INTERNSHIP TRAINING

AT

APOLLO HOSPITALS INTERNATIONAL LtD.

Gandhinagar, Gujarat

"STUDY ON DAMA PATIENTS ADMITTED TO THE MEDICINE SERVICE AT APOLLO HOSPITAL"

Submitted By

SUDEEP MALOT

Post Graduate Diploma In Hospital and Healthcare Management

2014-2016

Under the guidance of

Kirti Udayai (Asst. Dean, Academic and Student Affairs)

International Institute of Health Management Research,

New Delhi

The certificate is awarded to

SudeepMalot

In recognition of having successfully completed his Internship in the **Operation Department**

and has successfully completed his Project on

"To identify the reasons for DAMA among patients admitted to the Medicine service at Apollo hospital from a variety of perspectives".

From 15th February to 15th May,2016

AT

APOLLO HOSPITALS INTERNATIONAL LTD

Gandhinagar, Gujarat

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

We wish him/her all the best for future endeavors

Deputy General Manager
Operation Department
Apollo Hospitals

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Sudeep Malot** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone Internship Training at **Apollo Hospitals International Ltd. Gandhinagar, Gujarat** from **15th February, 2016 to 15th May, 2016.**

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dr. A.K. Agarwal
Dean (IIHMR, New Delhi)

Kirti Udayai
Asst. Dean.
(IIHMR, New Delhi)

CERTIFICATE OF APPROVAL

The following dissertation titled **"To identify the reasons for DAMA among patients admitted to the Medicine service at Apollo hospital from a variety of perspectives at Apollo Hospitals International Ltd, Gandhinagar, Gujarat "**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 dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name

Signature

Certificate from Dissertation Advisory Committee

This is to certify that **SudeepMalot,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He/ She is submitting this dissertation titled**"To identify the reasons for DAMA among patients admitted to the Medicine service at Apollo hospital from a variety of perspectives"** in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

for Kirti Udayai

Mrs. Kirti udayai
Asst. Dean (IIHMR)

Deputy General Manager
Operations Department
Apollo Hospitals

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH,NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"To identify the reasons for DAMA among patients admitted to the Medicine service at Apollo hospital from a variety of perspectives"**and submitted by SudeepMalotEnrollment No. PG/14/060 under the supervision of KirtiUdayai (AsstDean, Academic and Student Affairs) for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 15th February 2016 to 15th May 2016 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Sudeep Malot

Signature

FEEDBACK FORM

Name of the Student: Sudeep Malot

Dissertation Organization: Apollo Hospitals International Ltd.

Area of Dissertation: To identify the reasons for DAMA among patients admitted to the medicine service at apollo hospital from a variety of perspectives.

Attendance: Regular

Objectives achieved:
(a) Reasons for DAMA discharge
(b) Identify contrast between doctors & patients regarding DAMA.

Deliverables:
(c) Communalities identified in DAMA.

Strengths:
(a) Hardworking.
(b) Motivated
(c) Team person.

Suggestions for Improvement:
(a) Increase knowledge base.
(b) Have an eye for details.
(c) Put your heart and soul in any work at hand.

Signature of the Officer-in-Charge/ Organization Mentor (Dissertation)

Date: 13 Sept 16
Place: Ahmedabad

7

ACKNOWLEDGEMENT

Hard work, guidance and perseverance are the pre requisite for achieving success. Support from an enlightened source help us to proceed on the path to it.

On the very onset of this report, I would like to extend my sincere and heartfelt obligation towards all the personages who have helped me in this endeavour. Without their active guidance, help, cooperation & encouragement, I would not have made headway in the project.

My deepest sense of gratitude towards **COL. Gautam Pathak (Deputy General Manager of Operations), Mr. Santosh Cherian (Sr. Executive – Operations)** and all my **Team members** for their immense support and guidance. Thanks and appreciation to all the people at Apollo for their support.

I am extremely thankful and pay my gratitude to my guide and mentor **Kirti Udayai (Asst Dean, Academic and Student Affairs),** IIHMR, Delhi for her valuable guidance and support.

I am highly fortunate to express my deep sense of gratitude and indebtedness to **Dr. Ashok K Aggarwal,** Dean, IIHMR, New Delhi for his invaluable inspiration.

At last but not the least all my friends, colleagues and family who have directly or indirectly helped me complete this project report.

TABLE OF CONTENTS

INTRODUCTION OF HOSPITALS

VISION OF HOSPITAL:

Apollo's vision for the next phase of development is to 'Touch a Billion Lives'

MISSION OF HOSPITAL:

"Our mission is to bring healthcare of international standards within the reach of every individual. We are committed to the achievement and maintenance of excellence in education, research and healthcare for the benefit of humanity."

Apollo group of hospitals started when the founder and visionary person of this group Dr. Pratap

C. Reddy has started Apollo hospital at Chennai on September 18, 1983 with 150 bedded from that day onwards to till this group is developing at its best and remain leading brand in corporate health sector. This group has changed the national healthcare family and provides world class healthcare services to not only Indian but outside the country.

Today Apollo hospital group is recognized as the "**ARCHITECT OF HEALTHCARE**" in India. Apollo hospital has long history of a compliant with its unique ability of resource management. Apollo hospitals, Ahmedabad opened in May 2003. A multispecialty quaternary care hospital further strength the healthcare delivery keeping with the tradition of delivery healthcare at per with the best in the world Apollo relies a great deal on innovation, introspection and improvement to render tender loving care to patient. Apollo hospitals, Ahmedabad provides holistic healthcare that includes prevention treatment rehabilitation and health education for patients. Their families and client by touching their lives Apollo hospitals International limited is a 400 bedded hospital from then 232 functional beds in area of 10 acres in Gujarat offering world class diagnostic investigation, medical and surgical facilities.

HOSPITAL OVERVIEW

- A state-of-the art modern facility in the heart of the Gujarat state, it is spread over 10 acres and has a built-up over 440000 square feet. Currently the hospital has 276 beds with a capacity to expand to 400 beds.
- Right from the infrastructure to the latest medical technology acquisition, Apollo hospitals has always kept its patients first and strived to deliver not world class but world's best care to it patients since its inception in 2003.
- Apollo hospital, Ahmedabad is a tertiary care flagship unit of the Apollo hospital Group.
- The hospital focuses on centres of excellence like cardiac sciences, orthopedics, cancer, emergency medicine and solid organ transplants besides the complete range of more than 35 allied medical disciplines under the same roof.
- Apollo Hospital, Ahmedabad provide holistic health care that includes prevention, treatment, rehabilitation and health education for patients, their families and clients by touching their lives.

Some of the crucial hubs in the Apollo Circle of Life include:

Hospitals: Nearly 8065 beds across 46 owned and managed hospitals in India, rest of Asia and Africa.

Reach Hospitals: Phase 1 to 25 Apollo Reach Hospitals on the anvil across semi-urban and rural India.

Pharmacies: Largest branded network of over 1000 hospital based and stand-alone Apollo Pharmacies.

Clinics: Dedicated chain over 100 super-specialty outpatient Apollo Clinics.

Telemedicine Centers: Over 100 Telemedicine Consultation Centers across India and neighboring countries.

Health Insurance: Stand-alone health insurance company through a JV, the Apollo Munich Insurance Company.

Health Education: Medvarsity, Nursing and Hospital Management Colleges, DNB Programs.

Clinical Research and Site Management

Global Projects Consultancy

SPECIALITIES:-

Facilities available in Apollo Hospital, Ahmedabad

- Allergy & asthma
- Blood bank transfusion medicine
- Cardiothoracic surgery
- Head & neck surgery
- Diabetology & endocrinology
- Intensive & critical care
- Neurology
- Radiology & laboratory services
- Anaesthesiology
- Breast surgery
- Ear, nose & throat(ENT)
- gastroenterology (surgical) &(medical)
- Hamate-oncology & stem cell transplantation

- Internal medicine
- bariatric & weight loss surgery
- cardiology
- dermatology
- emergency medicine
- general surgery
- hyperbaric oxygen therapy
- infection diseases
- radiology & imaging services
- nephrology
- obstetrics & gynaecology
- joint replacement unit
- joint transplantation unit
- neonatology
- ophthalmology
- paediatrics cardio thoracic vascular surgery
- physiotherapy
- psychiatry
- renal transplantation unit
- Rheumatology department
- rheumatoid & immunology
- wellness & immunology
- spine surgery
- pulmonology & chest medicine
- urology
- oncology
- comprehensive blood cancer care(CBCC) unit

AWARDS & ACCOLADES:

1. Apollo hospitals, Ahmedabad was accredited by the NABH on February 2011

2. Apollo hospitals, Ahmedabad department of transfusion medicine(blood bank) was accredited by NABH on March 2010

3. Apollo hospitals, Ahmedabad was assessed & accredited in accordance with the standard ISO 15189: 2003 “medical laboratories- particular requirement for quality & competence “ for its facilities in the field of medical testing on November 2012.

MILESTONES:-

- More than 35 clinical specialties under one roof.
- First corporate hospitals to have Liver Transplant program in the state.
- More than 85 ICU beds, highest in a private hospital in the state.
- NABH accreditation for hospitals & blood Bank, NABL accreditation for all clinical laboratories.
- Dedicated intensive units for stem Cells Transplant & solid organ transplants.
- Only private hospitals in the state having in house blood bank(NABH accredited)
- CT scan, MRI and other high end diagnostic facilities.
- Dedicated modular joint replacement theatres with laminar air flow
- Dedicated wing for international patients
- Only CDC authorized center for immigration health checkup (USA, Australia, and Canada) in Gujarat

Front Office:

Front Office of the hospital includes help desk, admission desk and OPD billing counter. Help desk is located adjacent to the emergency department. Admission desk is located in Main Lobby of the hospital. Help Desk mainly deals in guiding patients about the services and procedures of the hospital and making appointments of the patients. Admission Desk deals with admission of all the patients including casualty and visiting doctor's patients. Patients fill an admission the details of the patient. All the information regarding empty beds is available to the admission staff through HIMS. Patient details are updated immediately on HIMS. Patients or patient's attendants are provided with a file containing rules, patient's right and duties, passes for visitor's. OPD billing counter deals with OPD patient services, a form is filled by the patient first. A unique number is given to new patients i.e. UHID number. This UHID number helps when patient again visits the hospital also without this number patient can be identified using mobile number. All data is updated immediately on HIMS.

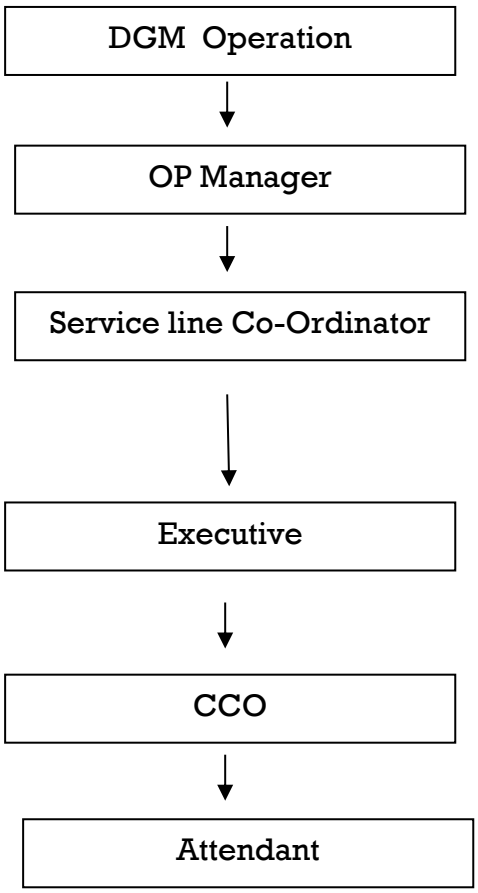
Executive Health Check-up:

Located on the ground floor of the hospital department mainly deals with fully body check-up of patients. Different packages that can availed by the patients include: Pre-employment check-up, Executive health check-up, Comprehensive cardiac check up and Executive health check up. Both walk-in and appointment system is there. The aim of Executive Health Check Up is to extend the healthy life expectancy of population, to avoid untimely death and to improve the quality of life for people with a disease or disability.

