient copy (original) and accounts copy (duplicate) for Accounts Department in case of cash patients. 3 copies are generated in mediclaim cases – one for TPA (original), one for patient (duplicate) and one for the accounts department (duplicate)
- Patient relative is informed regarding the bill.

- Patient relative sent to billing section half an hour after patient's file goes to the Billing Department by Ward nurse / Sister – In – charge.

Cash Patients

Payment is done. Patient is handed over an original Bill and final clearance slip/ payment slip to be shown to the nurse on floor and **Security Clearance Slip** to be shown to the security Personnel posted on the floor.

Mediclaim Cases

- In case of mediclaim,the sanctioned amount is crosschecked with the TPA desk
- In case the bill exceeds the initial sanction, intimation to the TPA company is sent regarding further authorization.
- As soon as further authorization is received the patient /relative is informed.
- In case the final authorization received is less than the actual bill the patient is requested to pay the difference.
- Accordingly the bills raised are cleared, signature of the patient / blood relative is taken on the original bills and mediclaim papers and a photocopy of both is handed over to the patient for his / her reference.
- A photocopy of the discharge summary is also handed over to the patient and **the original is sent to the TPA.**

5.4 Patient Counseling

- Prior to final discharge of patient from the hospital the ward nurse counsels the patient regarding the diet, medications, follow up procedure etc as mentioned in the discharge summary.
- Patient follow up visit dates are clearly informed. Patients discharge records are entered in the ward admission / Discharge register.
- Patient along with the relatives leave the hospital. In case of old patients they are taken to the hospital exit area in wheelchairs by ward attendants and seen off.
- An ambulance is provided if request is received from the patient and billing for the same is done and payment received.

5.5 Leave against medical advice (LAMA)

- In case patient / relatives seek discharge against medical advice ; the same is indicated in the patients case record by the **Primary Treating Consultant/ Resident Medical Officers**.
- Patient / relatives are informed about the patients condition and the consequences that may follow after discharge.
- Even after that the patient/relative are keen on taking discharge a written consent is taken from the patient / relative stating that they have been explained about patients condition and the consequences that may follow and that the hospital shall not be held responsible for any ill consequences related to the patients conditions due to early discharge against medical advice.
- Records are entered in the LAMA register of the respective patient ward.

- Discharge Summary is prepared and the above mentioned steps are followed.

5.6 Medico legal cases

- Medico legal forms are to be filled and intimation to the police is sent by EMO (Emergency Medical Officer) / Nurse
- All investigation reports in original and evidential materials shall be preserved. Staff nurse on duty will be responsible to ensure preservation.
- Details of the MLC will be documented in wards by nurses / EMO
- MLC on admission, discharge to home, transfer to another hospital or death will be documented and the police will be intimated.

6. Death of Patient

- In case the patient expires the primary treating consultant / Medical Resident Officer / Nursing staff informs the patient relatives. Patients relatives are allowed time with the body.
- Ward nurse makes necessary preparation for cleaning the body. Body is cleaned by designated staff and wrapped in clean sheet. The “on duty medical officer” prepares two copies of the Death Certificate and the Death summary. The Death summary should include the cause, date and time of death. The Death certificate and the Death summary is stamped. Body is handed over to the patients relatives or kept in the mortuary within an hour of death. Body is handed over to the relatives along with one copy of death summary and death certificate and the

other copy is attached to the patients case records. If the body is to be kept after proper labeling on wrist/ ankle & showing to the relatives.

- The body to be shifted to mortuary by the General Duty Assistant / Housekeeping staff.

- Before keeping the body in the mortuary, the security in charge confirms the machine is switched on or is in working condition.

- In case of Medico **Legal Cases** the local police station is informed and they will decide the need for post – mortem. Here the body is not handed over to the relatives by the hospital but is handed over to police.

