Training Needs Identification for Streamlining the Patient Discharge Processes

A Dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

By

Col Vijay Singh

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May 2015

TO WHOMSOEVER IT MAY CONCERN

1. This is to certify that **Col Vijay Singh** 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 **BLK Super speciality Hospital** from **05 Mar** to **15 May 2015**.

2. The Candidate has successfully carried out the study, **"Training Need Identification for Streamlining the Patient Discharge Process",** which was designated to him during the internship training and his approach to the study has been sincere, scientific and analytical.

3. The Internship is in fulfilment of the course requirements.

4. I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr Preetha G S,
Associate Dean
(Research),
IIHMR, New Delhi.

CERTIFICATE OF APPROVAL

The following dissertation titled **"Training Need Identification for Streamlining the Patient Discharge Process"** at **"BLK Super speciality Hospital"** 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**
Dr Poonam Rajput	Rajput
DIVYA AGGARWAL	Divya
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Certificate from Dissertation Advisory Committee

This is to certify that **Col Vijay Singh**, a student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled "**Training Needs Identification for Streamlining the Patient Discharge Timings in BLK Super Speciality Hospital** " in partial fulfillment 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.

Dr.(Mrs) Preetha G
Assistant Professor
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Date- May 2015

Mr Puneet Gupta
Manager
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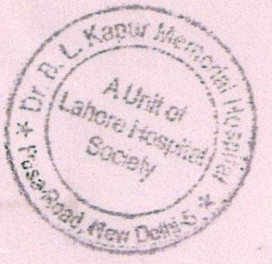
Date- May 2015



DLK
Super Speciality Hospital

Radiant Life Care
Private Limited

Ref: - BLK/HR/2015/MAY/184

Dated: 23.05.2015

TO WHOMSOEVER IT MAY CONCERN

Sub: - Dissertation Completion Letter

This is to certify that **Col. Vijay Singh** has undertaken dissertation at BLK Super Speciality Hospital from **13th February, 2015 to 18th May, 2015** in the department of **HR Department.**

During his tenure, his conduct was found to be excellent.

We wish him all the best for his future.

Yours Sincerely,
For BLK Hospital

Puneet Gupta
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Certificate of Completion

Date: - 18/05/2015

TO WHOM IT MAY CONCERN

This is to certify that Col Vijay Singh has successfully completed his three months Training and Project in our organization from Feb 13, 2015 to May 18, 2015. During this tenure he has worked in the HR Department on the **"Training Needs Identification for Streamlining the Patient Discharge Process at BLK Super Specialty Hospital"** under my guidance and my team's supervision .The candidate has successfully carried out the task/study assigned to him and his approach has been sincere, scientific and analytical.

Col Vijay Singh has done a good work and has produced a quality report during this period.

We wish him/her good luck for his/her future assignments

(Signature)

Mr. Puneet Gupta

Manager

Learning &Development

BLK Super Specialty Hospital

FEEDBACK FORM

Name of the Student: Col Vijay Singh

Dissertation Organisation: BL Kapur Super Speciality Hospital

Area of Dissertation: Training Needs Identification for Streamlining the Patient Discharge Process

Attendance: 95%

Objectives achieved: Complete Satisfaction as per Dissertation

Deliverables: Improve Training and Discharge Process

Strengths: Good interpersonal skills. Presented practical solutions & evaluated situations in detail.

Suggestions for Improvement:

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

Date: 18 May 2015
Place:

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Training Needs Identification for Streamlining the Patient Discharge Timings in BLK Super Speciality Hospital"** and submitted by Col Vijay Singh Enrolment No. PG\13\73 under the supervision of Dr. (Mrs) Preetha for award of the **Post- Graduate Diploma in Health and Hospital Management** is my original work and has not formed the basis for the award of any degree, diploma in this or any other institute or other similar institution of higher learning.

Vijay Singh

Signature

Date : ..20.. May, 2015

ACKNOWLEDGEMENT

I express my gratitude and sincere thanks to Dr Preetha G, Professor at International Institute of Health Management and Research, New Delhi, for her valuable guidance and co-operation in this endeavour.

I am thankful to the Management and HR Department of BLK, Super Specialty Hospital at Pusa Road, New Delhi, for giving me the opportunity to carry-out this Assignment. I would also like to express my gratitude to the functionaries and the staff of all medical and non-medical administration departments of the hospital who were extremely helpful in elucidating in detail, the nuances of the tasks and duties performed by them and helping us in completing this report.

I would be failing in my duty if i do not express my sincere gratitude to Mr Siraj Mehmood Ali Khan, AVP Administration for his foresight and generous support without which we would not have been able to set our goals for this Dissertation as well as the Summer Training last year. Our heartfelt thanks to the complete staff of HR Department of BLK Super Specialty Hospital for extending us this enlightening opportunity to observe and understand the varied facets of latest trends in technological advancement and management techniques required in a Multi-Specialty Hospital.

Col Vijay Singh

ABSTRACT

The administrative workforce is the major workforce constituent of the hospital, almost to the ratio of 3:1 to the medical staff. The patients spend maximum time and interaction with these employees. The training of the administrative staff is organised at regular intervals for achieving the laid down quality standards, patient satisfaction, development and growth of the individual as well as the organizations goals. Before, onset of any training, conducting a training need analysis is the initial step to begin with.

The aim of the study was to conduct a training need identification for the administrative staff involved in the discharge process and suggesting suitable modifications to the annual training calendar for the year 2015 .This would reduce the billing and discharge timings in the hospital with the aim to satisfy patients, be an important step towards achieving the laid down quality standards and increase job efficiency of the employee, ultimately leading to the growth and efficacy of the Organization.

Methodology

The first step was collecting the data on the present discharge process and the time taken for the billing. Thereafter carrying out the analysis of this data and the drawing out the inferences. This data was collected for a period of three months from 01Jan 2015 to 31 Mar 2015.
The second step was to study the training and initiatives undertaken by the Manager Learning and Development at the HR Department for the staff involved in the discharge procedure mainly the Nursing staff and the Billing staff, this included behavioural training conducted for the Staff .All the activities undertaken by these employees after the patient was marked for discharge by the doctor/consultants were also studied. Feedback from patients undergoing the discharge process was taken and specific cases were analysed over various days.
The third step was to analyse the whole process, identify the gaps and recommend the training needs of these employees in order to streamline the discharge process.
The study is descriptive in nature with both aspects of Qualitative and Quantitative research methodology. Questionnaires', interviews and feedback from patients undergoing the discharge procedure were also taken.

Results and Findings

The results show that almost the entire nursing and the billing staff should undergo refresher trg and deptt wise trg on soft skills, stress management and inter departmental coordination. Almost 33 % nurses require training in communication skills, team activities, grooming and etiquettes. From the researcher observation it is felt that immediate individual training is also required in NABH standard awareness and the HMIS. Some sessions should be included in unit training on equipment since majority of the nursing strata are fresher's so to meet the needs of the patients, this can be organised by the departmental head/supervisors as hitherto fore.

Conclusion

Training need identification is important from both the organizational point of view as well as from an individual's point of view. In this study it is found that immediate training is required for Communication skills, NABH standard awareness, stress management,

coordination between departments and patient discharge processes. Annual training calendar for the Nursing Staff and the Billing Staff is to be suitably modified to address the issue. Taking regular feedback from the discharged patients and their relatives is also important so as to know the effectiveness of the training sessions held

ACRONYMS / ABBREVIATIONS

1. Superintendent - Supdt.
2. Training - Trg
3. Communication- Comn
4. Section-Sec
5. Hospital Information System-HIS
6. Electronic Medical Record-EMR
7. Information System--IS.
8. Information Technology IT.
9. Equipment-Eqpt
10. Discharge-Disch
11. Managers-Mgrs
12. Human Resourses-HR
13. Digital Radio-DR
14. House Keeper/Keeping-HK
15. General Duty Assistant-GDA
16. Delivery Challan-DC
17. Third Party Administrator-TPA
18. Management-Mgt
19. Documentation-Docu
20. On Job Training-OJT
21. Head of Departments-HODs
22. Re – Ordering Level.=ROL
23. Contingency–Contin.
24. Command and Control–Comd and Cont
25. Management System-Mgt Sys
26. Equipment Schedule-Eqpt Schedule
27. Nursing Station-NS

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CHAPTER I - INTRODUCTION

1. Hospitals have become more and more complex with the enormous progress of medical sciences in all dimensions. The role of the hospital is to function as the hub of the whole system of health care, so as to improve the quality of life with a healthier total population.

2. Administration of hospitals is very complex responsibility for all managers as it involves clinical and non-medical services and their interwoven tasks and responsibilities. While clinical management is effectively carried out by physicians and nurses, the support (non-medical) services are mostly provided by non-medical resource managers. Administrative functions are normally considered as "nuisance functions" and do not enjoy high status within a hospital system. The Administrator and the HR Manager also do not generally perform any extensive medical function. Therefore, hospital tends to develop only the 'medical services' to keep pace with the growth in size and complexity. The study of non-medical administration departments in a Super Speciality Hospital gives an overview of the enormity of their tasks and how important these services/departments are to support the main hospital functions in the Healthcare Industry.

BL Kapur Super Speciality Hospital

3. Dr. B L Kapur, an eminent Obstetrician and Gynaecologist, set up a 200 bed hospital in Delhi which was inaugurated by the then Prime Minister, Pt. Jawahar Lal Nehru on 2nd January, 1959. By 1984, the hospital had become Delhi's premier Multi Specialty institute offering General Surgery, Ophthalmology, ENT, Dentistry, Pulmonology, Intensive Care and Orthopaedics, apart from Mother & Child Care. In the late 1990s, the Trustees of the hospital felt the need to upgrade it to a Tertiary Care Hospital and tied up with Radiant Life Care Private Limited to re-develop and manage the facility. The attainment of NABH & NABL accreditation in the very first year of operations is testimony to the hospital's commitment for patient safety and quality.

4. **Journey** BLK Hospital offers one of the most comprehensive bouquets of services for Tertiary and Quaternary Care, at par with country's most renowned institutes like AIIMS and Tata Memorial in Mumbai. BLK has India's largest Bone Marrow Transplant centre which is amongst the biggest in Asia. BLK Cancer Centre is amongst the most comprehensive cancer centres of its kind, with over 100 beds dedicated for Oncology services. The Bariatric program is the largest in North India. Besides the domestic patients, Hospital's international patient base has grown significantly over the last 12 months, owing to it being one of the most advanced healthcare facilities in the region.

Vision & Mission

5. **Vision** To create a patient-centric, Tertiary Healthcare Organization focused on non-intrusive quality care utilizing leading edge technology with a human touch.

6. **Mission**

(a) Achieve Professional Excellence in delivering Quality care.
(b) Ensure care with Integrity and Ethics.
(c) Push frontiers of care through Research and Education.
(d) Adhere to National and Global Standards in Healthcare.
(e) Provide Quality Healthcare to all sections of the society.