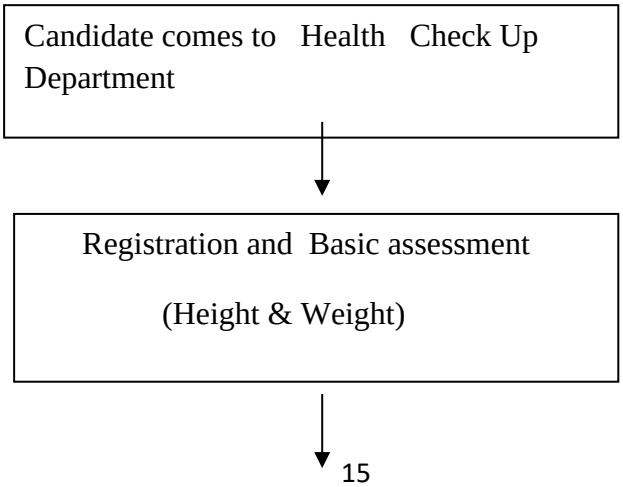
Immigrants Health check Up department:

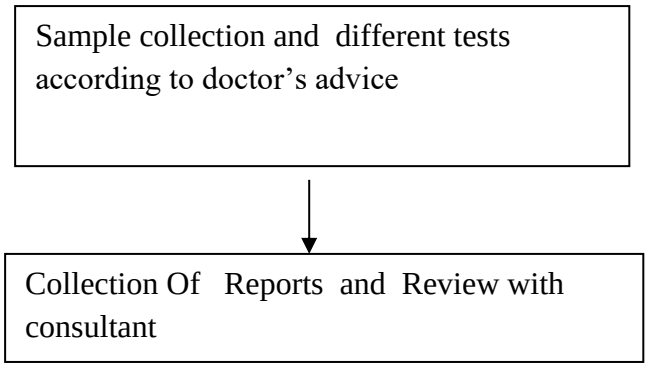
Health check up for Immigrants had started in June 2007 for USA. At that time 2 consultants were there. After that in December 2009 health check up for Australian Immigrants has started. In November 2010 health check up for Canadian Immigrants has also started. Presently 3 consultants are there. And also after 20th July they are also going to started for Health check Up for Malaysian Immigrants.

❖ **Hierarchy :**



Process Flow :



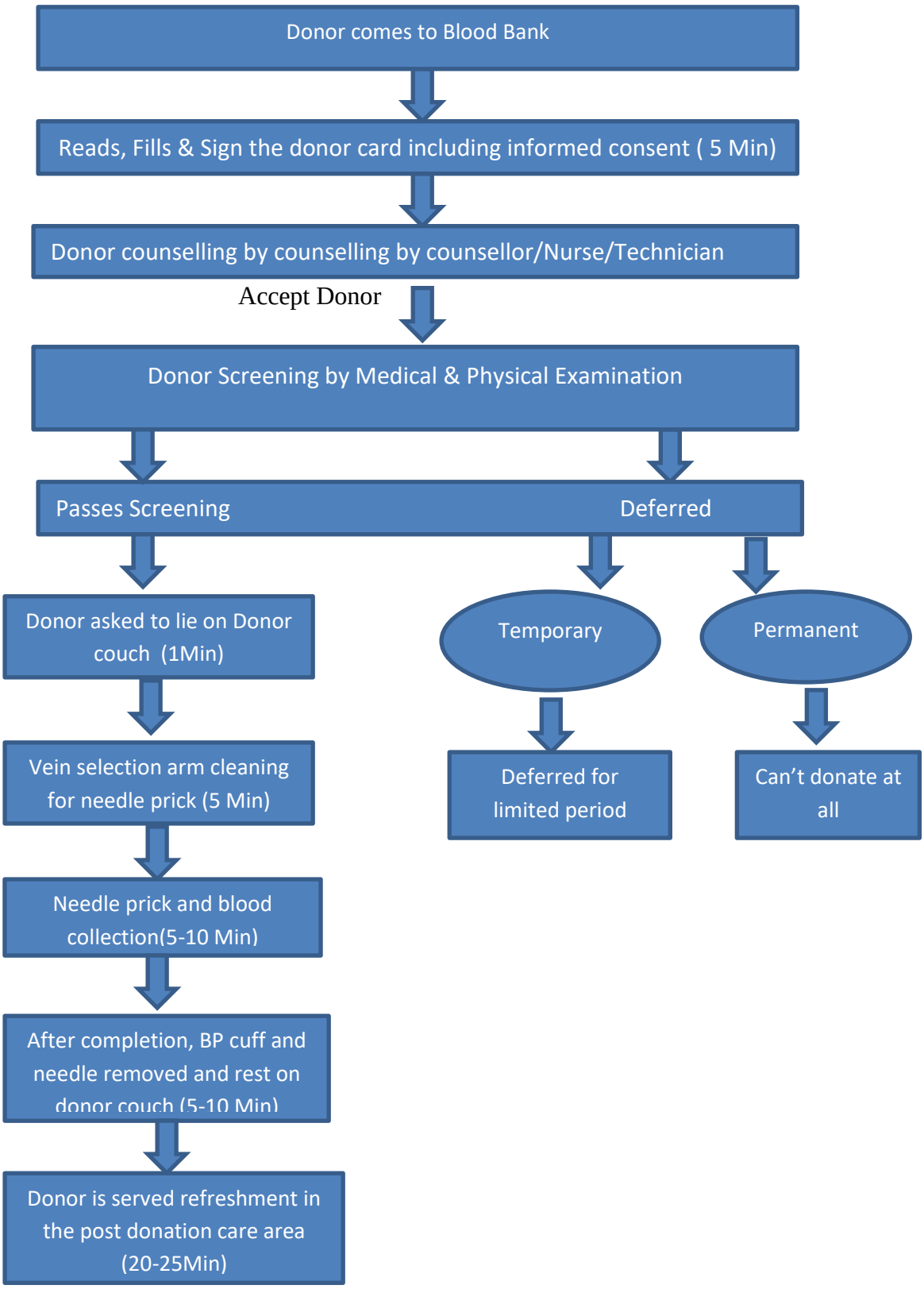


Billing Department :

The billing department plays an important role, as liaison office between the management and the patients, in addition to its primary duty of billing. The immense patience, human relations and hospitably is the need of the hour to alleviate the problems who are in distress, as the words spoken and deeds undertaken by the staff working at this department project the theme of humanity. One of the commonest problems faced by the discharged patients of all the hospitals is the delay in discharge due to slow bill generations. The same can be overcome or reduced to a great extent by computerizations of billing system and having a user friendly hospital information system (HIS) in place.

Blood Bank

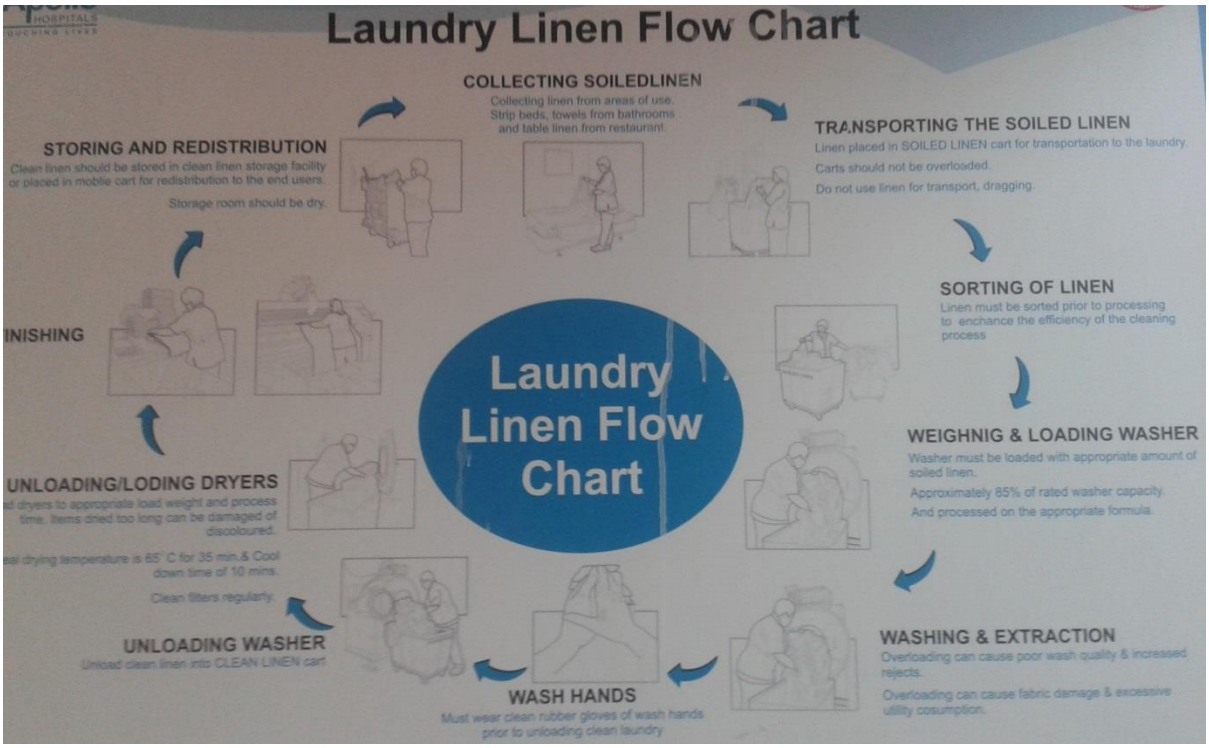
Blood Bank of the hospital deals with the collection, testing, processing, storage and preservation and issue of blood and its product. Blood bank is fully equipped to carry out activities of collection, testing, processing, storage and preservation and issue of blood.


Donor comes to Blood Bank
Reads, Fills & Sign the donor card including informed consent (5 Min)
Donor counselling by counselling by counsellor/Nurse/Technician
Accept Donor
Donor Screening by Medical & Physical Examination
Passes Screening
Deferred
Donor asked to lie on Donor couch (1Min)
Vein selection arm cleaning for needle prick (5 Min)
Needle prick and blood collection(5-10 Min)
After completion, BP cuff and needle removed and rest on donor couch (5-10 Min)
Donor is served refreshment in the post donation care area (20-25Min)
Temporary
Permanent
Deferred for limited period
Can't donate at all

Laundary Department:

Department deals with adequate supply of linen to all departments of the hospital, confirming to highest standards of cleanliness and hygiene.

Process Flow



INVENTORY:

Inventory is an idle resource which is usable and has value. It may be men, money, materials, plant acquisition, spares and other stocked to meet future demand.

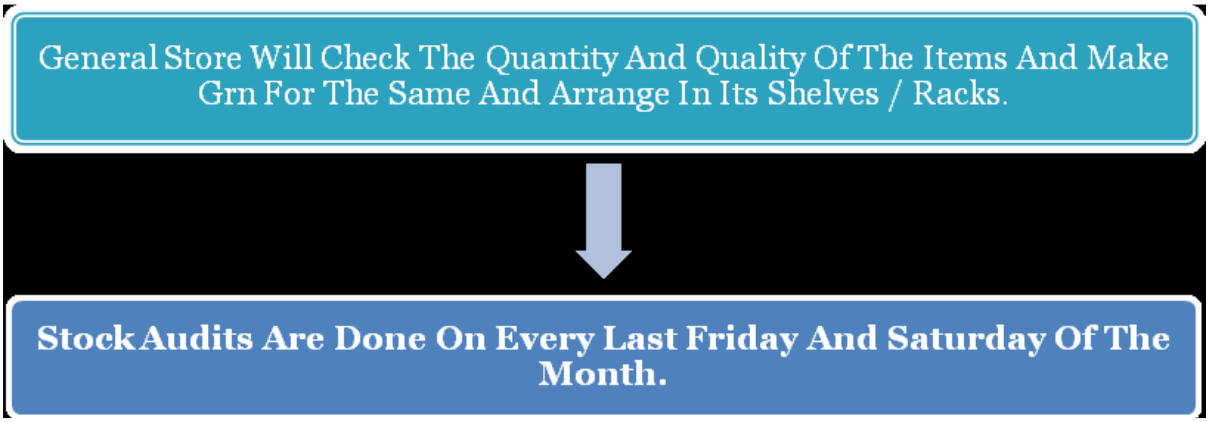
TYPES OF INVENTORY:

a. Official Inventory

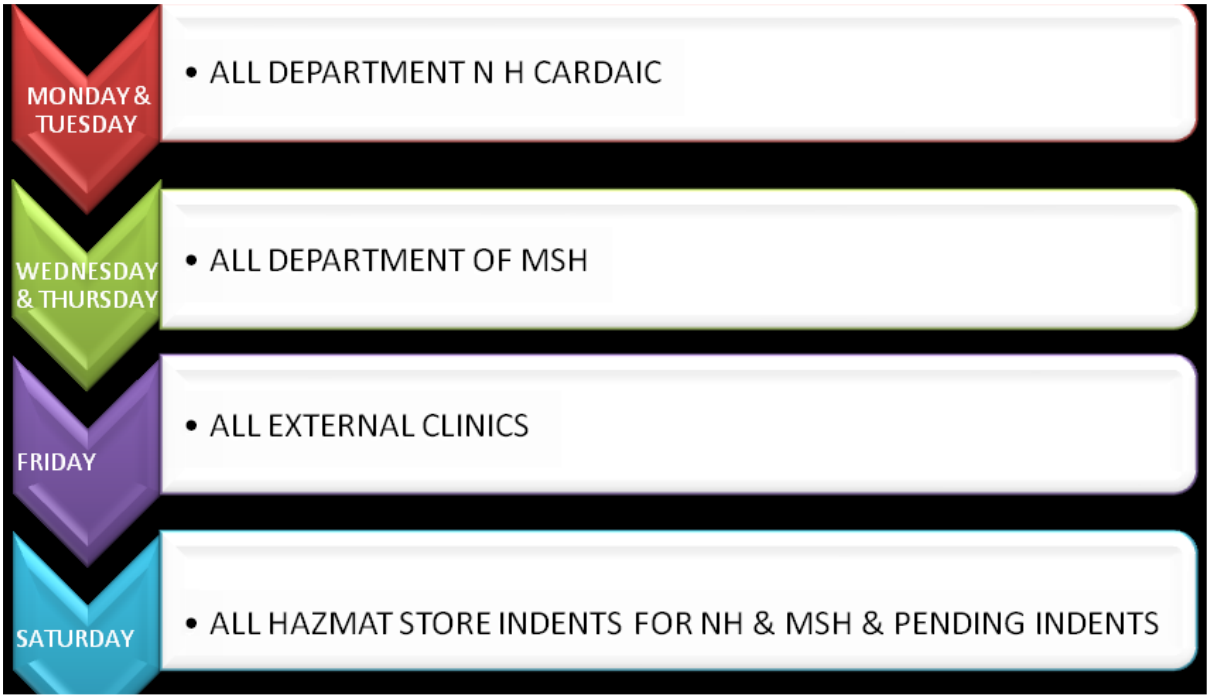
b. Unofficial Inventory

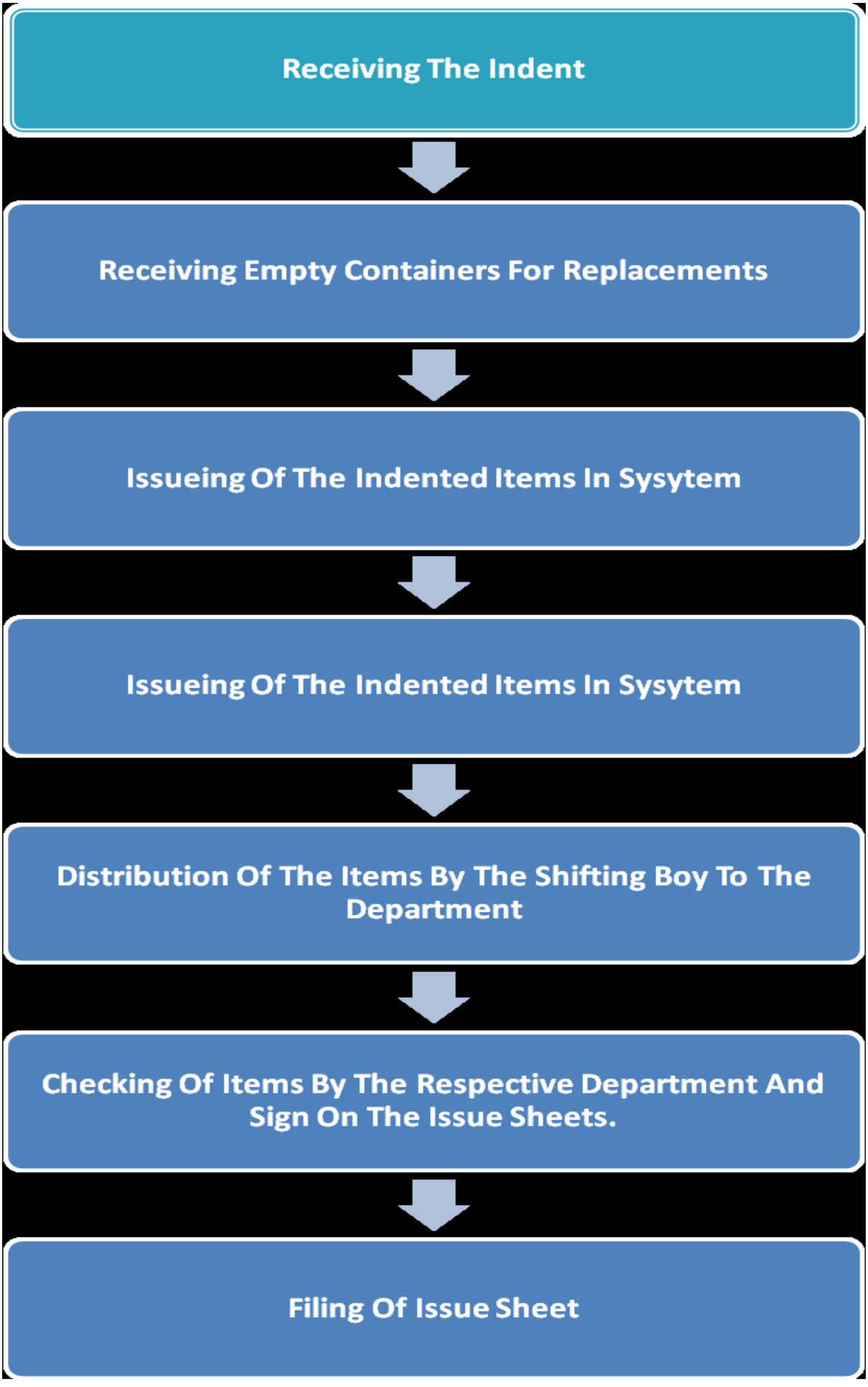
General Stores (Non-medical Inventory) The General stores module handles transactions related to all non-medical inventories in a hospital. The module helps in tracking the inward / outward goods, stock level, cost of inventory and fast moving and non-fast moving items etc., for planning avoiding unnecessary stock pileups**.**


Based On Consumption –15 Days Once Purchase Requests Are Raised From General Store
(Marketing Items , Visiting Cards , Letter Heads Are Items Which Are Not Stored The Pr Will Be Raised As And When It Is Required.)
After Approval From In-charge Inventory & Head Inventory
Purchase Request Approval Will Be Sent To Purchase
Purchase Will Make Po And Mail / Fax The Same To The Vendor
Supplier Will Supply In 3 To 7 Days
Items Will Be Received In Receiving Store & Sent To G.Store



INDENT SHEDULE:

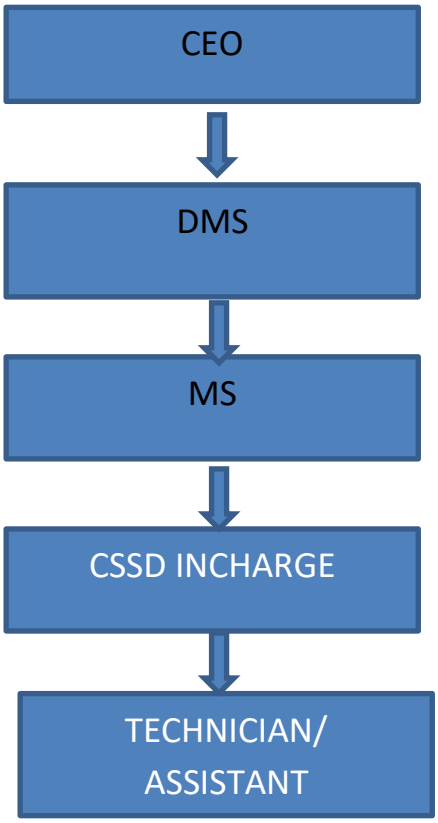



Receiving The Indent
Receiving Empty Containers For Replacements
Issueing Of The Indented Items In Sysytem
Issueing Of The Indented Items In Sysytem
Distribution Of The Items By The Shifting Boy To The Department
Checking Of Items By The Respective Department And Sign On The Issue Sheets.
Filing Of Issue Sheet

CSSD Department

The purpose of CSSD (Central Sterile Supply Department) is to make reliable sterilized articles available at the required time and place for an agreed purpose in the hospital in the most economical way, having regard to the need to conserve the time of users(doctors and nursing staff). The CSSD department within the hospital receives, sorts out, sterilizes, stores and dispenses sterilized goods to the various departments within the hospital. To establish and maintain standardized sterilization procedure throughout the institution.

Organogram:



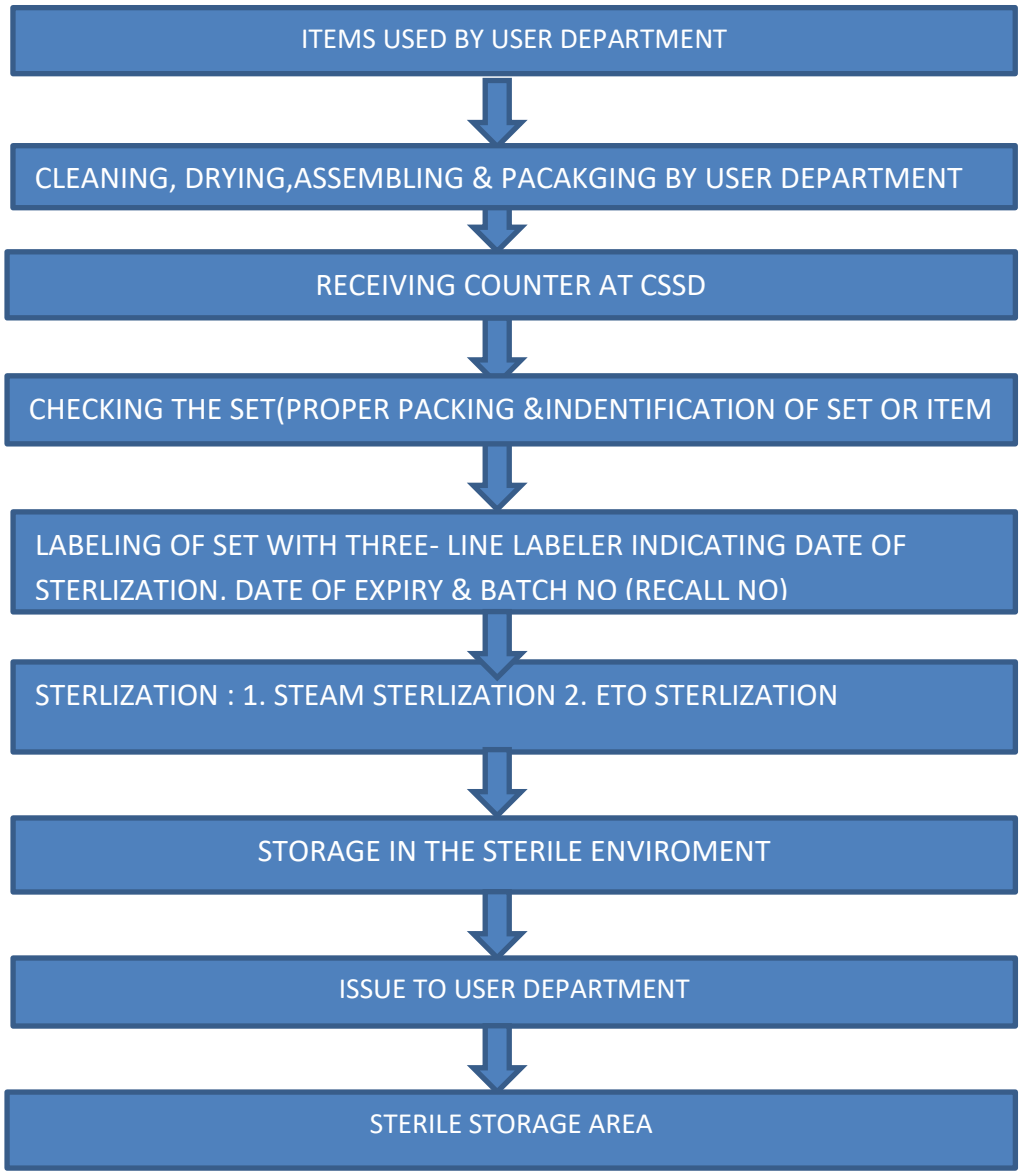
Objectives :

The main objective of CSSD Department are :

- To provide sterilised material from a central department where sterilised practice is conducted under controlled environment, thereby contributing to the incidence of hospital infection.
- To maintain record of effectiveness of cleaning, disinfection and sterilization process.
- To monitor and enforce control necessary to prevent cross infection according to infection control policy
- To maintain an inventory of supplies and equipment
- To stay updated developments in the field in the interest of efficiency, Economy, accuracy and patient care.

- To provide a safe environment for the patients and staff.