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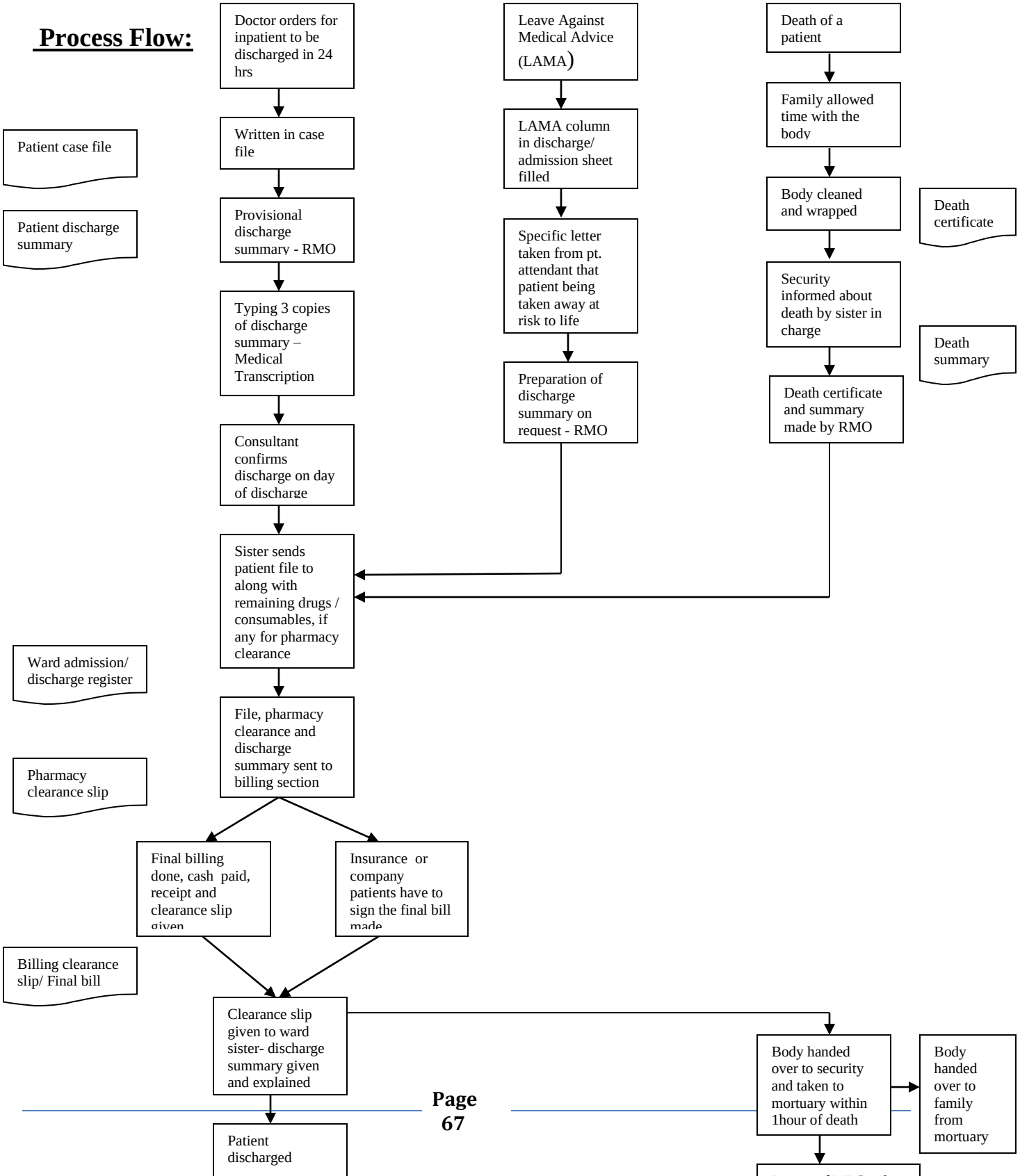
Process Flow:



Transfer to Post Discharge Location

Transport

When transport is to be used, it is be booked at least 24 hours, where feasible, in advance of discharge. The Transport Service should be informed of the individual's mobility and should be given details of any equipment that need to accompany them. The maximum waiting time for such transport, after the booked time, should be no more than the locally agreed time.

Items To Be Given To The Patient On Transfer Or Discharge

- Copy of Discharge Letter
- The individual should be given, either detailed in the immediate notification or clinical summary:-

a) The name of the responsible doctor to whom they may obtain further information;

b) Information detailing packages of care, professional involvement. .

- Prescription medication /card as required.
- Out-patient Appointment Card.
- Property / valuables previously held in safe keeping.