The Problem Definition

7. Technological advances enabled treating patients for ailments that were considered to be terminal in the past, this phenomenon increased discharge planning complexities for patients with multiple conditions. Due to shortened treatment /procedure timings, the time patients spent at the hospital are also shorter. As a result, nurses now have shorter windows of opportunity to get to know the patients and their needs that are critical for the discharge planning .Equally important are the billing staff who have to close the documents, prepare the bills and give final clearance.

8. Accurate data about who is leaving the hospital on a given day is not always available, so admitting departments continuously struggle with this uncertainty, especially during peak demand. Patients are disappointed to have their scheduled operations delayed or cancelled, “Hospital admissions and discharges cannot be scheduled like a “hotel reservation system” and therefore bringing to the fore the urgency of initiative taking and crisis management.

9. The increased demand for hospital beds is overwhelming, and freeing-up of available inpatient beds is a top priority since it has a direct bearing on the hospitals revenue.. Therefore, delays in discharge planning and unsynchronized patient flows are not tolerable.. Due to such a complex nature, there is a challenge in predicting accurate information regarding the status of beds ,in terms of the number of patients cleared after discharge. The admitting department is supposed to work with those predictions in preparing the admissions of that day.

10. Less accurate information will aggravate the problems that are already occurring at the admission end owing to delays ,and transfers resulting in cancellations of operations and admissions. This reinforces the arguments in describing the need for directing focus on the discharge process .Within the focus of this study reside these pertinent problems which cause undue friction and tensions between patients and the staff .

(a) **Achieving Discharge of Patients Prior to 1200 AM**. The hospital billing cycle is from 1200AM of the admission day to 1200AM of the discharge date. That is to say that patients who get admitted in the time window of 1200 AM (Noon) till 1159 AM of next will be treated equally as regards counting of the days for billing or counting Average Length of Stay(ALS) are considered. For the hospital it makes better sense to admit patients prior to 1200 AM and discharge them after 1200 AM. As regards patient it is more beneficial to get admission after 1200 AM and to secure his discharge before 1200 AM.

(b) **Judicious Approach** However a balanced and judicious approach will suggest admission of patient after 1200 AM and release of patient before 1200 AM so that a patient does not feel cheated. In order to discharge patient before 1200 AM there is a need to study the pattern of timings of day in which discharge decisions / orders are taken / marked. For data analysis the time of decision has been considered as that time when it gets ‘recorded’ or ‘marked’ by the physician in the HMIS. Planning for admissions is that planning which is carried out to synchronize admissions in accordance to the expected discharges.

(c) If there is lack of understanding in the sequence and structure of the discharge process, it will results in: lack of consistency, hidden inefficiencies, and difficultly in analyzing and improving the process.

(d) **Process Delay.** The second problem that belies the discharge process are delays that reoccur very frequently with patients marked for discharge. Ideally a patient should take no more than bare 60 minutes to clear the premises of a hospital once final decision to discharge him has been taken as part of pre-planned discharge, exceptions may be in case of transfers of patients to a higher level of care or to a similar care somewhere else owing of medical condition of the patient. More over since all information on tests, medications and billing upto the previous day has already been done on HMIS.

CHAPTER – II OBJECTIVES

Aim

(a) To identify the training needs of employees in order to streamline the discharge process

(b) To propose focus areas for training and initiatives for reducing the discharge process**.**

Objectives.

(a) To Identify time related activities in discharge process of patients.

(b) Identify wasteful activities in discharge process.

(c) Identify the training needs of the concerned staff for reducing the discharge timings

Overview

(a) Study Area. under aegis of HR Dept BLK Hospital.

(b) Duration. 15 Feb 2015 to May 2015

(c) Sample Size. Patient discharged from 01 Jan to 31 Mar 2015.

(d) Data collection.

(e) Primary and Secondary

(f) Interview and Feedback from the billing staff, nursing staff and the discharged patients

(g) Analyzing the current training activities

(h) Secondary – From existing HIS records with billing section and in patient wards.

CHAPTER – III REVIEW OF LITERATURE

LITERATURE REVIEW

10. This section will review literature that emphasizes the need for identifying delays occurring in hospital that impede patient flow process related to discharge phase. With relevance to inpatient units, it includes some of what has been written and done in terms of discharge planning. It declares the call for recuperating this aspect of the patient's hospital experience as an effort that partakes in improving patient flow, relevant studies on training of staff to improve the discharge process have been discussed. These are appended in the subsequent paragraphs

Study - Analysis, Modeling and Improvement of Patient Discharge Process in a Regional Hospital

Research Paper published at University of Windsor by Nancy Khurma
http://scholar.uwindsor.ca/etd

Patient Flow and Throughput

11. Hospitals are experiencing on going pressure to provide satisfactory care and the resources involved are having trouble realizing expectations. Researchers did not only go after the reasons for this increase in pressure, as they know that parts of it go back to the root changes in the nation's population's heath status. However, a special effort was spent in studying all sorts of delays that are occurring in hospitals based on observation . It was meant to be affordable and simple to learn and use. By utilizing it, the study suggests that time-wise feasible real-time assessments can be done that will bring to light the delays and inefficiencies occurring in a particular process at a hospital. In a Canadian hospital when the delay tool was put in operation on general internal medicine and gastrointestinal services for 6 months, it found that "30% of 960 patients experienced delays" each averaging to 2.9 days. The study also showed that most delays occurred in the following frequency:

(a) Scheduling of tests (31%).
(b) Unavailability of post-discharge facilities (21%).
(c) Physician decision-making (13%).
(d) Discharge planning (12%).
(e) Scheduling of surgery (12%).

12. A pilot study conducted at Chelsea and Westminster Hospital, London, was used to define the reasons to which delays could be attributed and their resultant costs (Table). 'Combined social and therapy delay' describes hold-ups affecting 'medically fit' patients who were awaiting review from more than one service—physiotherapy, occupational therapy or social services—for whom it was not possible to determine which of these three services was/were preventing discharge. A delay was recorded for each day during which these patients were not seen or, in the case of social services, during which no progress was made. The number of days delay that prevented timely discharge from hospital ('delay to discharge') was 184 days (20.7%). The mean duration of 'delay to discharge' per patient was 2.2 days[20]

Table . Causes of Delays and Associated Resultant Costs.

Service accounting for delay	Delay to discharge (%)	Total delays (%)	Cost per patient (£)	Annual ward cost (£)
Combined social and therapy delay	25.8	28.8	145.9	149,290
Lack of downstream bed (nursing home or rehabilitation centre)	20.4	14.1	115.2	117,861
Social worker	16.8	13.9	95.2	97,432
Occupational therapy	9.0	8.7	50.7	51,859
Physiotherapy	5.2	4.9	29.2	29,858
Patient requesting to remain in hospital	4.6	7.6	26.1	26,715
Medical or surgical review	4.1	4.9	23.0	23,572
Nursing referral	3.5	2.3	20.0	20,429
Radiology/procedure: having test	2.7	8.9	15.4	15,715
Radiology/procedure: reporting test	2.7	0.9	15.4	15,715
Doctor referral	1.1	0.9	6.1	6,286
Patient transport	1.1	1.4	6.1	6,286
Pharmacy	1.1	0.9	6.1	6,286
Doctor delay: other	0.8	0.5	4.6	4,714
Other delay	0.3	0.2	1.5	1,572
Radiology/procedure: requesting test	0.3	0.5	1.5	1,572
Laboratory: reporting sample	0.3	0.5	1.5	1,572
Discharge prescription: incomplete	0.3	0.3	1.5	1,572
Laboratory: lost sample	0.0	0.0	0.0	0.0
Total	100	**100**	565.3	578,303

13. However, when defined in terms of delay days, and due to the length of the delays, awaiting post-discharge facilities was found to cause 41% of them, hence being the most important problem. Even though this study proposes an indicative tool that can highlight and quantify delays, it admits that the delay tool's abilities stop there, and further efforts, tools and analyses should be carried out to decide on optimal courses of action. Another attempt to improve the efficiency of patient flow was conducted in Lucile Packard Children's hospital in California. The hospital faced many problems when it had to delay and turn away patients due to the lack of capacity. The flow was defined from admission through discharge and all the steps were laid down for the purpose of reengineering the process. The objective was to "achieve lasting performance improvement".

14. The study was directed to measure the effectiveness and improve the following areas:

(a) Reducing patient placement delays.
(b) Decreasing diversion volumes and understanding causes.
(c) Improving accuracy of bed availability and admission predictions.

(d) Reducing the number of medically unnecessary patient days and payment denials.
(e) Decreasing the frequency of discharge delays.
(f) Improving bed turnaround time.
(g) Enhancing the consistency of care performance.
(h) Reducing variances from established standards of care.

15. To bring about findings and recommend measures for these improvements, distinct measures were set that became standards of performance. Continuously, the goal was to increase care and service coordination, create and sustain cultural change and redefine/reinculcate staff job functions through training. To be able to trace what has been done throughout each week, reports were created about patient admission, bed assignments, delayed discharge and bed turnaround among others. Meetings specially conducted for evaluation of patient flow performance where carried out, and most of what is discussed there is fed by that week's report.

16. **Learnings from the Study**

(a) Modifying the nursing supervisor position such that they are capable of making appropriate decisions in bed assignment and staffing based on their solid clinical knowledge. Nurse supervisor should be able to manage and organize situations such as at peak demand levels, and to encourage case managers to be more involved and active in facilitating the discharge planning process.
(b) The results of this measure and the redefining of job responsibilities showed a 40% increase in the ability to anticipate patient discharge.
(c) Medical Consultants/ residents involvement in improving predictability by timely completing patient rounds and patient discharge orders.
(d) This paper brought promising idea that might be applicable in many other hospitals, through bed management concept . The Bed Manager title was given to a nurse that practices the identification of empty beds and allocation of waiting patients to them.
(e) Admission clerks are informed about empty beds, and they assign new patients to them, rather than active personnel in identifying those empty beds. The process of bed management is shown in Figure 1.
(f) The research effort emphasized on the training that they should receive in order to be accountable and pro-active bed managers. A fundamental portion of the bed management process is communication.
(g) In Figure 1 below, arrows are connecting this duty with all the stages for any patient case. To communicate information about numbers of admissions and discharges effectively and timely throughout in a large hospital is a challenge. Placement ,Stay, Discharge, Emergency Admission, Elective Admission, Bed availability and management all affect one another differently.