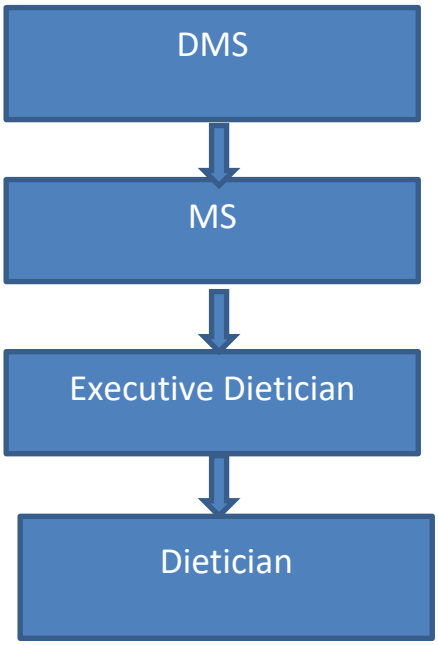
PROCESS FLOW :



Dietary Deparment:

- Nutrition plays an important role in the overall management of any disease. It takes committed and understanding physician Dietician- Nursing care team to see that the basic diet objectives are pursued.
- The Dietary department serves as an integral part of patient care. The patients recovery is added by an nutritionally balanced diet prepared under constant supervision and hygienic conditions to add speedy recovery. Counselling of the patient and family is a core activity carried out which leads to better understanding of the diet plan. Different type of diet ordered for patient.
- The department also extents counselling to outpatients with or without referral.
- Additionally the department is also involved in community nutrition education programmes and imparting training to the students (interns) of various colleges/ universities.

Organogram:



Role of the departments

- To plan and implement the patient diet therapy, education and counselling, advice patients and their families on specific problems prior to their discharge to hospital or as referred from out- patient clinics.
- To maintain good nutritional status of the patients.
- To assess and correct the deficiencies, if any

- To educate the patient's above the diet prescriptions.
- To impart knowledge to nurses, medical and paramedical students, Interns and doctors on the principle of diet therapy.
- To work in close coordination with the Food and Beverages. Service department starting from menu planning to the feedback on the delivered diet.

Operations department

The operations department plays as a link between patients and higher authority. Like medical care is important for patient same as it the proper hospitality for the patient is also a vital task of hospital. To make all process of hospital effective and efficient the operations management works 24hrs.

The operations department covers all the actives of hospital. The head of operations manages clinical as well as non-clinical departments too. For the smooth running process of each department have their own managers whose responsibility is to fulfill all the patient requirements, to solve the patient problems, and play an important role in providing quality of care so that they can make their patient satisfied.

Departments that covers under the operations:-

- Outpatient department
- Inpatient department
- Radiology and laboratories
- Emergency department
- Admission and registration
- OT/ Cath lab/ ICU

Radiology & Imaging Department

The Unit

The unit is located in the C Block on the ground floor

Case Mix

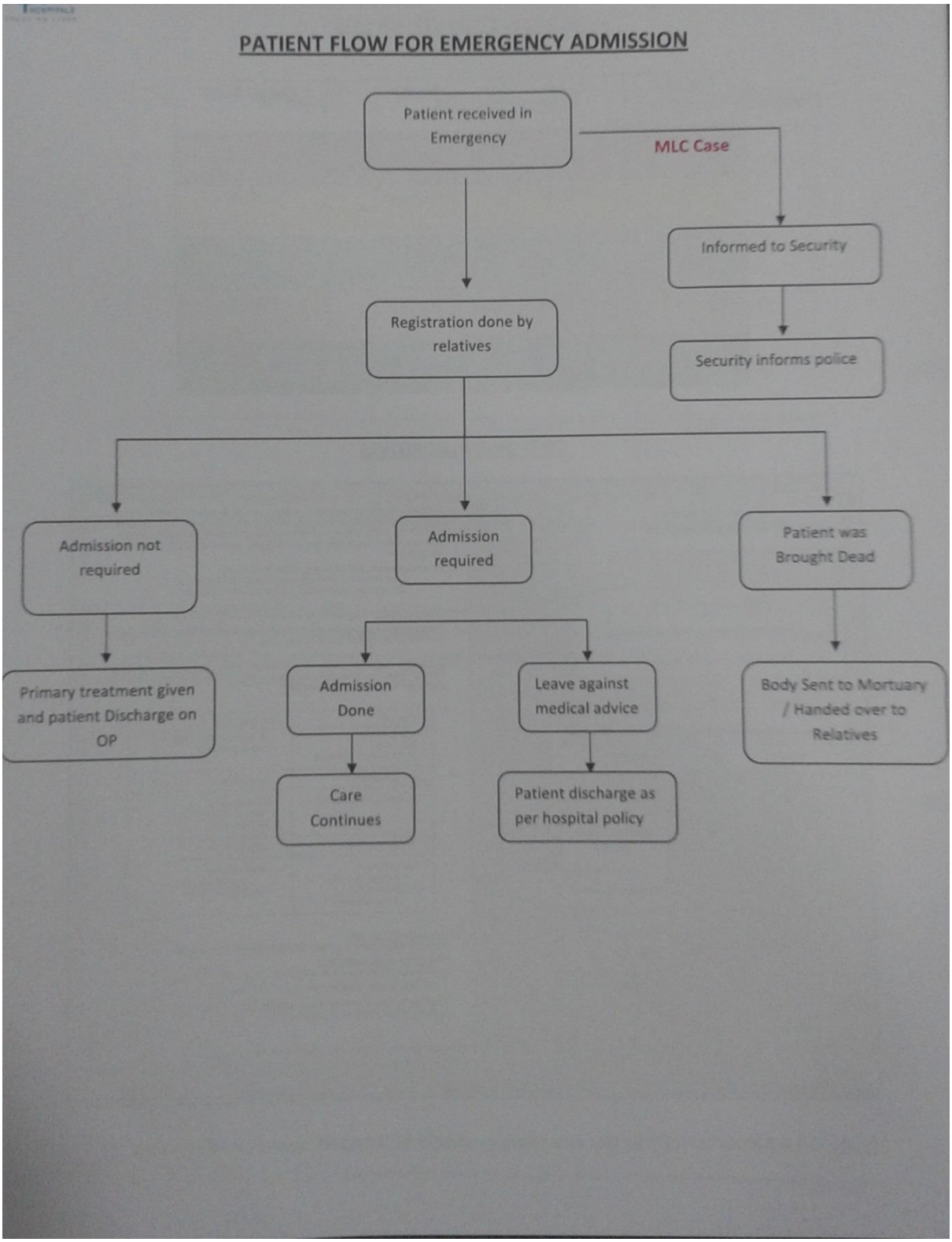
Provide radiological services to all patients visiting Apollo hospitals.

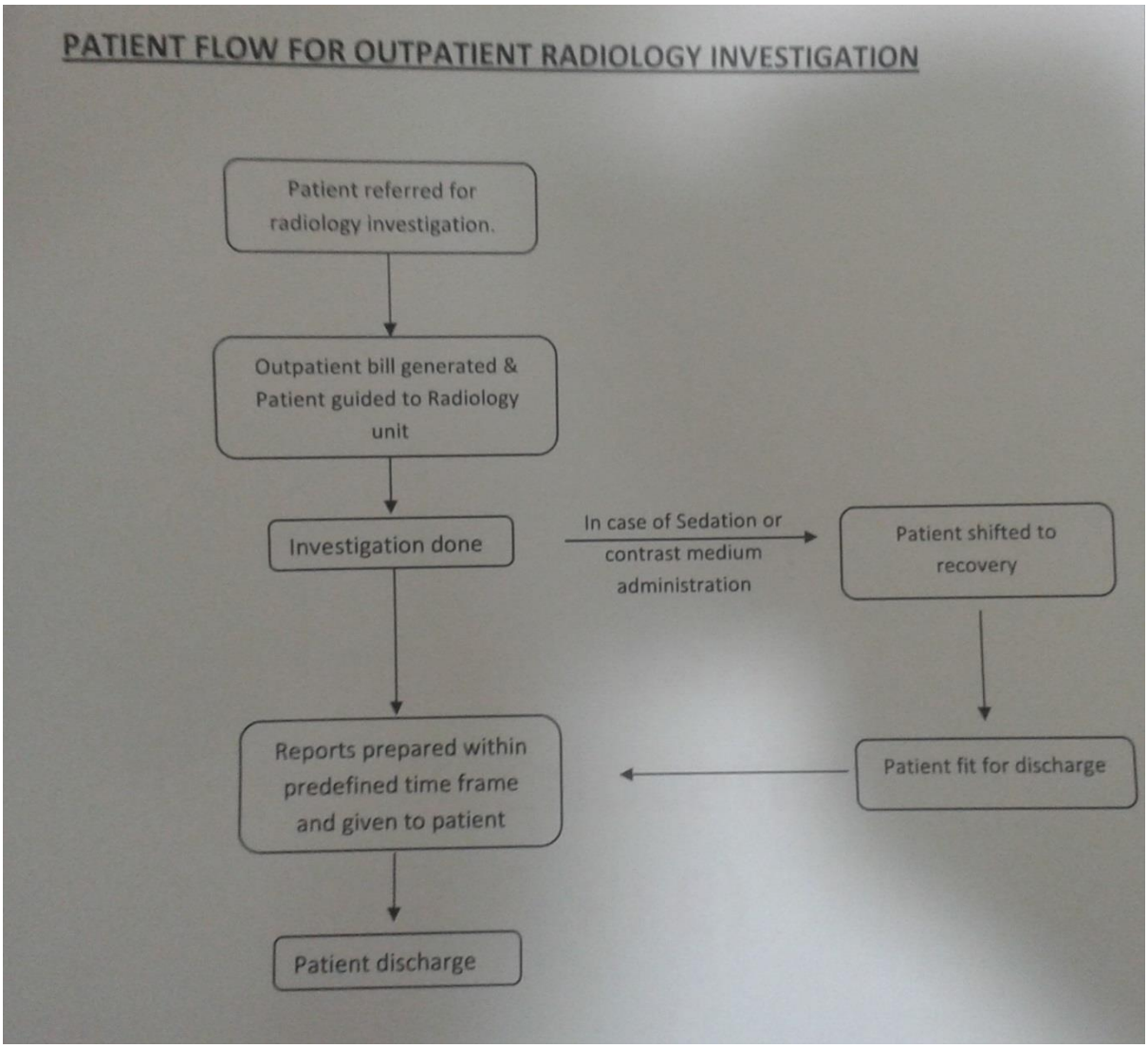
Scope and complexity of services:

Radiological services available include :

- MRI Scan 1.5 tesla
- 64 slice CT Angio
- Spiral CT – Single slice
- Ultrasound with Doppler
- X-ray 2 machines including fluoroscopy

- Others special radiological investigations
- Mammography
- DSA Lab
- Portable unit & Ultrasounds machines


PATIENT FLOW FOR EMERGENCY ADMISSION
Patient received in Emergency
MLC Case
Informed to Security
Security informs police
Registration done by relatives
Admission not required
Admission required
Patient was Brought Dead
Primary treatment given and patient Discharge on OP
Admission Done
Leave against medical advice
Body Sent to Mortuary / Handed over to Relatives
Care Continues
Patient discharge as per hospital policy



Emergency & Ambulance Department:

The Unit

The Emergency is located at ground floor in B Block of the main building.

Case Mix :

All type of Emergency cases medical, surgical, accidents, poisoning are admitted to the unit.

Bed Strength:

There are in all 9 beds in the Emergency departments.

There is one barrier nursing room and triage area, observation and procedure room.

Service includes:

- Patient assessment(Physician and Nursing team)
- Provision of care as per treatment plan.
- Emergency blood, Urine and other body fluid investigations as appropriate
- Bed side ultrasound whenever required
- Emergency radiological investigations like X- ray, CT Scan, MRI etc.
- Resuscitation and emergency care to patients
- Transfer of patient to ICU, OT, Cath Lab, Wards
- Discharge of patients after adequate treatment
- Patient and family education

Ambulance services are to facilitate the transportation of needy patients depending on the triage for diagnostic/therapeutic guidelines. Apollo ambulance services are one of the services rendered by hospital to the patient who needs diversion either to or from hospital in want of diagnostic or therapeutic purpose.

Hemato Oncology Ward :

The Unit

The hemato Onco is located on C Block on 2nd Floor of the main hospital building

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 20 bedded including 6 bedded STICU

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of Care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Silver Wing Ward:

The Unit

The silver wing is located on 2nd Floor C Block in main hospital

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 14 private rooms, 18 semi private rooms and 1 deluxe rooms – total 33 bedded units.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of Care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Liver transplant ICU :

The Unit

The Liver transplant ICU is located on 3rd Floor, B Block of the hospital building

Case Mix :

The unit provides intensive care for patients post liver transplant

Bed Strength :

There are 2 beds in the unit.Liver transplant patients are admitted to the unit except in times of bed shortages, when other speciality patients may also be admitted.

Service Includes:

- Patient assessment
- Provision of intensive care as per treatment plan
- Invasive monitoring including central venous pressure & invasive BP Monitoring
- Ventilator Management
- Blood, Urine and other body fluids investigation as per appropriate
- Bedside chest Xray/ultrasound
- Echocardiography/ECG
- Personal Needs
- Bed side dialysis
- Bed side physiotherapy
- Dietary need
- Isolation Management
- Transfer of patients to wards
- Patient and family Education

Platinum Wing :

The Unit

The Platinum wing is located on 3rd Floor, D Block in main hospital

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 10 beds in this unit. All beds have central oxygen and central suction.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Labour Ward/ LDR :

The Unit

The ward is located on 3rd Floor, B Block in main hospital

Case Mix :

All types of Gyaenacology, obstetric and pediatric cases are admitted to the unit. In case of bed shortages pediatric patients may be admitted in other wards. Other specialities patient may be admitted in LDR in case of bed shortage.

Bed Strength :

There are 3 standard beds, 4 Semi private beds, 6 Single rooms and 1 LDR suite room.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Labour room is in 3rd floor and OT (4th Floor) conduct caesarean delivery
- Provision of care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate

- Personal Needs
- Bed side ultrasound whenever required
- Discharge of patients
- Patient and family Education

Deluxe Wards :

The Unit

The Executive/ Deluxe ward is located on 3rd Floor, C Block in main hospital

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 14 private rooms and 8 semi Private rooms total 22 bedded units.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary needs
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Private/Semi Private Ward & Barrier Nursing :

The Unit

The PSP ward is located on C Block on 1st Floor of the main hospital building

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Barrier room for burn cases, TB, Swine flu or other infection cases area admitted in it

Bed Strength :

There are 12 Semi private, 6 Private, 4 Standard and 6 Barrier nursing beds in this unit

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of Care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Oncology Ward :

The Unit

The Oncology ward is located on D Block on 1st Floor of the main hospital building

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 13 beds in this unit and have central oxygen and central suction.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of Care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

Standard Ward :

The Unit

The Standard ward is located on B Block on 1st Floor of the main hospital building

Case Mix :

Medical, Surgical and pediatric patients are admitted to this unit, except in times of bed shortages other speciality patients may also be admitted.

Bed Strength :

There are 43 beds in this unit.

Service Includes:

- Patient assessment by physician, Surgeon, Nursing, Dietary, Physiotherapy, interdisciplinary clinical care team)
- Provision of Care as per treatment plan
- Blood, Urine and other body fluids investigation as per appropriate
- Personal Needs
- Bed side physiotherapy
- Dietary need
- ECG, Bedside ultrasound and bedside X-ray, sugar by glucometer, pulse oxymeter monitoring whenever required.
- Transfer of patients to wards
- Patient and family Education

PROJECT

TO IDENTIFY THE REASONS FOR DAMA AMONG PATIENTS ADMITTED TO THE MEDICINE SERVICE AT APOLLO HOSPITAL FROM A VARIETY OF PERSPECTIVES.

Introduction

Patients who leave against medical advice are both a concern and a challenge for individuals in the health care field, because discharge against medical advice may expose patients to an increased risk of adverse medical outcomes including morbidity and mortality. Children as minors in health decision making may be more vulnerable. Professional liability is a concern for physicians caring for such patients[1]. The medical importance of patients leaving against medical advice has not been well studied in our communities. One aim of this review is to remind health care professionals of this entity hoping this will be a stimulus to carry out more studies on such patients and encouraging to take more initiatives towards clear unified system of management.

Definition

DAMA, **Discharge Against Medical Advice**, is a term used in health care institutions when a patient leaves a hospital against the advice of their doctor. While leaving before a medically specified endpoint may not promote the patient's health above their other values, there is widespread ethical and legal consensus that competent patients (or their authorized surrogates) are entitled to decline recommended treatment.

DAMA is a well recognized problem in medical practice. It occurs in both inpatient wards and emergency departments. The majority of studies have been done with in-patients, some have looked at outpatients. The phenomenon of DAMA is worldwide and is not limited to the developing world[5].

DAMA is a universal problem, plaguing both rural and urban hospitals. However, interest in this area has generally focused on large urban hospitals and on specific patients groups, such as the general medicine service or psychiatric patients. Although, DAMA is sometimes a relatively rare occurrence, the reported incidence showed great variation depending upon patient population and type of treatment setting. Report of DAMA incidence is widely variable ranging between >20% in large urban hospitals, especially among alcoholics, drug abusers and psychiatric patients, to <4% for medical admission and <1% in small rural hospitals and medical wards. DAMA studies in children are scanty, mostly retrospective and of fewer sample size despite the vulnerability of children.

Knowing the risk factors for DAMA is one step in designing intervention strategies. There has been long standing but sporadic research on contributing factors to LAMA, but most research has targeted admissions for alcohol, drug abuse, and psychiatric problem.

As patients who leave hospital against medical advice represent a high risk population, early identification of patients at risk may facilitate earlier implementation of preventive strategies, thereby decreasing the occurrence of DAMA and improving health outcomes. Patients at risk for leaving the hospital against medical advice often can be identified on the basis of their medical histories or on the basis of their behaviour while in the hospital. The early markers or indicators exhibited by the patients who DAMA should alert the admitting physicians to the possibility of an impending DAMA. Often the earliest signs of such behavior can be found in the nursing notes.

The predictors of DAMA fall within two broad categories: (1) patient variables – socio-demographic characteristics, diagnosis, treatment history, behavior; and attitudes toward treatment – and (2) provider variables – hospital setting and structure, staffing patterns, admission and discharge policies, and physicians' clinical style and experience.

Regarding patients demographic data, results have been diverse and sometimes conflicting. However, certain trends have emerged; younger age, male gender, non-insurance, low socio-economic status, alcohol and drug abuse, psychiatric disease, persons with less social support (single), lack of primary care physician and past history of DAMA all have been reported as risk factors for DAMA. Among variables attributable to providers, studies cite failure to orient the patient to treatment on intake, punitive or threatening atmosphere on the inpatient unit, difficulties in doctor-patient relationship, failure to establish a supportive provider-patient relationship and inadequate unit staffing patterns. Although common sense would suggest that only individuals with less life threatening conditions would sign against medical advice, there are several reports of patients with very serious diagnoses and extreme life threatening conditions who have left against medical advice.

DAMA is a multifactorial etiology involving a great diversity of influences; thus, patients leave the hospital against medical advice for a variety of reasons.

Ealier studies indicated that patients DAMA for reasons like dissatisfaction with their care, patients expected a shorter stay, need to take care of personal, family or financial affairs, patients felt better, patients are not improving and not receiving adequate nursing/medical care, preference for another hospital, beliefs that the condition was terminal, dislike of the hospital environment, and not wanting to be used for learning/teaching purposes or for financial difficulties. The only report from the Kingdom about DAMA among hospitalized children by Al Jurayyan et al from the southeastern part of the Kingdom, revealed number of reasons for parents who take their children against medical advice namely; problem of care of siblings at home, false parental judgment of improvement, living far away from hospital, frequent blood extraction, parents living outside the province, child refused to stay, and prolonged hospitalization.

Some observers consider that most cases of discharge against medical advice reflect failure to reach consensus between the attending physician and patient regarding the need for continued inpatient care. This failure may reflect, in part, poor communication and lower trust between the physician and the patient. A well-recognized fact is that lack of patient's trust on medical care providers interferes with communication about diagnosis, prognosis and appropriate treatment.

Poor communication contributes to dissatisfaction and disagreements in quality of care being offered and affects compliance with regard to admission, medications and follow-up. For pediatric patients in particular, well-informed caregivers are more likely to take rational health decisions concerning their sick children. Vincent et al, examining the reasons in patients and relatives taking legal actions against doctors, found that the decision to take legal action was determined not only by the original injury, but also by insensitive handling and poor communication after the original incident.

Ending a hospitalization prematurely can have implications for evaluation and resource utilization system. Leaving against medical advice is likely to result in greater subsequent utilization, including more return visits, and perhaps greater costs for the subsequent care of an initially inadequately treated condition. If hospital care is incomplete, the patient may continue to be ill and require readmission. For conditions such as inadequately treated meningitis, endocarditis, diabetic ketoacidosis, or even pneumonia, inadequate treatment can be devastating. Subsequent care may be more difficult and more costly. Overall costs of caring for an individual patient over time may be higher for patients who leave the hospital prematurely. Therefore, preventing discharge against medical advice is likely to benefit both patients and health care systems.

The medico-legal implications of DAMA need to be given serious consideration as the caregiver might not be protected from malpractice charges. There is little evidence that DAMA provides any malpractice protection[7]. Many hospitals have a release form for patients to read and sign prior to leaving hospital against medical advice, relieving the hospital and medical staff of any responsibility related to the patient's decision or its consequences. Hospital authorities should recognize that forms signed by a patient who is leaving against medical advice designed to protect the hospital in the event of an untoward consequence might have no legal protective value. The danger in such forms is that a physician may be tempted to rely on them instead of good clinical judgment and adherence to the recommended guidelines. The legal standard for protection from lawsuits continues to be good clinical practice with thorough documentation. Use of discharge against medical advice is not a safe road to legal immunity.

Al Saddique, reporting his experience as one member of the medico-legal committee of the Ministry of Health in Riyadh, has tressed that poor documentation is a great enemy and is unfortunately very rampant in the profession particularly in small hospitals, clinics and even specialized polyclinics. The patient's chart or file can be looked as a legal document that could be used at any time in a court of law for or against health care providers. The sicker the patient the more comprehensive and detailed should be the progress notes.

Legislation giving the health authorities the right to keep patients, especially children, in hospitals when they believe that their life might be endangered or the community health might be adversely affected, may be necessary to protect patients, especially minors. Al Jurayyan etal enquired about the legal implications when a parent or legal guardian discharges his or her child against medical advice and about our role as child advocates. The current trend in hospital practice in Saudi Arabia appears to be that physicians tend to be contented with parents signing that well known statement: “I, hereby, sign to take my child against medical advice.” This might be acceptable in circumstances which are not life threatening and where paediatricians may adjust the treatment protocol after exploring the reasons for discharge. Some researchers pointed out that the exact role of court ordered treatment or force detention of patients has been argued legally and ethically by the legal, medical and academic communities. Others believe that since patients are admitted voluntarily to a general hospital, a discharge against medical advice is

merely a withdrawal of the original consent, all competent adults possess the autonomy to make this decision.

Hospital discharge against medical advice may represent failure of medical care. Potential interventions are limited, but influence strategies may have a role. Research on this issue suggested that appropriate strategies, designed for the purpose of keeping the patient in the hospital, could prove effective. These strategies or plans include psychiatric consultation for patients who show a loss of control or awareness, or reorientation approaches such as allowing the patients to wear street clothes.

It is important to target those individuals with any indication of LAMA during their hospital stay in an attempt to decrease their risk of such non-compliance by communicating extensively with respect to all facets of care, while avoiding conflict, and providing a caring and accepting environment for the patient. Physician-patient communication skills should be applied to prevent discharge against medical advice. Complaints about the lack of clear, sympathetic explanations point to deficiencies in communication, and failure to appreciate that, in some circumstances, the emotional needs of patients may be as important as their physical needs. Communication assumes a special importance when things have gone wrong. Patients often blame doctors not so much for the original mistakes, as for a lack of openness or willingness to explain.

While the difficulties health workers often face in patient care attributable to limited facilities, busy schedules and uncooperative uneducated caregivers were acknowledged, the need for improved communication between the health team and patients/caregivers, conveyed in an easily understandable plain language cannot be overemphasized. Words are as necessary as drugs in the treatment of patients. Direct communication of the reasons for continuing the hospital stay, involvement of patients in decision, specific advice about treatment and empathy with the difficulties associated with being in hospital may prevent a few discharges against medical advice. Moyse reported a lower rate of DAMA from a Canadian community hospital, contributing factors to these results may include familiarity in a small community, limited options for hospital or doctor shopping, family physicians that care for their patients in the hospital as the attending physicians.

The role of the social workers in the pre and post discharge management of patients requesting for DAMA cannot be over-emphasized.

As part of control measures for DAMA, attitudinal change among health workers towards cases of DAMA, particularly in children who are minors is recommended. The assumption that patients who leave against advice reject medical care merits critical examination. These patients are frequently readmitted to the same hospital. Clinicians who dismiss or reject patients who leave against medical advice are potentially misinformed about this phenomenon and liable to misjudge these patients' motivations and needs. A patient who leaves the hospital against medical advice may be unable to accept hospital care at the time, but may be able to do so after addressing other needs. The challenge for health care professionals is to broaden the terms of engagement in a way that both preserves professional standards of care and increases the access

of patients with limited personal or financial resources. Ironically, these difficult-to-care for patients may be precisely those most in need of care.

Existing research does not specifically address this question, although findings suggest that efforts should focus on the first 2 weeks after departure. Reasonable recommendations would include giving the patient a specific follow-up appointment at the time of departure, ensuring that the patient receives appropriate prescriptions (or, preferably, the medications themselves) and providing the patient with a written summary of his or her hospital stay to assist health care providers in the event the patient presents to a different hospital. Follow-up by telephone would be desirable, since patients who leave against medical advice often lack a primary care provider and are likely to miss follow-up appointments.