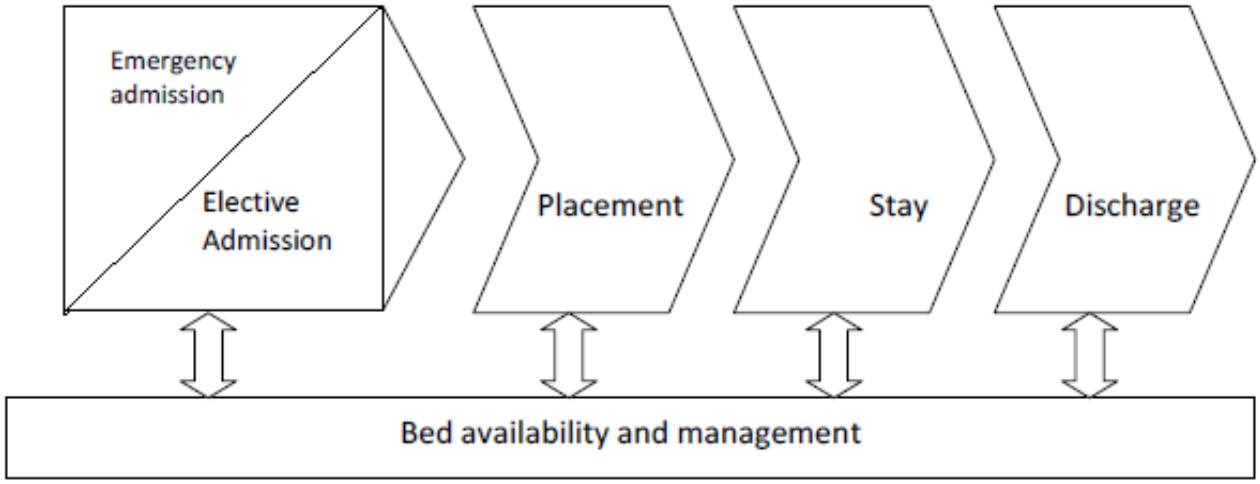


Figure : Bed Management Process

(h) The author describes it as being "...much like morning rush hour on highways" . The following needs to be done to make sure that the communication of information is done in a way that would allow bed management to be productive:
(j) Keeping the lines of communication with the inpatient to make sure that any new or upcoming issues are known and addressed right away.
(k) The night shift supervisor should have a report ready in the morning for the bed manager, the medical directors, and the unit manager to insure continuity of information and reduce double processing. The bed manager here uses this report to discuss patient throughput issues.
(l) Discharge data should be collected as well as a scheduled admission list.
(m) Nurses should meet every morning allowing unit charge nurses to be familiar with the potential discharges from other units
(n) Based on known discharges, possible discharges and staffing, a plan is set by charge nurses and the bed manager for scheduled admissions with keeping a proper margin for emergency admissions.
(o) Bed managers should do rounds during the day to check on bed status, and keep associated departments like billing and front desk informed of the situation.
(p) Using latest information technology in providing access to real-time information regarding demand for beds and current hospital capacity can be a key solution. Replacing paper-documented information relating to the arrival, transfer and discharge of patients with an electronic data base, can allow instant analysis and timely updates and processing of patient information.
(q) System dynamics modeling technique that "combines both qualitative and quantitative aspects and aims to enhance understanding of complex systems, to gain insights into system behavior." At a hospital setting, the outcome of these models can be patient pathways, information flow and resource use - wherever dynamic activities are taking place.
(r) Specially designed behavioral training and communication training modules for the nursing staff. Also training on team building, inter departmental coordination and crisis management.
(s) Discharge planning that is not flexible or modifiable as new information comes to light is as bad as no planning at all" hence the need for discharge planning
(t) Certain **other learning issues** persistent to the problem are as under :-

(i) Improving liaison
(ii) Planning as far ahead as possible
(iii) Improving communication
(iv) Creating and maintain clear and concise documentation.
(v) Improving patient assessment

(u) Developing a computer software to manage discharge - and more importantly to ease the sharing of information. The software should enable the following:-

(i) Capturing data relevant for discharge liaison including referral, assessment and discharge details that are in the hospital patient system.
(ii) Nurses to send electronic referrals direct from the ward or from the discharge liaison office to the social services offices at any time of the day or night.
(iii) The extraction of the most recent status for each patient from the hospital patient system to keep social services up to date. Instant access to information such as patients' next of kin, mobility mental state and any changes in discharge date is possible.
(iv) Social services to maintain their own memo data in relation to a particular case,

Studies on Training Needs Analysis. A literature Review and Reappraisal

http://dx.doi.org/10.1016/j.ijnurstu.2003.12.003

Study By - Dinah Gould, Daniel Kelly Isabel White, Jayne Chidgey

17. Training needs analysis is the initial step in a cyclical process which contributes to the overall training and educational strategy of staff in an organization or a professional group. The cycle commences with a systematic consultation to identify the learning needs of the population considered, followed by course planning, delivery and evaluation. Although much has been written about training needs analysis in relation to post-registration nursing education, there is disagreement concerning its impact on the training cycle and its potential to influence service delivery. This stimulated the literature review presented below. Initial searches of nursing databases identified 266 works. Twenty three (8.6%) contained empirical findings relating to post-registration nursing education in which assessment of training needs was presented as the major aim. Most of these accounts were concerned with the training needs of nurses in more than one organization and were classified as macro-level training needs analysis. However, seven studies were concerned with a single, specific organization (micro-level training needs analysis). Despite their smaller scale and more limited scope, micro-level training needs initiatives demonstrated greater methodological rigour, were more likely to consider the stakeholder perspective, to generate findings which could positively influence the rest of the training cycle and showed the greatest potential for influencing service delivery and quality of patient care. The review drew attention to the similarities between the training cycle and the audit cycle and resulted in the development of a model which could be used to evaluate the effectiveness of the process and outcomes of future training needs analysis initiatives.

Study Training Needs Analysis J Nurs Manag. 1994 Jul;2(4):181-5, Sheperd JC

18. The training needs analysis model described is based on a PhD study initiated by the author in 1989 when three individual schools of nursing in Birmingham were amalgamated to form The Birmingham College of Nurse Education. It was agreed at that time that a rationalization of post-registration education be undertaken as a matter of some urgency, in order to identify a framework for the development of post-registration education, which could go some way in meeting practitioner needs across three educational sites. One way of effectively meeting this objective was to undertake training needs analysis of qualified nurse practitioners which would also include the identification of nurse manager's perceptions of practitioners needs.

19. Following a review of the literature, it was felt that existing approaches to post-registration education did not generally allow for the consideration of training needs and therefore the educational programmes offered were not, in the main, meeting individual practitioner need. The research therefore developed a methodology for effectively assessing the training needs of qualified nurse practitioners and for drawing conclusions, in order to make recommendations for future post-registration education, planning and development strategies with the described model being successfully utilized.

Study DR. V.RAMA DEVI; M.MALLIKA RAO

EXCEL INTERNATIONAL JOURNAL OF MULTIDISCIPLINARY MANAGEMENT STUDIES
Online available at http://zenithresearch.org.in/

20. The delivery of valuable health care depends on an expanding team of trained health care professionals. As people are critical assets for the organization, the development of this asset is essential for the continued health and prosperity of the organization. The training needs assessment is a critical activity for the training and development function. It is against this backdrop the paper is addressed to study training needs identification of nursing staff in a Health care organization. The study was conducted through a survey among 110 nursing staff and 30 DMOs using structured questionnaires. The findings of the study revealed that the training need gap is relatively more for enthusiasm in learning followed by Team Spirit and clinical skills. The training need gap is the least for communication, followed by planning & organizing skills. There should not be any compromise in the quality of services to be provided to the patients as the health care organizations deal with the valuable life of the people and the need for trained professionals in health care sector can hardly be overemphasized.

Learning Points from the Studies

People often "jump the gun" by assuming that training is the best solution to performance problems. Before you make that assumption, be sure training is the best solution after conducting a performance and need analysis.

21. From the above studies the following relevant learning issues and take away lessons emerged:-

(a) Conducting a training needs analysis to identify the gap between what the job expects an employee to do, on the one hand, and what the employee is actually doing, To identify discrepancies/ conflicts between what an employee ought to be doing and that which he or she can do.

(b) Setting up of job standards. Standards set should be levels of expertise or skills one has to comply with to do a job properly. Whenever one does not meet the required standards, the need for training should arise. Training based on such a need (or needs) will aim to address that need, and by eliminating it, will supply the employee with the skills to do the job properly

(c) The training issues should be identified and addressed for different levels of needs which can be differentiated as under :-

(i) **Organisational Needs** These concern the performance of the organisation as a whole. Here identification of training needs is done to find out whether the organisation is meeting its current performance standards and objectives and if not.

(ii) **Occupational Needs** These training needs are those which relate to skills, knowledge and attitudes an individual must have to carry out a job irrespective of who he or she is. An example could be a billing clerk having knowledge of IT HIS Software and processing skills.

(iii) **Individual Needs** these concern the performance of one or more individuals (as individuals, rather than as members of a group).

(iv) The individual needs may be personal, performance-related or career-related, and will include needs, amongst others for:

(aa) Updating knowledge, skills and job-related competences

(ab) Increasing job satisfaction and the fulfillment of personal goals

(ac) Identifying personal strengths and weaknesses; identifying and achieving work values and work targets;

(ad) Developing communication, personal effectiveness and life skills;

(ae) Improving qualifications;

(af) Individual learning and self-development;

(ag) Building self-awareness, self-confidence and motivation.

(ah) The organization is also able to pitch its course input closer to the specific needs of the participants.

(aj) Find out if the learning is being applied at the workplace.

(ak) Ensure training improves continuously.

(al) Track the development of staff knowledge and skills.

(am) It also saves a lot of money for the organization as otherwise money is just unnecessarily wasted on those training programs, which are either not needed by the employees or they have no interest in undertaking them.

(an) Lastly, time, which is the most important resource today, is also saved, as the training programs conducted are the ones, which are actually needed by the participant.

CHAPTER – IV METHODOLOGY

22. Before dwelling on the methodology of conduct of the study it is pertinent to discuss the various departments namely Billing Department and Nursing Department involved in the involved discharge process and the conduct of employees recruitment and training done by the HR Department .These are discussed in succeeding paragraphs

23. The study commenced with the identifying of the billing process in the hospital and tasking and responsibilities of the staff involved. It was also pertinent to conduct interviews of this staff and the responsible managers .Feedback from the patients who were marked for discharge was taken and also from their relatives some of them had been staying in the hospital/nearby after travelling from other states.

24. Broadly the methodology of the conduct involved two phases namely :-

(a) **Phase I**

(i) Understanding the functioning and responsibilities of the departments involved
(ii) Carry out study of the training and initiatives taken by the HR Department
(ii) Critically analyzing the process and the timings
(iii) Interview of the concerned staff and feedback from the patients/relatives.

(b) **Phase II**

(i)Identifying the gaps and focus areas for training needs and improvement.
(ii) Recommending measures and initiatives for including in the curriculum.

BILLING DEPARTMENT

25. Billing Department coordinates with various department i.e., Wards, Marketing, Medical Administration, Pharmacy stores, Lab services while facilitating discharges and other billing process i.e. receiving cash, final discharge billing, In house recovery call, facilitating TPA and Corporate patients, Bill Audit, Bill Despatch and patient handling.

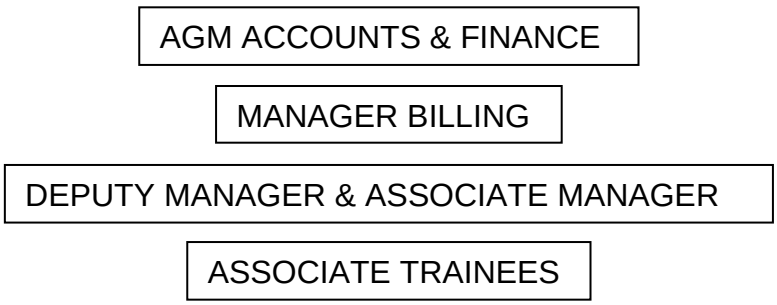
26 **Objective** -To manage in-out process through customer satisfaction and accurate billing

27. **Quality Objectives.** The primary quality objectives of the deptt are as under :-

(a) Provide accurate, timely and high quality service to clients.
(b) Customer feedback.
(c) Initial response to complaints and queries within three working days

28. The deptt is headed by a AGM Account and Finance who has a Manager Accounts and Finance and a Deputy Manager under him. The actual billing work and compiling is done by the Managers and the Trainees. The behavioral training of this staff is organized by the HR Deptt on need basis when detailed by the AGM, the training on the functional and technical aspects is carried out at the deptt itself.

The deptt chart is as under:-



NURSING DEPARTMENT AT BLK HOSPITAL

29. The Nursing Department at BLK Hospital is headed by **Mrs Rossanna Jose** who is the Nursing Supdt and the deptt comprises of a staff of 975 employees which include Nurses, Ward boys and other support staff. The Nursing staff comprises of more than 50% of the total hospital workforce of 1800 employees.

30 The deptt is organized into the Nursing Division and the Nursing Education Division The Nursing Division has Deputy Nursing Supdt, Assistant Nursing Supdt and the Nursing Supervisors followed by the Nurses. The training division is headed by the Nursing Educator and the Clinical Educator who organize the training and education of the Nurses on functional aspects. The behavioral training is organized by the HR deptt on request and detailment of the staff by the Nursing Supdt. The training needs assessment is carried out at the deptt itself by the Supervisors.

31**.** The nursing department is huge and has a good mix of nurses from all over the country. The total strength of nursing staff is 975 who are taking care of all the nursing process in the hospital. The nursing department looks after the nursing stations and the various wards. They are employed at the ICU"s (MICU, SICU, PICU, NICU) OT"s, O.P.D, Clinics Dialysis, Unit Chemotherapy Unit, Blood Bank, Emergency Unit and many other stations. There are also Specialty Nurses (Infection Control) who look after infection control and waste disposal procedures.

32. The hospital has a separate nursing education team consisting of two members under the divisional head who constantly takes care after the technical training needs of the nurses. The nursing team provides training every day to the nursing staff from 1pm to 2 pm as per the training calendar prepared every month. Nursing Induction covering technical aspects takes place every month for new joiners; which is a one week session.

33. The Nursing Training being organized by the HR Department is as under :-

(a) Unit Training
(b) Records Management
(c) Management of International Patients
(d) Departmental Training on different topics
(e) Communication Skills training
(f) Soft Skills training
(g) Grooming Standards & Personal Hygiene
(h) Training of different codes in the hospital

(j) Quality Indicators
(k) Fall Prevention
(l) Pre and Post op Care
(m) Input and Output Charting
(n) Fire Safety Training with mock drills
(o) Hospital Infection Control Policies & Hand Hygiene
(p) Bio Waste Management
(q) Admission & Discharge Process

Human Resource Department

34 The Human Resource Department in any Hospital is the hub of all activities pertaining to the selection, orientation, training, appraisal and the cadre management of the Hospital. Human Resource Management is the management of employee's skill, knowledge abilities, talent, aptitude, creativity, ability. Different terms are used for denoting human resource management. Human resource management (HRM) is concerned with the personnel policies and managerial practices and systems that influence the workforce. In broader terms, all decisions that affect the workforce of the organization concern the HRM function.

35. The activities involved in HRM function are pervasive throughout the organization. Line managers, typically spend more than 50 percent of their time for human resource activities such hiring, evaluating, disciplining, and scheduling employees. Human resource management specialists in the HRM department help organizations with all activities related to staffing and maintaining an effective workforce.

36 The Human Resource Department at BLK Hospital is organised as under-
(a) VP Ms Pratima Jain
(b) Managers –02 (Manager HR and Manager Learning and Development)
(c) Deputy Manager HR and Executive Training and Development
(d) Executives HR Deptt

FUNCTIONS OF HUMAN RESOURCE MANAGEMENT

37 The broad functions of the HR Department are listed as under-
(a) Administration
(b) Benefits
(c) Compensation
(d) Employee Relations & Employee Services
(e) Health and Safety
(f) Leave of Absence
(g) Payroll Administration
(h) Performance Appraisal
(j) Record- Keeping
(k) Separations and Terminations
(l) Training & development
(m) Planning and organizing Orientation Programme for all the new joinees.
(n) Initiating and Planning Orientation Schedule for Management Trainees/ Interns in the organization.

(o) Coordinating for all trainings which take place in the organization like Communication skills, behaviour Training.
(p) Maintaining the record for all the in-house and external training held in the calendar year like attendance record, training hours etc.
(q) Planning and drafting the monthly calendar and compiling the inputs from the respective user departments.
(r) Maintaining Feedback for the trainings held.
(s) Certification for the training sessions held.
(t) Compiling the monthly training record from the user department

38 At BLK Hospital, HR and Training Deptt acts as a very significant department managing and controlling the above listed functions. The training at the deptt is conducted by the Manager Learning and Development Mr Puneet Gupta,only the behavioural training for the Nursing Staff and the Billing staff is being organised .The key training focus areas are:-

(a) Soft Skills training
(b) Insight induction
(c) Communication skills
(d) Service Excellence
(e) Measuring Training Effectiveness
(f) Engagement Activites

39. The main training in the hospital is conducted only in the form of very short modules on selected topics. These modules basically have subjects of soft skills and behavioral training and are listed as under :-

(a) Business Communication -8 hrs
(b) Service Excellence – 4 hrs
(c) Interpersonal Skills 4hrs
(d) Quest for excellence -4 hrs
(e) Patient Centricity -4hrs
(f) Personal Grooming -4 hrs
(g) Handling Difficult Patients -4 hrs
(h) Team Building -4 hrs
(j) Insight Induction-8hrs
(k) Manager as a trainer-4hrs

Human Resource Department Initiatives

40**.** The major initiatives taken by the HR department include:-

(a) Orientation Session which involves welcoming of new employees, giving them a facility round of the organization so that they could get well oriented to the organization. It is followed by a brief presentation entailing the rights, responsibilities, organization policies, behavioral aspects, the organization rules and regulations which they need to adhere.
(b) Conducting Communication Skill training for Paramedical Staff and Nursing Staff.
(c) Planning and organizing Orientation Programme for all the new employees.
(d) Initiating and Planning Orientation Schedule for Management Trainees/ Interns in the organization.

(e) Coordinating for all trainings which take place in the organization.
(f) Maintaining the record for all the in-house and external training held in the calendar year like attendance record, training hours etc.
(g) Planning and drafting the monthly calendar and compiling the inputs from the respective user departments.
(h) Maintaining Feedback for the trainings held.
(j) Certification for the training sessions held.
(k) Compiling the monthly training record from the user department.
(l) HR Responsibilities (Nursing Recruitments)
(i) Filling of vacant nursing positions.
(ii) Maintaining the Walk- in status of nursing candidates, every Thursday.
(iii) Issuing Letter of Intent and closing the selected candidates

41. A number of initiatives have been taken by the HR department towards employees engagement, motivation and employee satisfaction, these include:-

(a) Connexions (monthly) Connexions, these are monthly cultural events. A host departments is detailed which performs for the hospital staff. A cake cutting ceremony is organized and employee recognition prizes are distributed.
(b) Employee recognition activity (monthly)
(c) Great Job Done initiative (continuous process)
(d) Birthday celebration (monthly)
(e) Bank help desks (weekly by bank of Baroda)
(f) Festival celebration like Holi, Diwali, Christmas Eid and New Year.
(g) Award of loyalty bonus.

42. In addition mails are sent to employees on every festival. Selected employees are invited from interactive session ‘’Choti si Mulaqat” motivational though of the day are displayed on the intranet and prominent places in the hospital. Regular employee satisfaction surveys are conducted. A wall of pride is made were photographs of best employee of the month is displayed.

ANALYSING CURRENT PATIENT DISCHARGE ACTIVITIES

Responsible Resources

43. It is important to understand who is responsible for what in the work environment to avoid mistakes, double processing, and missing activities. In this case, the job positions that are directly or indirectly connected with the discharge process are: the physician, clinical resource nurse, the nursing supervisor, the on duty nurse, the unit manager, the billing manager, the associate billing managers, admission clerk with the front office, the IT Department and the Med Supdt are kept in the loop .All the information is real time on the HIS Software after being marked for discharge by the physician during his round.

The Discharge Process

44. Currently, the discharge process at the hospital is well laid down in the SOPs and has an identified process structure. It is mainly witnessed as the point where the patient is ready to leave in a days time, and what needs to be done right before/after that. However there is a list of activities that happen well before that point in time. They directly influence

how the patients proceed through their stay. Each patient is unique based on the type and severity of illness, age, gender, social standing and multiple other factors. This can be misleading, and results in the perception that a generally common process cannot be defined precisely for all the in patients. What lacks is an understanding of what most patients go through under the sequence of involvement of those responsible resources.

Identifying the Discharge Process Sequence and Structure

45. A series of interviews of the staff responsible were conducted over a period of time. The collected information was used to form a picture of the sequence of the discharge process. Figure 3 shows a flow chart of the process when the patient undergoes a relatively simple discharge procedure. It includes certain activities common to all patients; however it does not encompass billing process and related activities. Right after a patient is admitted he is assigned a number and his details are put on the HMIS. An admission record sheet asking for certain information is filled out for the patient. One of the fields is the diagnosis, which gives an indication of the expected length of stay (ELOS) parameter. If the patient diagnosis falls under one of the clinical pathways that are defined by the hospital, then the patient's treatment is set off according to that pathway that has day-by-day instructions.

46. After the admission, a Multidisciplinary History and Physical Assessment are done mainly by the physician. It is a document that has a thorough general patient health analysis. The fields present in this document related to discharge are:

(a) Location the patient was admitted: home, rest/retirement home, long term care, complex continuing care, and others...

(b) Information of contact persons: the decision maker, family spokesperson, care partner.