The following points summarize the recommended guidelines by Devitt et al for physicians faced with the decision to discharge a patient against medical advice:

1. A careful, thorough, and well-documented examination is the best defense.
2. The severity of the illness should be assessed as well as the severity of the risk if the patient is discharged.
3. When a high degree of risk is involved, the physician should engage in a constructive dialogue with the patient about grievances. Often, this opportunity for communication will be sufficient, and the patient can be persuaded to remain in the hospital.
4. In a lower-risk case, it is still good practice for the physician to explore the patient's thinking about the discharge. Maintenance of a patient-physician alliance is still important for follow-up care.
5. Before discharging a patient against medical advice, the physician should ensure that the patients withholding of consent for further hospitalization is informed with respect to risks, benefits, and alternatives.

Problem Statement

Leave Against Medical Advice (LAMA), also called discharge against medical advice (DAMA), is an act whereby a patient takes his/her discharge contrary to the recommendation or will of the attending physician. The issue concerns hospital management, staff and patient as well as the third party where applicable. Leave Against Medical Advice (LAMA) poses potentially serious consequences on the utilisation of resources and may impact on an institution's finances.

Approximately one percent of inpatient discharges are against medical advice. Discharges against medical advice (DAMA) are of interest because they are associated with higher patient morbidity and risk for hospital readmission. Discharges against medical advice are also of interest because they can present ethical challenges for the physician. Information from both providers and patients regarding the reasons for DAMA are necessary for identifying workable strategies to reduce DAMA. However, there has been no study to date comparing the reasons for DAMA from multiple perspectives.

Scope of the Project

Understanding more about patients who leave against medical advice can inform solutions to minimize the negative effects of these discharges. Some of the solutions may be related to improving continuity of care and access to community-based services. Other opportunities likely lie in taking a more patient-centred approach that includes both formal and informal care networks. Strategies aimed at decreasing the number of patients who leave against medical advice and reducing the risks and poor outcomes for those who do may be needed. Discharge against medical advice (DAMA) is a problematic issue for physicians worldwide, which can disrupt the physician-patient relationship, have adverse medical outcomes and increase healthcare costs. The prevalence of DAMA varies considerably, depending on geographical area; in countries where healthcare services are not free at the point of delivery, financial constraints can often lead to patients discharging themselves as soon as they feel some improvement. There is limited information in the literature about reasons for discharges against medical advice (DAMA) as supplied by patients and providers. Information about the reasons for DAMA is necessary for identifying workable strategies to reduce the likelihood and health consequences of DAMA. The objective of this study is to identify the reasons for DAMA based on patient and doctors.

Review of literature

The only report from the Kingdom about LAMA among hospitalized children by Al Jurayyan et al from the southeastern part of the Kingdom, revealed number of reasons for parents who take their children against medical advice namely; problem of care of siblings at home, false parental judgment of improvement, living far away from hospital, frequent blood extraction, parents living outside the province, child refused to stay, and prolonged hospitalization. Al Jurayyan et

al enquired about the legal implications when a parent or legal guardian discharges his or her child against medical advice and about our role as child advocates. The current trend in hospital practice in Saudi Arabia appears to be that physicians tend to be contented with parents signing that well known statement: “I, hereby, sign to take my child against medical advice.” This might be acceptable in circumstances which are not life threatening and where pediatricians may adjust the treatment protocol after exploring the reasons for discharge.

Some researchers pointed out that the exact role of court ordered treatment or force detention of patients has been argued legally and ethically by the legal, medical and academic communities. Others believe that since patients are admitted voluntarily to a general hospital, a discharge against medical advice is merely a withdrawal of the original consent, all competent adults possess the autonomy to make this decision. In 2011–2012, a total of 25,137 admissions (or 1.3% of all admissions) to acute inpatient care across Canada—excluding Quebec—and nearly 60,000 visits (or close to 1% of all visits) to EDs (in Alberta and Ontario only) ended with patients leaving against medical advice. These rates are comparable to those found in other countries, and the acute inpatient care rate has been stable since 2007–2008.

Patients who left acute inpatient care against medical advice were more than twice as likely to be readmitted within a month (24% versus 9%) and more than three times as likely to visit the ED within a week (35% versus 11%), compared with those with routine discharges. They were also high users of hospital care overall, with an average of 2.3 inpatient admissions per year (versus 1.3 for other patients). In addition, nearly 13% of the patients who left acute inpatient care against medical advice also left the ED against medical advice. Targum et al reported 32% drop in discharge against medical advice from a large private general psychiatric hospital after the implementation of a new patient advocate position that was designed to orient new patients to the hospital and act as a staff-patient intermediary. Akiode et al from Nigeria have shown that LAMA can potentially be reduced by proper education and other factors such as improvement in hospital facilities and increase in skilled health manpower that might have enhanced patients’ confidence in the services.

Reasons for DAMA among patients diagnosed with psychiatric conditions or with a history of alcohol abuse have been identified in studies using a variety of methods including the retrospective review of patient medical records, interviews with patients or staff, and follow-up via telephone or mail. Reasons identified for DAMA from a detoxification/dual diagnosis unit at the Philadelphia Veterans Administration include family emergency obligations, financial obligations, and legal issues.

In the study by Baptist et al. (2007), the reasons for DAMA were identified following a review of the medical records of asthma patients who left against medical advice and included: dissatisfaction with care; patient was feeling better and; family obligations. Patient medical records provide a reliable source of information regarding the clinical condition of the patient and

may contain limited notes reflecting communications between patients and their providers from the medical staff's point of view; however, these notes likely do not provide the complete picture from patients' perspectives. Direct patient interviews may provide additional information that would be missing from a medical record, due either to the provider's failure to inquire or to the patient's failure to provide complete information. To our knowledge, reasons for DAMA based on direct patient and non-physician provider interviews in a general Medicine service have not been reported.

Previous research has found that as many as 2% of general hospital patients leave against medical advice. Additionally, evidence suggests that patients who leave against medical advice are more likely to return to hospital (often for the same diagnosis). Much of the previous research on patients who leave against medical advice has focused on specific medical conditions (such as asthma, pneumonia and substance abuse). Other studies were carried out for a given hospital or a defined area within a hospital (for example, an ED, psychiatric ward or pediatric unit).

The proportion of patients who leave hospital against medical advice varies internationally. American studies have found rates between 1% and 2%, and some European studies have reported rates as low as 0.3% and 0.4%. These estimates likely reflect many different factors, including how the studies defined hospitals. In Canada in 2011–2012, a total of 25,137 inpatients left acute care against medical advice. This represents 1.3% of all discharges from acute inpatient care across the country (excluding Quebec), a percentage that has remained stable since 2007–2008. As well in 2011–2012, close to 200,000 visits (or 3.2% of all visits) to EDs in Ontario and Alberta (where comprehensive ED data was available) ended when patients left without being triaged or medically assessed. An additional 58,756 ED visits (or 1% of all ED visits) ended with patients leaving against medical advice. This study focuses on those who left inpatient care and the ED against medical advice, not those patients who left the ED without triage or medical assessment.

One of the research also found that patients who left against medical advice were typically younger males, and many had histories of leaving against medical advice. Mental health or substance use problems were common diagnoses. Patients who left against medical advice were also more likely to leave hospital between evening and early morning hours and to live in low-income neighbourhoods. In addition, these patients showed a pattern of service utilization that has a significant impact on the health care system and presents challenges for the continuity of their care, as they on average had considerably more admissions and more readmissions to acute inpatient care and more visits to the ED than those with routine discharges.

Additionally, experts have suggested that for patients who visit the ED, wait times and perceived overcrowding are factors in decisions to leave without being seen or to leave against medical advice.17 However, analysis of two wait time measures using 2011–2012 data from Alberta and

Ontario EDs did not show large differences between those who left against medical advice and those who did not. Many factors contribute to length of time spent in the ED. These include the seriousness of a patient's condition, time needed for patient monitoring, waiting for diagnostic or laboratory test results and waiting for specialist consultation, among others. It is possible that improved communication with patients to ensure that they understand these aspects of ED care could help reduce the likelihood of their leaving against medical advice.

Studies have shown that patients may withdraw consent and leave the hospital for both medical and social reasons (including personal, family, or financial issues; conflicts with staff; dissatisfaction with hospital care, environment, or treatment interventions; and misunderstandings based on underlying medical, cognitive, and psychiatric issues). Multiple studies have shown higher rates of discharge against medical advice on the day that public assistance or welfare checks are available, underscoring the importance of financial issues as reasons for patients to leave the hospital.

Several predictors of discharge against medical advice have been repeatedly identified. Patients who have left the hospital against medical advice tend to be younger,to be male, to have Medicaid or to be uninsured, to come from a lower socioeconomic class, and to have a history or a current pattern of substance or alcohol abuse or other psychiatric problems. Repeatedly, current or past drug or alcohol problems have been consistently linked with leaving the hospital against medical advice. Other predictors have included the lack of a primary care physician, an increased severity of medical problems, living alone, and a higher number of hospital admissions. Against medical advice discharges are also associated with shorter hospital stays, as would be expected by their premature endings.

The role of race and ethnicity as predictors of discharge against medical advice has been debated in the literature. A number of studies have suggested that non white race is associated with a higher likelihood of such discharge. Patients who leave the hospital against medical advice represent an at-risk group for greater morbidity and mortality, as well as for readmission. In a study of 97 consecutive general medical inpatients, those who left the hospital against medical advice were 7 times more likely than were those who did not to be readmitted within the next 15 days (21% vs 3% rates of readmission). Moreover, patients who leave hospitals against medical advice are typically readmitted with the same diagnosis and often have worsened pathology since the previous hospitalization (leading to longer lengths of hospital stays in the follow-up admission).

Patients leave AMA for a variety of reasons, including dissatisfaction with the care received, family responsibilities and a sense that their health has improved.Identification of these factors and the characteristics of patients who are at risk for discharge AMA may help alert physicians to patients intending to leave AMA and thus to use strategies intended to keep the patient in hospital. In view of the lack of specific intervention procedures, influence strategies could be

used. Treating physicians who identify patients at risk for discharge AMA could use such psychological techniques. Accordingly, training in and understanding of these techniques by physicians would give them a tool to alter patients' behavior towards choosing beneficial decisions. The requirement for physician training in these techniques and the short length of stay of patients who discharge AMA necessitate, however, other strategies, such as communicating aspects of care and the dangers of leaving hospital prematurely.

Between 1 – 2% of hospitalized patients leave hospital against medical advice (AMA). The proportion has varied with study location and diagnosis, ranging from 0.6% in rural hospitals to 13% in inner city hospitals, and from 0.1% among postpartum patients to 51% for people in an anorexia nervosa inpatient treatment program. The variable having the strongest reported association with leaving AMA is having done so before. Other variables associated with leaving AMA have been younger age, male sex, membership in a visible minority, lower socioeconomic status, absence of health insurance, substance abuse, psychiatric disorders, and urban residency. In the United States, the total number of stays discharged AMA increased 41 percent between 1997 and 2011. For adults ages 45-64 years, the percentage of AMA discharges increased from 27 percent in 1997 to 41 percent in 2011. By payer, the share of AMA discharges increased from 25 percent to 29 percent for Medicare and decreased from 21 percent to 16 percent for private insurance.

OBJECTIVES

General objective: To identify the reasons for DAMA among patients admitted to the Medicine service at Apollo hospital from a variety of perspectives.

Specific Objectives:

- To compare and contrast the reasons given by the DAMA patients and those given by the doctors and staff of the hospital.
- To study and identify common characteristics among the DAMA patients.

METHODOLOGY

Study Area : The study was done at Apollo Hospitals. Patients who had taken discharge against medical advice were taken and assessed using questionnaire.