(c) Living arrangement: who lives with the patient, the type of residence, the mobility status.

(d) Planned discharge destination.

(e) Expected date of discharge.

47. At the end of this document there is a section referred to as 'functional assessment' that is done for the purpose of determining if social workers (for HIV Cases) should be involved with this particular case. When the patient has almost completed treatment and recovery, the nurses after marking of discharge by the physician notify the patient that they will leave soon, and notify the family/ relative that they should pick up the patient on the day of discharge at assigned time. As per instructions, discharging patients in the morning time is recommended, since they at times have to travel long distances also billing charges for next day after 1200hrs is avoided. The process flow chart is as under:-

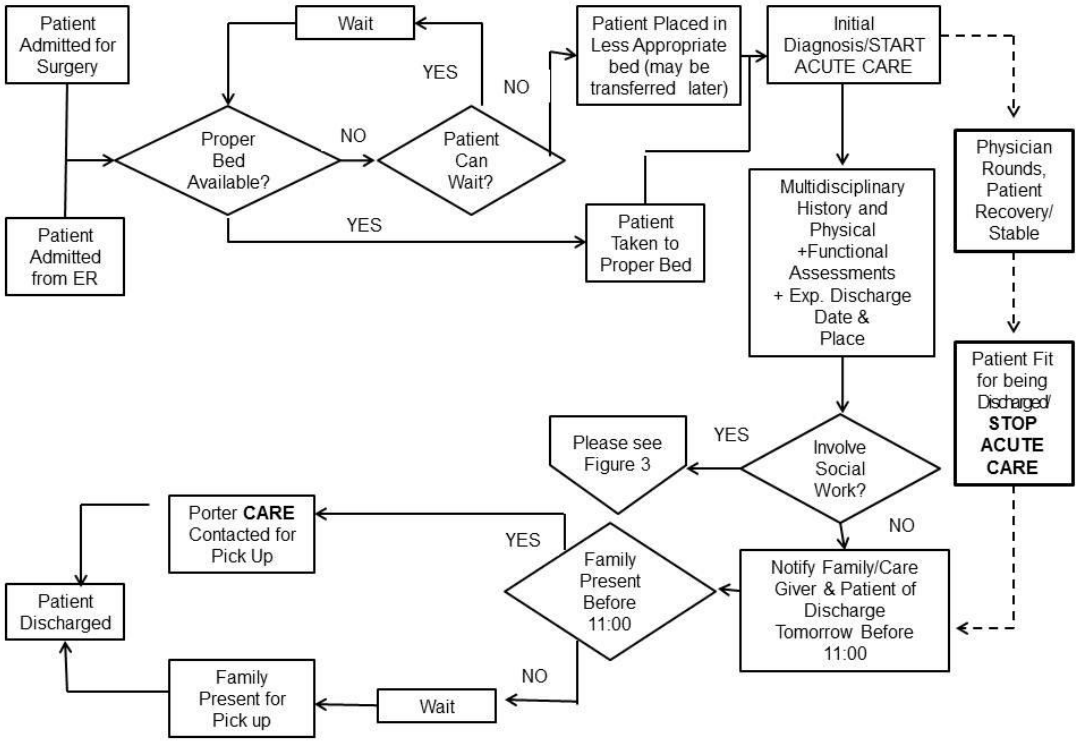


Figure 3: Patient Flow Chart - the Discharge Process

Activities after Discharge is Marked

48. The physician**/**consultant orders discharge of patient, his opinion of discharge is based upon the medical condition and medical parameters of the patient. This decision is often taken during his morning rounds and at times during evening rounds as well. The discharge may be pre-planned or impromptu. In most cases it is pre-planned and through continuous observation of patient by nurses and physicians.

49. In some cases where wards of patient demand immediate transfer to other hospital or leave against medical advice an impromptu discharge may be ordered. BL Kapur being a hospital providing tertiary and high quality of care is also suitably equipped and manned to provide tertiary care.

50. Transfers to super specialty facilities are very few but in very many cases patients are shifted to day care or to facilities/clinic in vicinity of patient residence. A very small number of patients obtaining treatment may not be able to respond to medical care and may die. Whatever may be the reason of discharge of a patient; his dues related to treatment are to be cleared.

51. In case of patient availing insurance/health schemes/corporate schemes, settlement of bill is continuously taken care as contractual obligations. In case of patient who are in the category of ‘cash paying’ a continuous financial advice is rendered by the department of billing and an endeavour is made to settle maximum of bills within 24 cycle.

52. A patient is marked for discharge on hospital HMIS by consultant/physician which initiates chain of activities as shown in Figure 4. The ward nurse updates patients’ record

files and these are collected and sent manually through a General Duty Person (GD) to billing office.

53. After the file reaches at billing office it is recorded and task distribution is done. In practice a GD collects the discharge files from 4-5 wards and brings them together. When a bundle of around 15 to 20 files reach the Billing Office it creates queuing at desks of Billing Executives leading to delays.

54. The bills are prepared by transporting information from the file of patient to HMIS, where it has been existing as such. On preparation of bills same are handed over to the relative of patient for clearance and in case of Third Party Agency to their agents (physically/on line).

55. Cash bills are settled by payment of liquid cash or electronic transfers and credit bills get settled as per contractual protocols. Many times, relatives of cash paying patients tend to raise objections to bargain a concession on the final bill, this is almost a routine event. This activity is not recorded but definitely contributes to delayed settlements and delayed departure of patients from hospital premises leading to disguised bed occupancy.

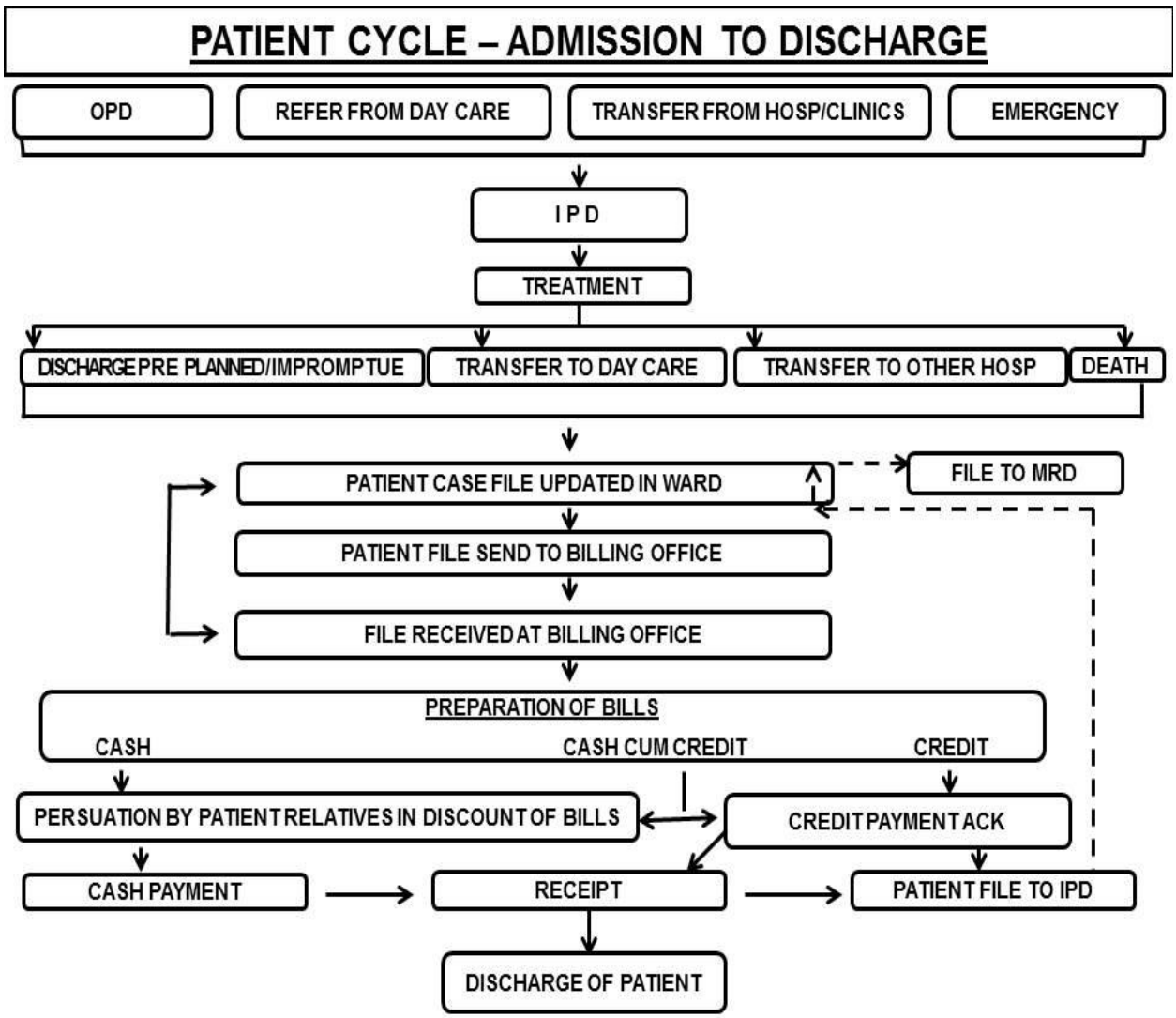


Figure 4 - Activities Post Decision of Discharge

COLLECTION AND ANALYSIS OF DATA – TIME RELATED ACTIVITIES

Data Collection

56. In order to reach at the root of the queuing problem at billing office and to understand delays in billing process there was requirement of obtaining adequate data, pertaining to time related activities of the discharge process in BLK Hospital. There was observable and conspicuous increase in activity around 1200hrs and the intensity continued till almost 1700hrs. To confirm and support this observation there was need to collect unbiased authentic data free from individual biases. As data required to analyses process, therefore it was most appropriate to obtaining data that got generate in the process itself. Though entire data was available at billing office as part of HMIS yet it was not generated at billing office itself. The generation of the data in the process required involvement of functionaries at respective wards (nurses and physicians), clerks and cashier at billing office and support of HMIS to record events on occurrence and register them at their designated destination.

57. Initially the data was obtained only for month of Jan 2015 and on basis of preliminary analysis data for quarter ending Mar 2015 was obtained.(Gen + data collection)

58. The data has been collected from billing office, which is near the front office in BL Kapur hospital Delhi. This data pertains to discharges that have taken place in quarter ending 31 Mar 2015. It despites a latest trend as available in the hospital and become relevant in regards to intervention in interval processes and protocols. The analysis of data, related inferences and recommendations may find their applicability in other corporate hospitals. The recommendations that may spring from analysis of data of BL Kapur Hospital may not be sacrosanct yet possibility of their advantageous advantages gained cannot be wished away.

59. Entire data obtained is a secondary data available on records and is related to factual events which are totally devoid of any biases of subjects, data collector or analyses.