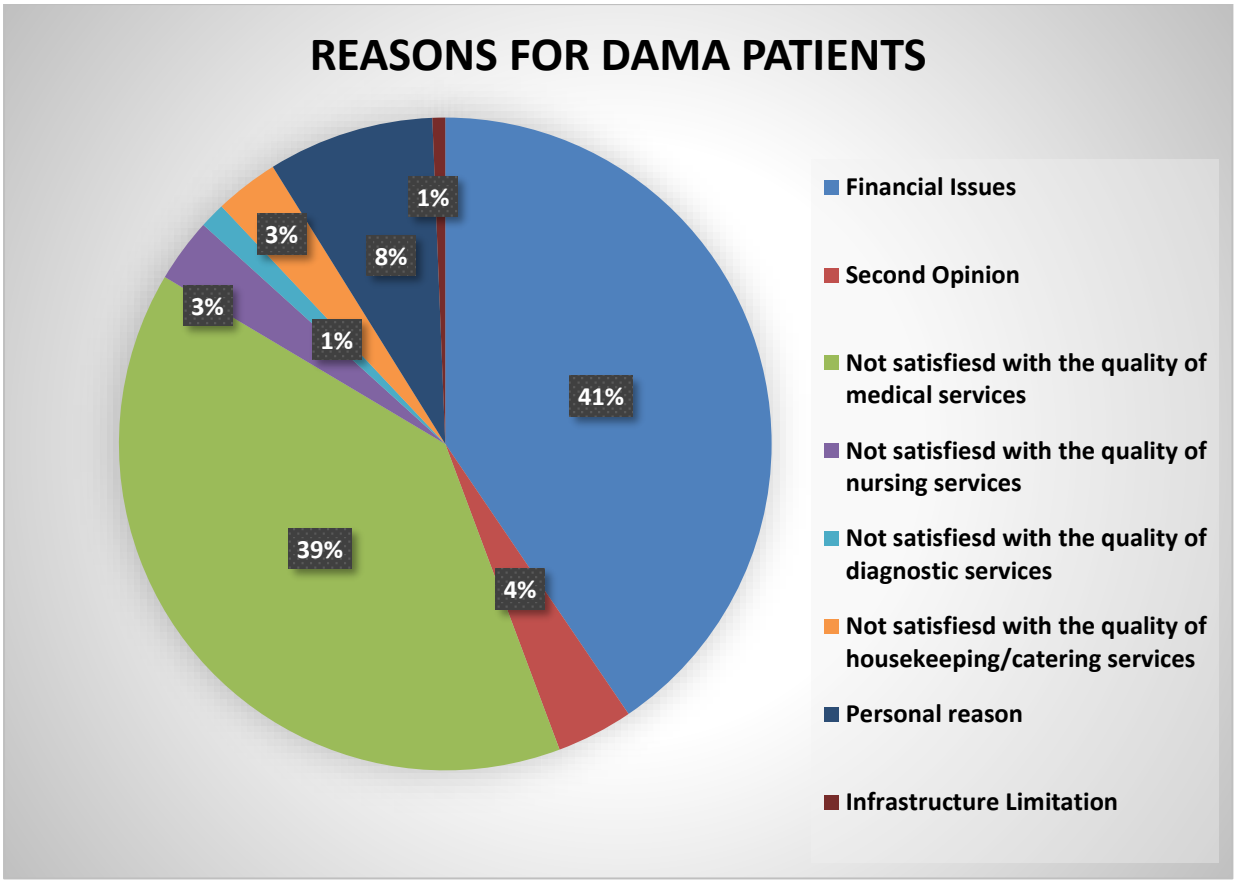
Sample design: Descriptive cross sectional study

Sample Population: DAMA Patients

Duration of study: 3 months (15th February 2016 – 15th May 2016)

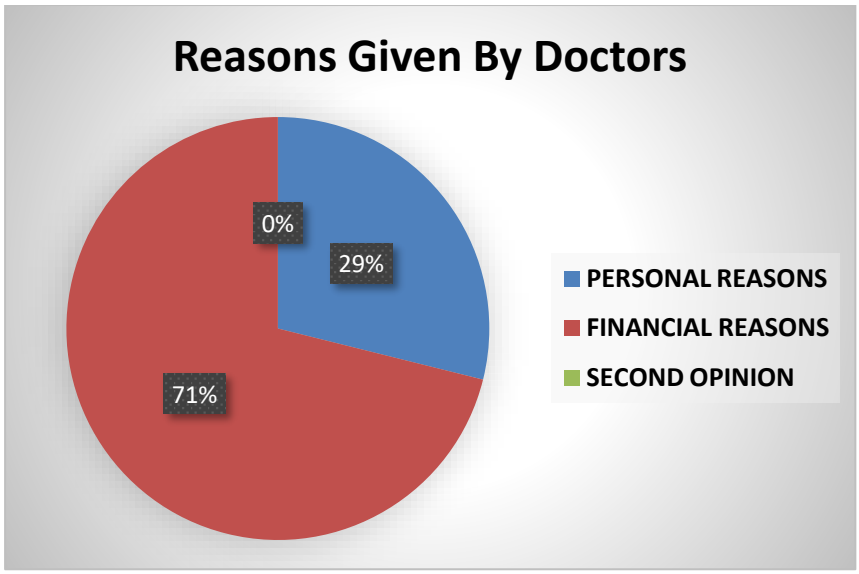
Data Collection Tools and Techniques: Telephonic Interviews and Feedback form

Data Analysis



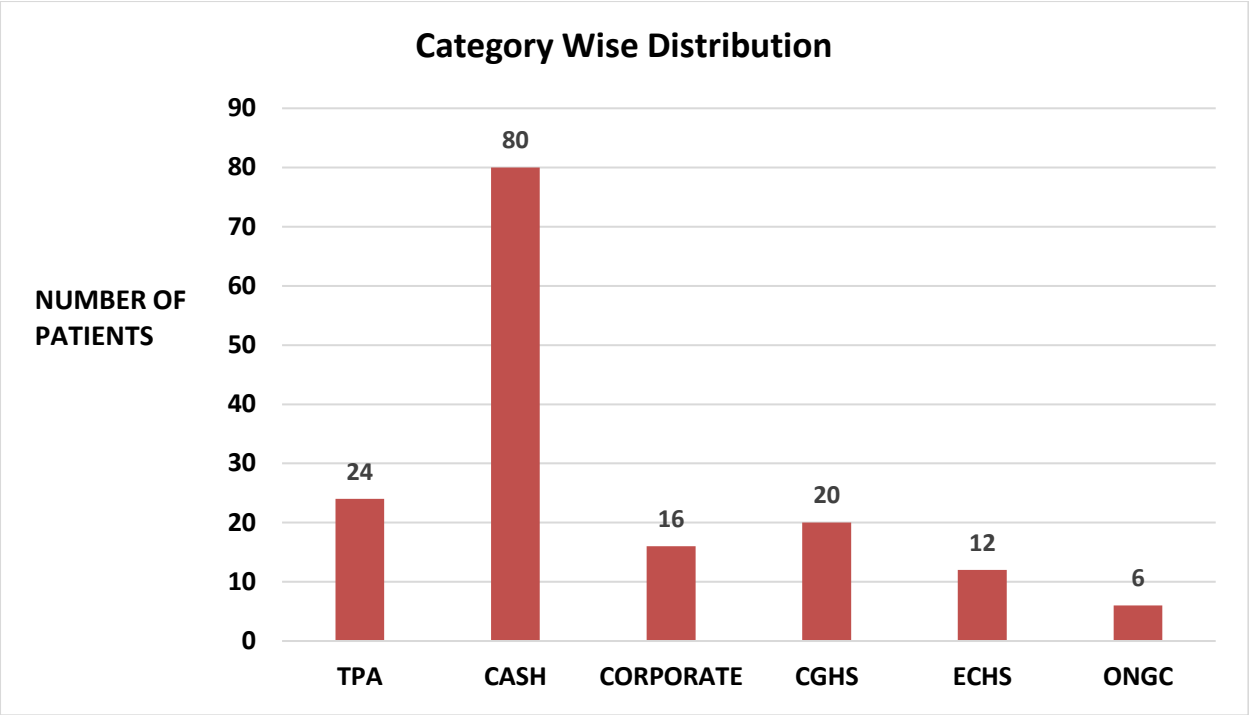
The graph represents:

- The main reasons given by the DAMA patients
- The two most common reasons are the financial issue and the not satisfactory medical services.
- Other reasons given by DAMA patients include second opinion, unsatisfactory nursing, diagnostic and housekeeping services and personal reasons.



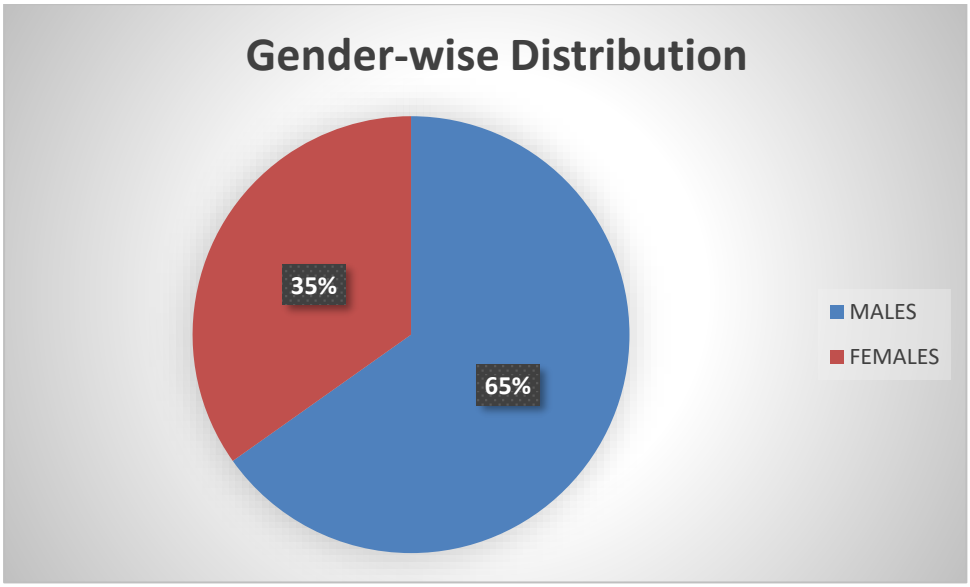
The graph represents:

REASONS GIVEN BY DOCTORS	REASONS GIVEN BY PATIENTS
• Financial reasons • Personal reasons • Second opinion	• Financial issues • Unsatisfactory medical services • Unsatisfactory nursing, diagnostic and housekeeping services • Personal reason • Second opinion

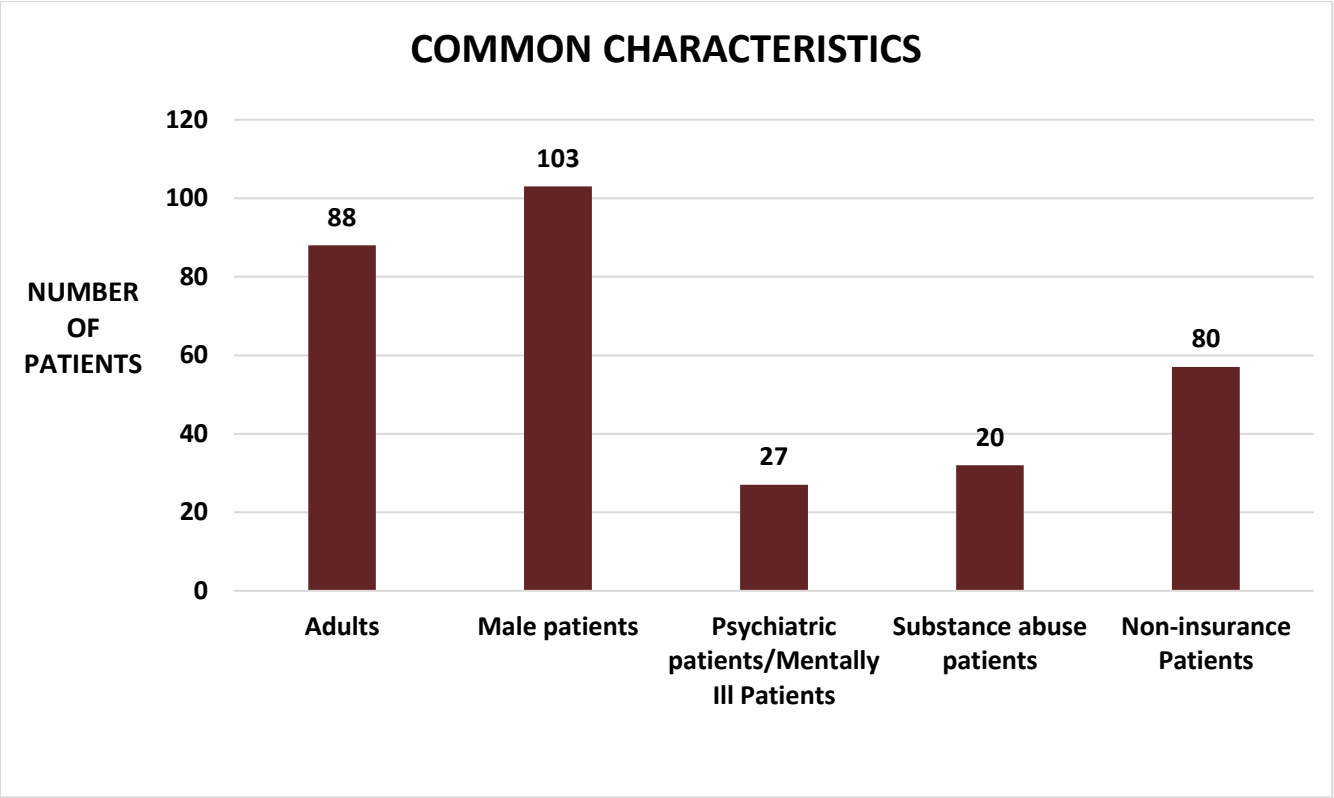


The graph represents:

- The DAMA patients mostly fall in the category of cash patients.
- Second highest category in TPA