60. The data collected has been generated in BL Kapur Hospital occurrence of related events in chain of hospital discharge process starting at the time decision of discharging a patient has been taken and recorded against his name and identification and finally culminating at clearance of bill and disposal of patient as per discharge remarks.

61. The original data contained u/m fields against each patient record:-

(a) Registration No.
(b) Encounter No.
(c) Patient Name.
(d) Sponsor Name.
(e) Payment Type.
(f) Marked For Discharge By(Consultant Dr).
(g) Mark For Discharge Date.
(h) Mark For Discharge Time.
(i) Mark For Discharge Remarks.
(j) Send For Billing By(Ward Nurse).
(k) Send For Billing Date.

(l) Send For Billing Time.
(m) Send For Billing Remark(Discharge/ Day care / death).
(n) File Received By (In Billing Office).
(o) File Received Date (atBilling Office) .
(p) File Received Time.
(q) Bill Ready By (Name of Person).
(r) Bill Ready Date.
(s) Bill Ready Time.
(t) Send For TPA By(Name of Person).
(u) Send For TPA date.
(v) Send For TPA time.
(w) Invoice Created By(Name of Person)..
(x) Invoice Date.
(y) Invoice Time.

Data Refining and Problem Identification.

Data Refining

62. The first step taken towards refining the data was removal of names of patients from the list to maintain confidentiality. This removal has affected over analysis in no way what so ever; in fact it has contributed to impartiality to some extent, however small it may be. The additional fields generated to calculation time differentials

63. The data was objectively corrected and refined. A very simple and rudimentary approach was adopted towards data refinement and correction. It was done in steps in tune with patient turn over cycle (Refer Figure 4) .The shape of consolidated data after removal of undesired fields and used for analysis in SPSS Ver 16.0 is as under mentioned:-

(a) Registration No.
(b) Payment Type.
(c) Mark For Discharge Date.
(d) Mark For Discharge Time.
(e) Mark For Discharge Remarks.
(f) Send For Billing Date.
(g) Send For Billing Time.
(h) Send For Billing Remark(Discharge/ Day care / deadth).
(i) File Received Date (atBilling Office) .
(j) File Received Time.
(k) Bill Ready Date.
(l) Bill Ready Time.
(m) Invoice Date.
(n) Invoice Time.
(o) Time Taken for Bill Preparation Cash.
(p) Time Taken for Bill Preparation Credit.
(q) Gap Between Bill Clearanceand File Received.
(r) Gap Between Bill Clearance and Mark for Discharge.
(s) Gap between file marked for discharge and received at Billing Office.

Data Improvement

64. As part of the Summer Training last year and this year's dissertation visits were made to different departments. During these visits it was observed in billing office that there were queues and commotion of activities ranging from relative of patient haggling over discounts to tracing a patient file not getting recovered readily. That was the starting point of observation and analysis that passed away for further probe and enquiry. The data of Jan 2015 was analysed using SPSS Version 16.0. On subjecting this data to compare means of paired samples results as given in Table 3 were indicative of strong correlation and significance. The mean time when file of patient marked from discharge is 12.55 hrs with stand and deviation of approximately 3 hrs. The mean time of patient file send for billing is 13.26 hrs with standard deviation of approximately 3 hrs (2hrs 55 min)

Table 4 : Means of Timings of Discharge Decision and Receipt of file in Billing office (Jan 2015)

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Dis_tm_mark	12:40:00.368	1305	02:44:46.203	00:04:33.668
	file_rcd_tm	13:35:36.874	1305	02:36:21.735	00:04:19.704

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Dis_tm_mark&file_rcd_tm	1305	.907	.000

Paired Sample Statistics.

Table 4: Means of Timings (Data of Jan – Feb 2015)

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Mark for discharge time	12:55:09	2766	03:01:50.130	00:03:27.445
	Send For Billing Time	13:26:23	2766	02:55:25.200	00:03:20.126
Pair 2	Send For Billing Time	13:19:24	2548	02:52:52.520	00:03:25.487
	File Received Time	13:40:31	2548	02:49:26.883	00:03:21.413
Pair 3	File Received Time	13:40:31	2548	02:49:26.883	00:03:21.413

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Mark for discharge time	12:55:09	2766	03:01:50.130	00:03:27.445
	Send For Billing Time	13:26:23	2766	02:55:25.200	00:03:20.126
Pair 2	Send For Billing Time	13:19:24	2548	02:52:52.520	00:03:25.487
	File Received Time	13:40:31	2548	02:49:26.883	00:03:21.413
Pair 3	File Received Time	13:40:31	2548	02:49:26.883	00:03:21.413
	Gap Between Bill Clearance and File Received	00:00:11	2548	00:01:21.798	00:00:01.620

Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Mark for discharge time & Send For Billing Time	2766	.954	.000
Pair 2	Send For Billing Time & File Received Time	2548	.989	.000
Pair 3	File Received Time & Gap Between Bill Clearance and File Received	2548	.000	.997

65. Table No 4 is indicative of strong correlation (correlation of 0.954 between the time file is marked for discharge and the time it is send for discharge. The evidence of delayed decision in discharging the patient is cogent and strong and so is the delay in transit of files from wards to Billing Office. Mean delay calculation from aforesaid means is approximately half an hour (13.26 – 12.55). On comparison of results against Pair 2 , on an average 20 minutes are spent in file movement from ward to billing office.

66. The billing cycle in hospital is starting and ending at 1200hrs during noon has its implications on availability of beds and patients turn over. Various studies have shown that ideally discharge decisions must get finalised by 1100 AM and billing/clearance should be completed within 30 min; so that patient gets out of ward by 1130 AM thereby allowing hospital staff to prepare the bed to receive a new patient. However in India average time taken between the decision to discharge the patient and his bill clearance taken approximately two and half hours.

67. After this problem has been identified, deeper analysis was conducted to see whether there was a difference in the level of accuracy of information coming from month to month accordingly data for entire quarter was obtained and analysed.

Software for Analysis

SPSS Ver 16.0 and MS Excel (2007) have been used for analysis.

Analysis of the Data

Marking Patient For Discharge

68. In the discharge process the first and fore most event that kick starts other subsequent activities is marking the decision of discharging the patient in HMIS of the hospital. There was no requirement of collection or refinement of this data and it was analyzed with SPSS Ver 16.0.The histogram generated depicts No of Cases (frequencies) on y – axis and timings of day (on 24 hourly cycle) on X-axis.

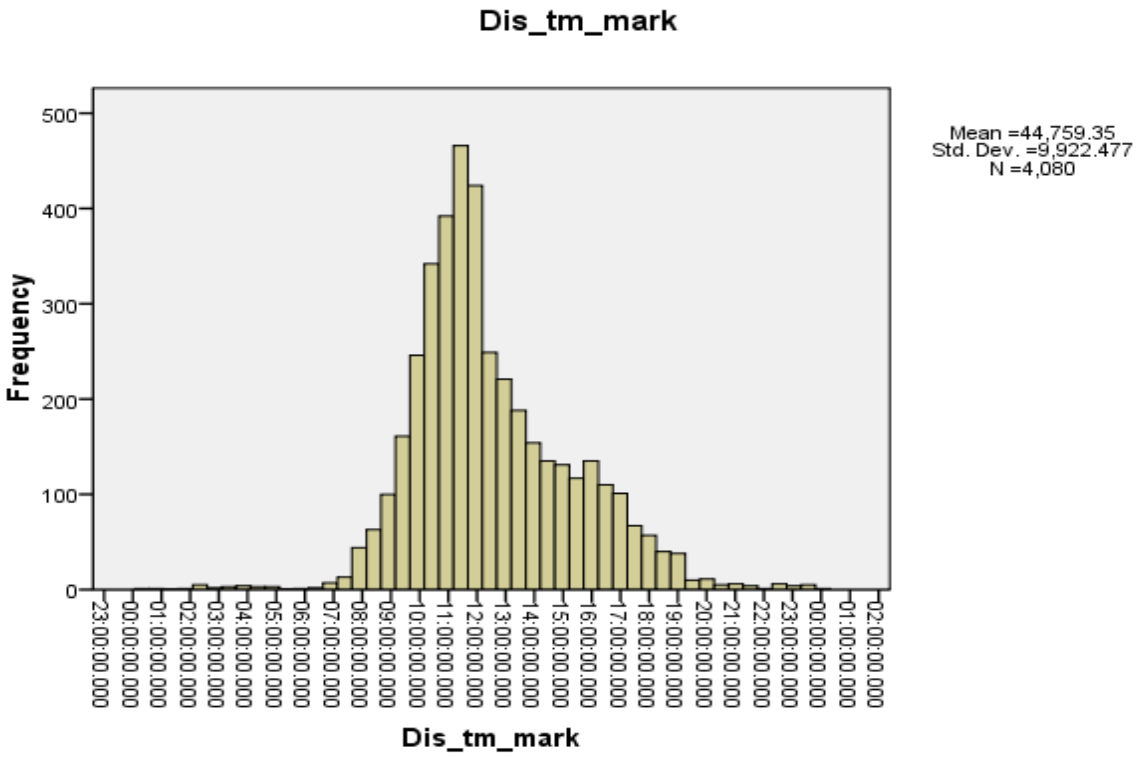


Figure 5 : Timings of Patient Marked For Discharge in Ward

The above histogram depicts frequency of discharges marketed in patient file as per timings of the day. As can be seen that negligible discharge decisions on taken between 1930h to 0730h. Majority of discharge decision are taken from 0900h to 1700h (over 100) and peak time for this decision window is from 1000h to 1200h.

Inference. The window of discharge decision lends itself to patients remaining in occupation of beds beyond 1200hrs of the day. This results in avoidable bed occupancy and commitment of hospital resources which are much to the disliking of patient relatives as well as to hospital management, alike.

Receipts of File at Billing Office

69. The time as recorded against each patient was taken and it was made to undergo two processes of analysis. One to generate a pattern of receipts of patient files marked for discharge in relation to the timings of the day. The second was to observe time differential or time lag between the time a patient was marked for discharge and his file was received in the billing office. SPSS 16.0 and M S excel software has been used to generate histograms, calculate time differentials in aforesaid events and to draw out average lag time between decision taken to discharge and initiation of discharge process after receipt of file at billing office..