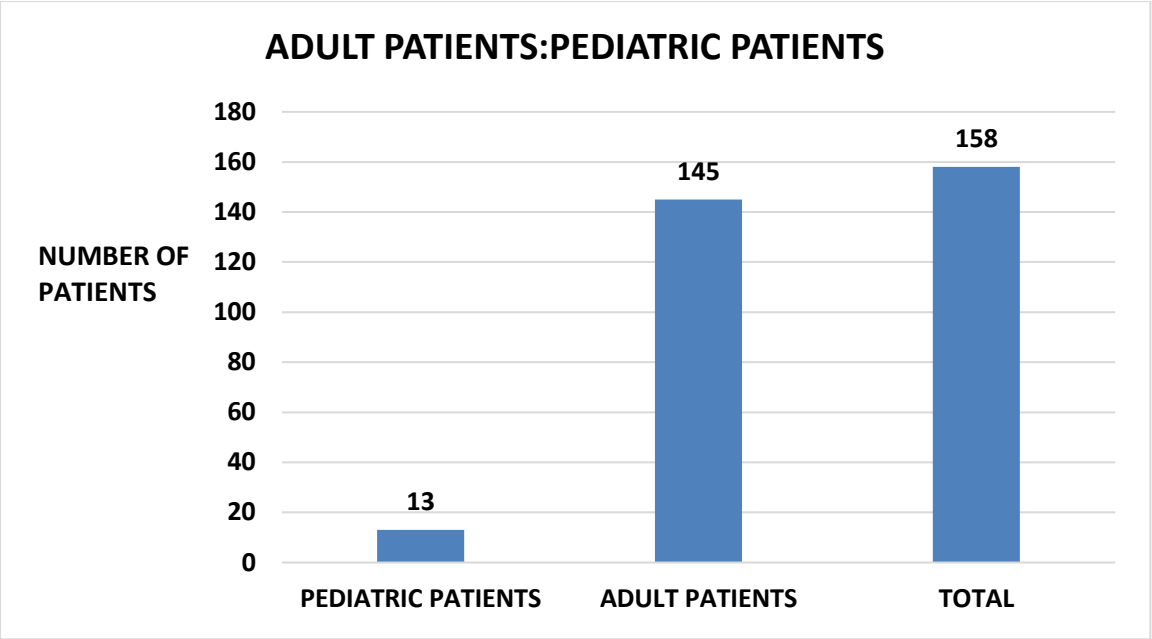


This graph shows that Discharge against medical advice is more common among males than females.



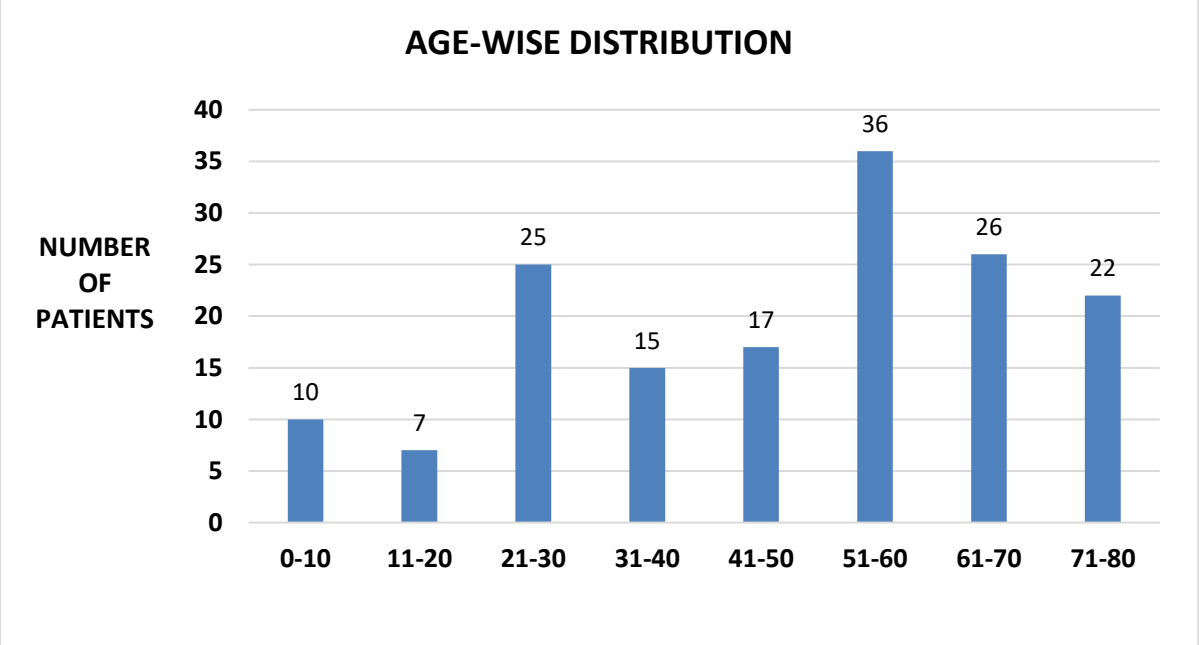
The graph shows:

Out of the total sample size more than 80 patients are adults, approx. 70 percent patients are males, around 25 patients are mentally ill, 20 patients are alcoholic or substance abused and around 80 patients are uninsured.



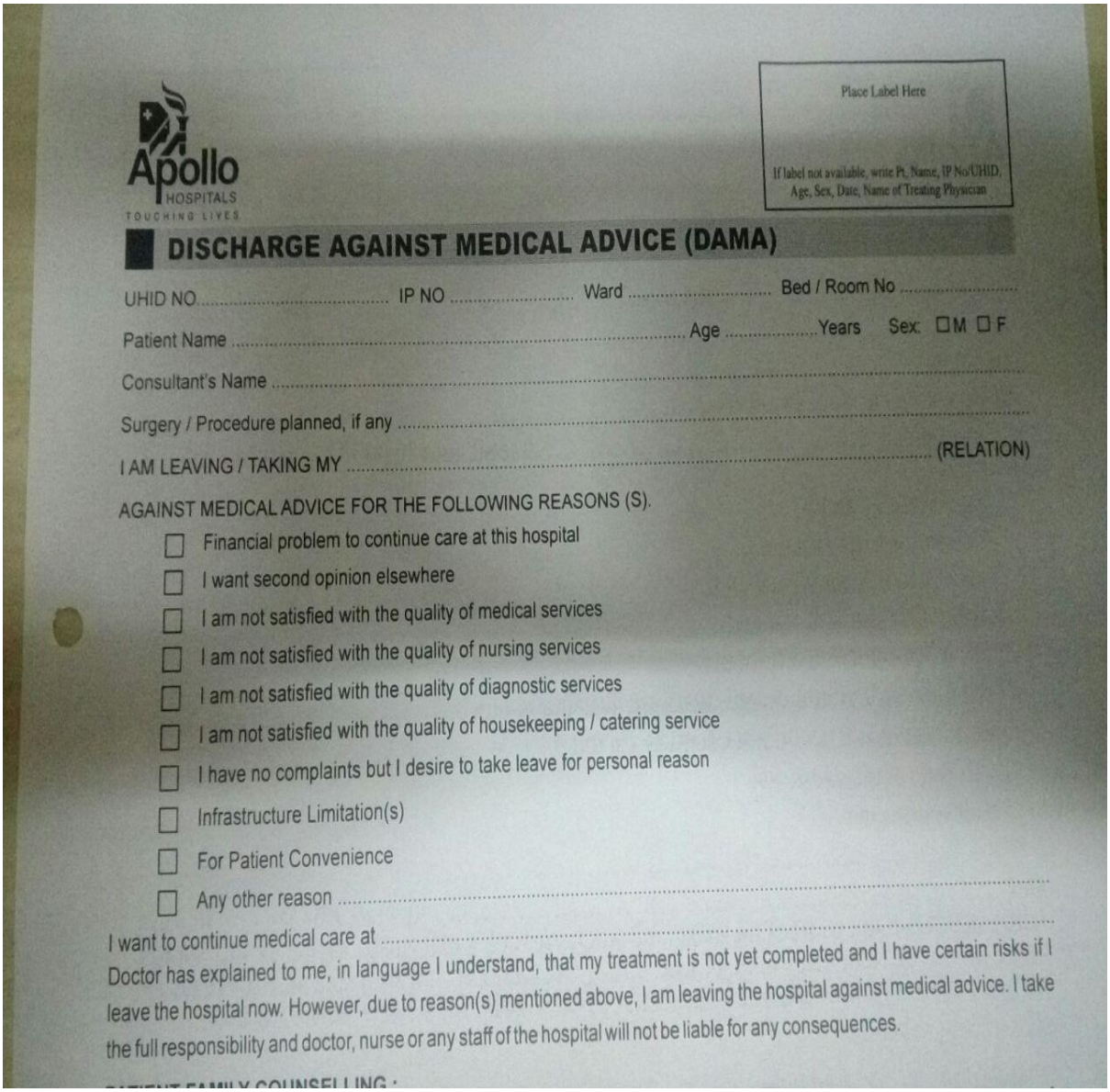
The graph represents:

The DAMA patients are mostly adult and only around 10 percent are paediatric patients.



This graph shows that DAMA patients are mostly in the age group of 51-60 and 21-30 i.e. younger and adult patients

DAMA QUESTIONNAIRE FORM



Apollo HOSPITALS
TOUCHING LIVES

Place Label Here

If label not available, write Pt. Name, IP No/UHID, Age, Sex, Date, Name of Treating Physician

DISCHARGE AGAINST MEDICAL ADVICE (DAMA)

UHID NO..... IP NO ..... Ward ..... Bed / Room No .....

Patient Name ..... Age .....Years Sex: ☐M ☐F

Consultant's Name .....

Surgery / Procedure planned, if any .....

I AM LEAVING / TAKING MY ..... (RELATION)

AGAINST MEDICAL ADVICE FOR THE FOLLOWING REASONS (S).

- ☐ Financial problem to continue care at this hospital
- ☐ I want second opinion elsewhere
- ☐ I am not satisfied with the quality of medical services
- ☐ I am not satisfied with the quality of nursing services
- ☐ I am not satisfied with the quality of diagnostic services
- ☐ I am not satisfied with the quality of housekeeping / catering service
- ☐ I have no complaints but I desire to take leave for personal reason
- ☐ Infrastructure Limitation(s)
- ☐ For Patient Convenience
- ☐ Any other reason .....

I want to continue medical care at .....

Doctor has explained to me, in language I understand, that my treatment is not yet completed and I have certain risks if I leave the hospital now. However, due to reason(s) mentioned above, I am leaving the hospital against medical advice. I take the full responsibility and doctor, nurse or any staff of the hospital will not be liable for any consequences.

PATIENT FAMILY COUNSELLING :

Challenges:

- Lack of Coordination among various departments
- Lack of proper doctor – patient communication
- Not receiving adequate nursing and medical care
- Lack of manpower

Conclusion :

- The patients who leave against medical advice are at increased risk of adverse health outcomes, readmission with respect to both morbidity and mortality than those who do not
- This study identified some of the characteristics such patients share when compared to those with routine discharges. Specifically, they are more likely to be males. They are also more likely to have mental health and psychoactive substance abuse diagnosis.
- Preventing discharge against medical advice is likely to benefit both patients and health care system.

Recommendations:

- Ensuring that patients are informed of the risks associated with early discharge, clearly communicating their expected course of care
- Planning for individual follow up will also be beneficial
- Consideration to be given to provide patient centered care
- Improving Patient-Physician communication
- Motivating staff for proper coordination with patients.
- Interim Bills should be reviewed twice

References :

1. Moyse HS. Discharges against medical advice: a community hospital's experience. Can J Rural Med 2004; 9: 148-153

2. Jeffer EK. Against medical advice: Part I, A Review of the Literature. Mil Med 1993; 158: 69-73

3. Jeffer EK. Against medical advice: Part II, The Army Experience 1971-1988. Mil Med 1993; 158: 73-76

4. Akiode O, Musa AA, Shonubi AM, Salami BA, Oyelekan AA. Trends of discharges against medical advice in a suburban surgical practice in Nigeria. Trop Doct 2005; 35: 51-52

5. Saitz R, Ghali WA and Moskowitz MA. Characteristics of patients with pneumonia who are discharged from hospitals against medical advice. American Journal of Medicine 1999: 107; 507-509

6. Franks P, Meldrum S, and Fiscella K. Discharges against medical advice: Are race / ethnicity predictors? J Gen

7. Saitz R, Ghali WA, Moskowitz MA. The impact of leaving against medical advice on hospital resource utilization. J Gen Intern Med 2000; 15: 103-107

8. Devitt PJ, Devitt AC, Dewan M. An examination of whether discharging patients against medical advice protects physicians from malpractice charges. Psychiatric Services 2000; 51: 899-902

9. Al Siddique AA. Medical liability: the dilemma of litigations. Saudi Med J 2004; 25: 901-906

10. Babekir AE. Leave against medical advice – how common is it? Emirates Medical Journal 1991; 9: 192-194

11. Letterie GS, Markenson GR, Markenson MM. Discharge against Medical Advice in an Obstetric Unit. Journal of Reproductive Medicine 1993; 38: 370-374

12. Devitt PJ, Devitt AC, Dewan M. Does identifying a discharge as “Against Medical Advice” confer legal protection? J Fam Pract 2000; 49: 224-227