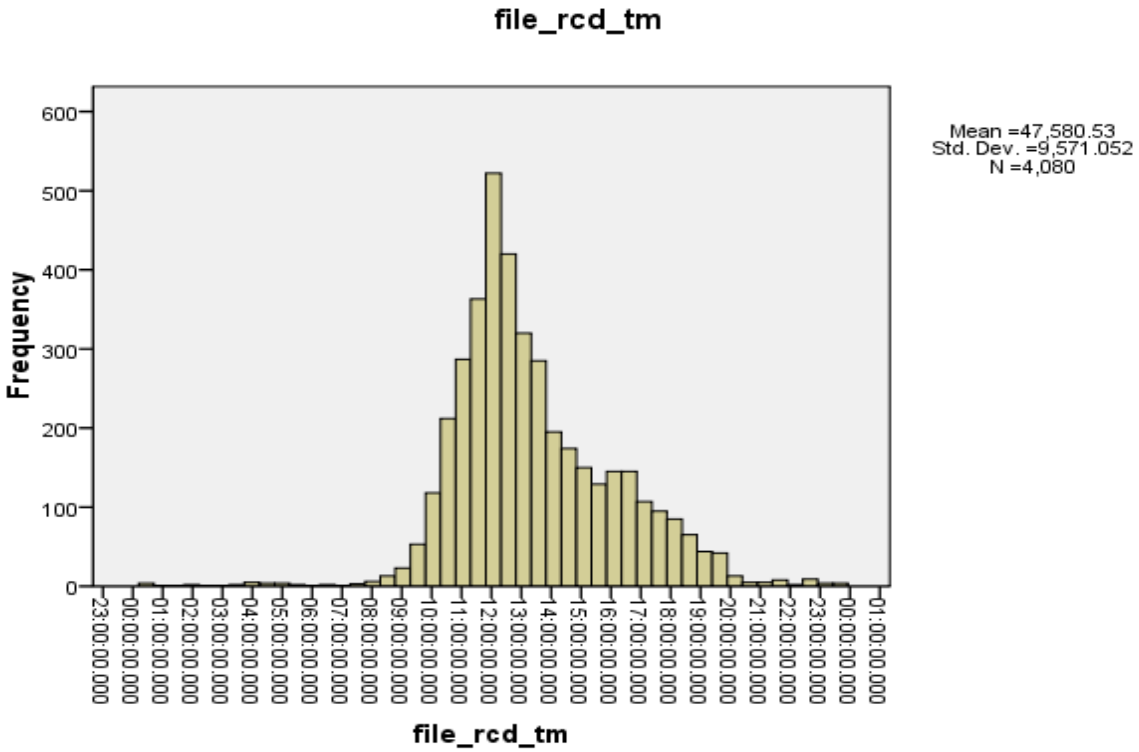


Figure 6 : Timings of receipt of Patient Files in Billing Office

70. The above histogram bars depict frequency of files received in Billing office during different ours of the day . These files are received after their dispatch from different IPD wards subsequent to patients marked for discharge. The receipts are negligible from 2000h to 0800h and there are significant No of files (>100 received from 1000h to 1730h). The peak times in which over 300 files are received is from 1130h to 1330h.

Inference In reference to the figure there is an apparent time lag between decision taken to discharge a patient and receipt of file in billing office. This delay can be well managed and reduced to nil by correct application of Hospital Management Information System(HMIS).

Time Taken For Preparation of Bills

71. The data as it was recorded with hospital was taken ipso facto and no alternation was made. It was analyzed to observe the work load on Billing office as per timings of day and the frequency of bills generated in hourly slots. Use of SPSS 16.0 and MS Excel was made to generate histograms and bar charts. While analyzing this data need was felt to segregate cash paying and credit paying patients. Accordingly filtering was resorted to refine this data by way of sorting it using filter in MS Excel. There were cases that were marked both for cash and credit in accordance with theirrespective health insurance policies and same were counted towards both i.e. cash as well as credit. There was no feasibility of separating them by creating fiction. The data as applicable to recorded facts was taken and sorted for intended analysis.

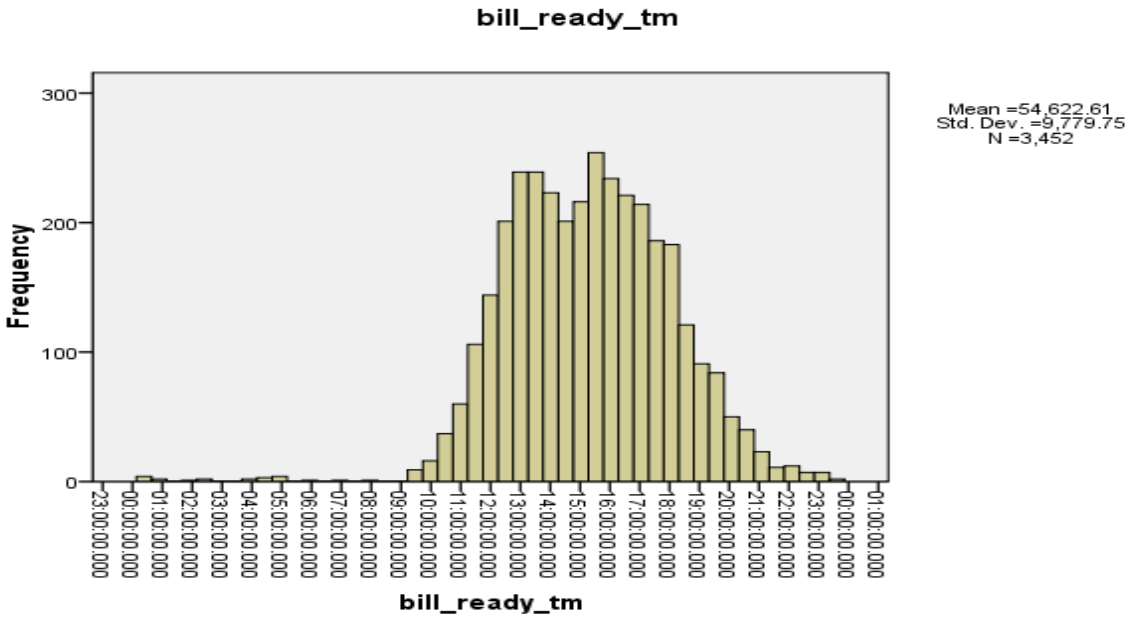


Figure 7 : Timings of Making Bills Ready for Delivery at Billing Office

In this figure frequency of preparation of bills in billing office is negligible between 0900hours to 2330hours However there is significant increase (>100) between 1100hoursto 1930hours. Peak activity (>200) in bill preparation is from 1200h to 1730 hours.

Inference The timings of significant activity in billing office are from 1100hrs to 1930hrs and the peak activity timings are from 1200hrs to 1730hrs . This has implications related to commitment of resources of manpower and automation. Max No of bills get prepared after 1200hours and the process is contributing to delayed discharges, requiring urgent intervention to save precious hospital resources translating in costs incurred by patient and the hospital.

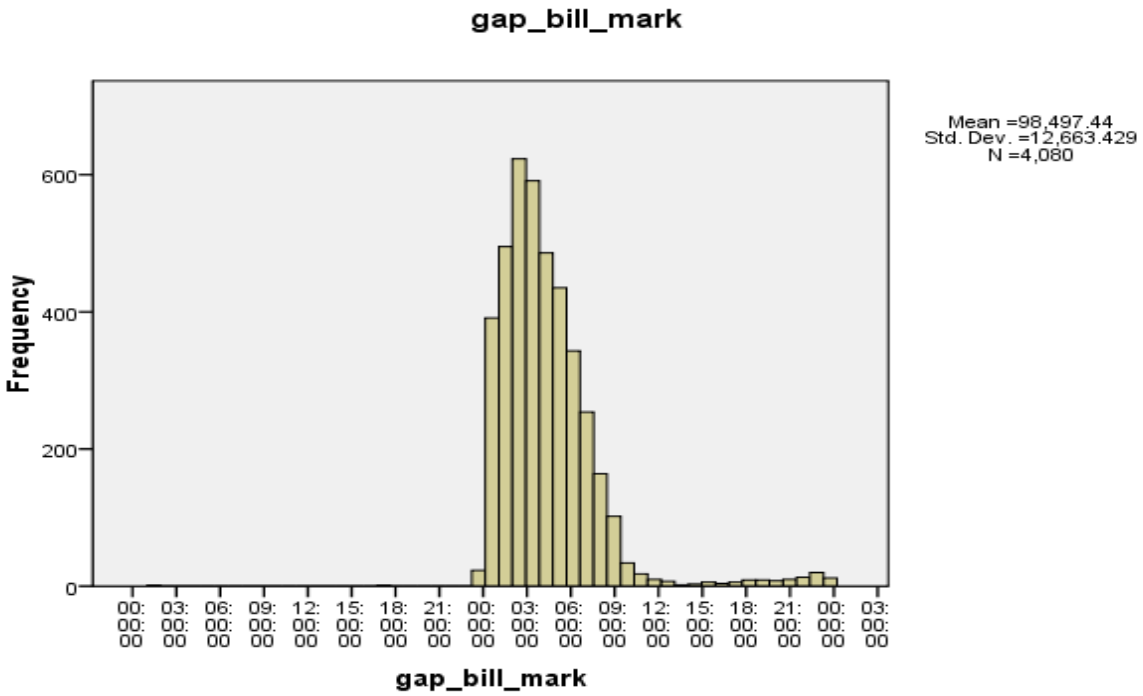


Figure 8 Time difference between Patient marked for Discharge and Preparation of Bill

Inference The acceptable delay in discharge being 03hrs much acceded by the time bills are prepaid for patients marked for discharge. To discharge patients by 1200 hrs there is a need to review entire discharge process holistically.

Time Taken to Prepare Bills for Cash and for Credit

72. There were patients that were marked for cash or credit or both under their billing remarks. For eg a patient marked for cash only had a blank space under credit column. This required filtering and using MS Excel cases of cash bills and cash/credit bills were filtered to obtain un ambiguous number so that correct averages are obtained. Similarly credit and credit cum cash cleaning cases were sorted out separately. This helped in analyzing average time taken in preparation of cash bills and credit bills.

Time Taken for Preparation of Cash Bill

73. The data analysis shows that more than 1/3 of total cash bills are prepaid within 45 minutes of receipt of file. Over 100 cases get cleared within 05 hrs. There are less than 50 cases which get prepared in almost 09hrs.

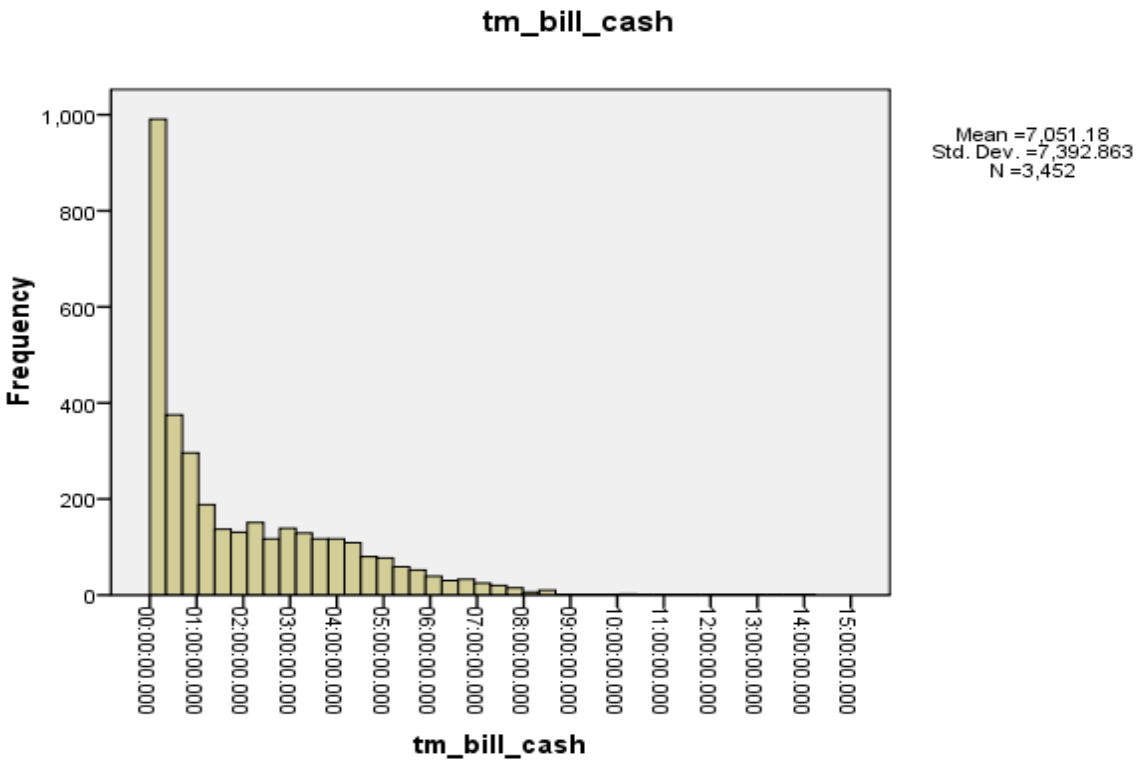


Figure 9 : Time Taken for Preparation of Cash Bill

Inference It is a case for introspection for such a significant time being devoted to preparation/finalization of case bills. These are cases where bill are overlapping cash and credit clearance.

Time Taken for Preparation of Credit Bill

74. More than half of bills get prepared within 30 minutes of receipt of files marked for discharge. In over 100 cases files get cleared with final bills in 2hours 30minutes

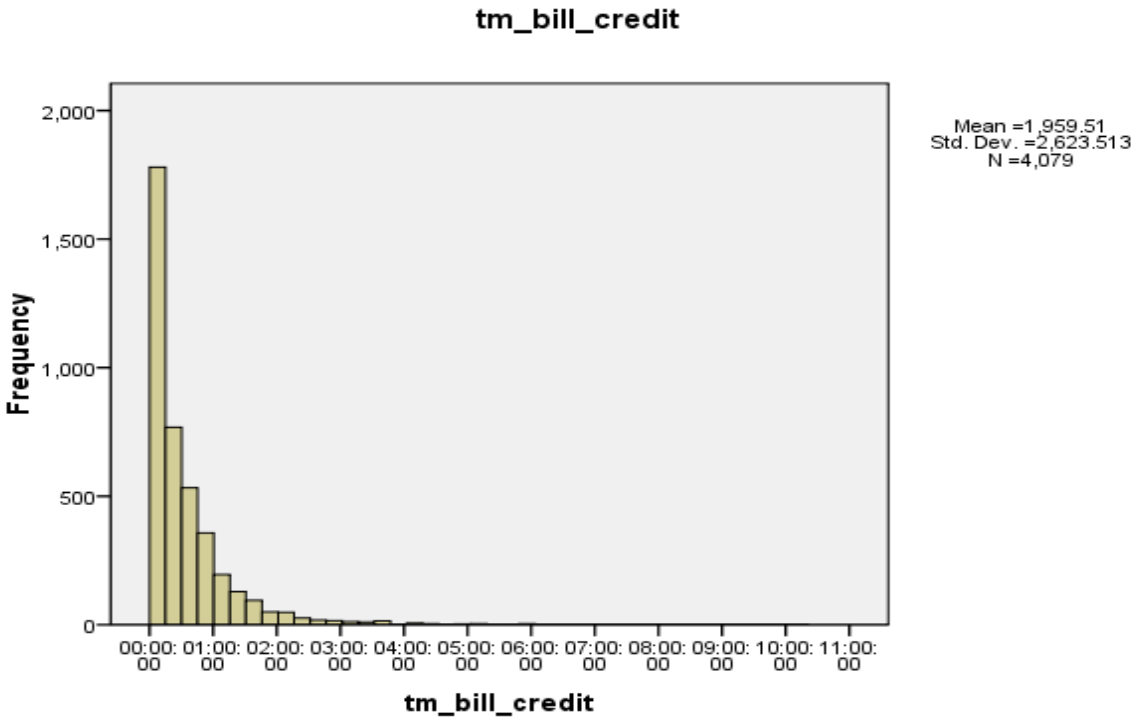


Figure 10 : Time Taken for Preparation of Credit Bill

Inference There is scope for reducing this time in preparation of bills. However in comparison to Figure 9 billing in credit is surprisingly faster than cash bills.

Time Taken for Move of File and Preparation of Cash / Credit Bill

(a) Receipt of file There is average delay of over 45 minutes receipt of file in billing office after decision of discharge has been taken by consultant.

(b) Cash bills The average time taken at billing office in preparation of cash paying bills is almost 70 minutes. This is in addition to time spent in receipt of file stated afore.

(c) Credit Bills Average time taken in preparation of Credit Bills is 30 minutes

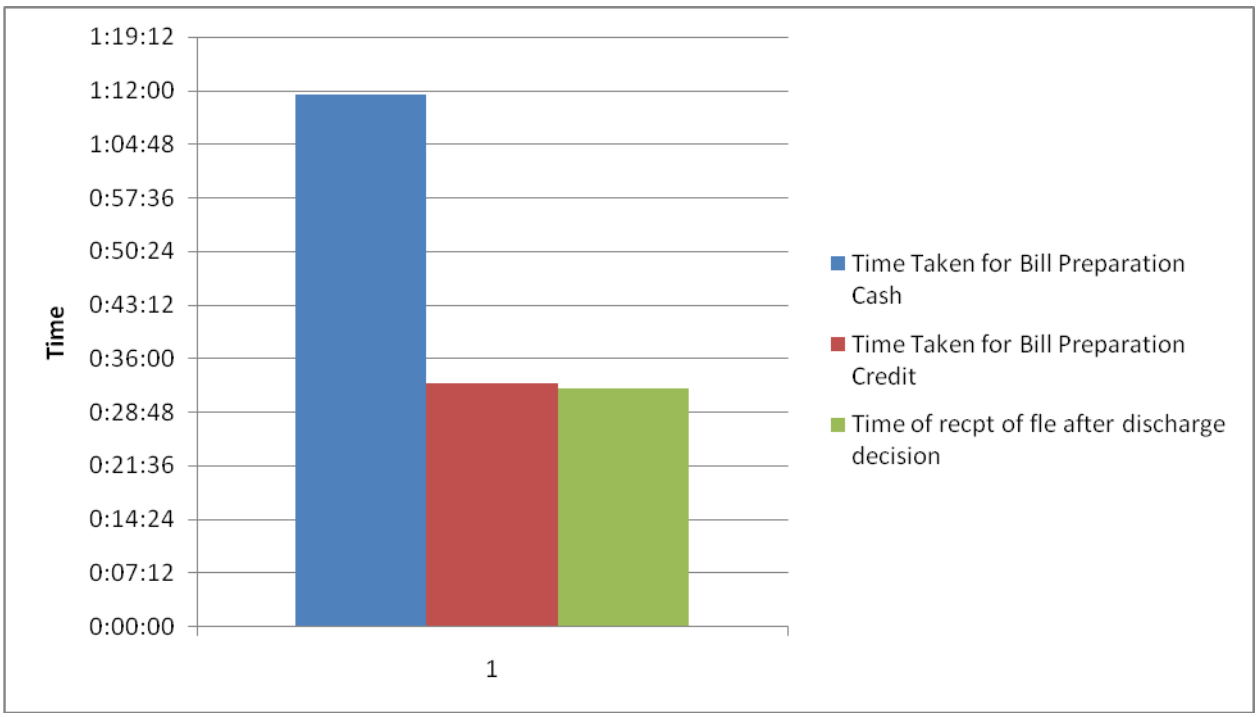


Figure 11 : Time Taken for Move of File and Preparation of Cash / Credit Bill

Inference In an automated environment bars as shown in figure can be made to vanish or reduced significantly to less than15 minutes

Timings for Clearance Of Bills

75. This data was obtained as was recorded. It was recorded in real time of 24 hourly cycle. This data was analyzed without any refining process on SPSS and during the analysis need was felt to draw out time taken for entire discharge process i.e. time when case marked for discharge and time when bill is cleared. This differential of time generated another field which helped in analyzing average time taken in clearance of cash and credit bills. Tools used for analysis are SPSS 16.0 and MS Excel

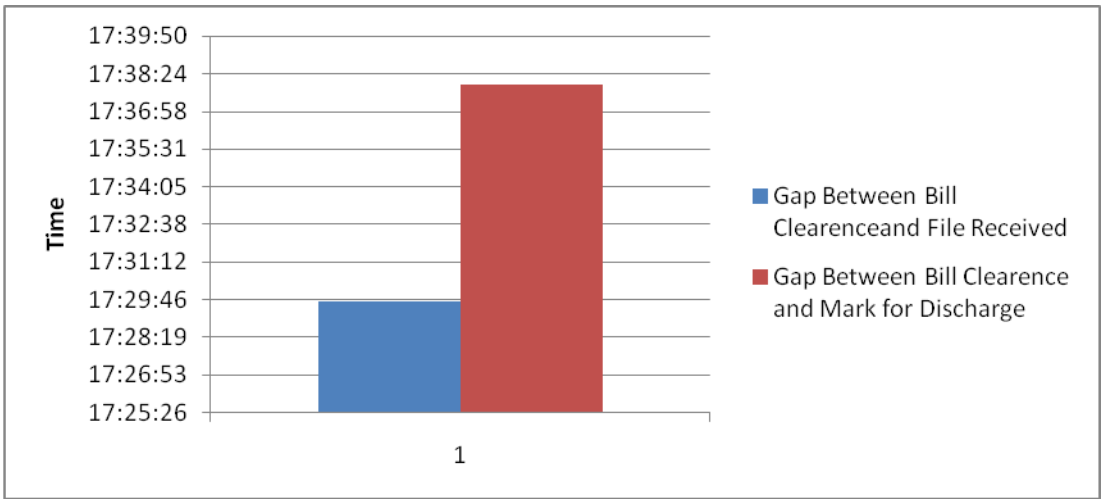


Figure 12 : Average Timings of Bill Clearances and Entire Discharge Process

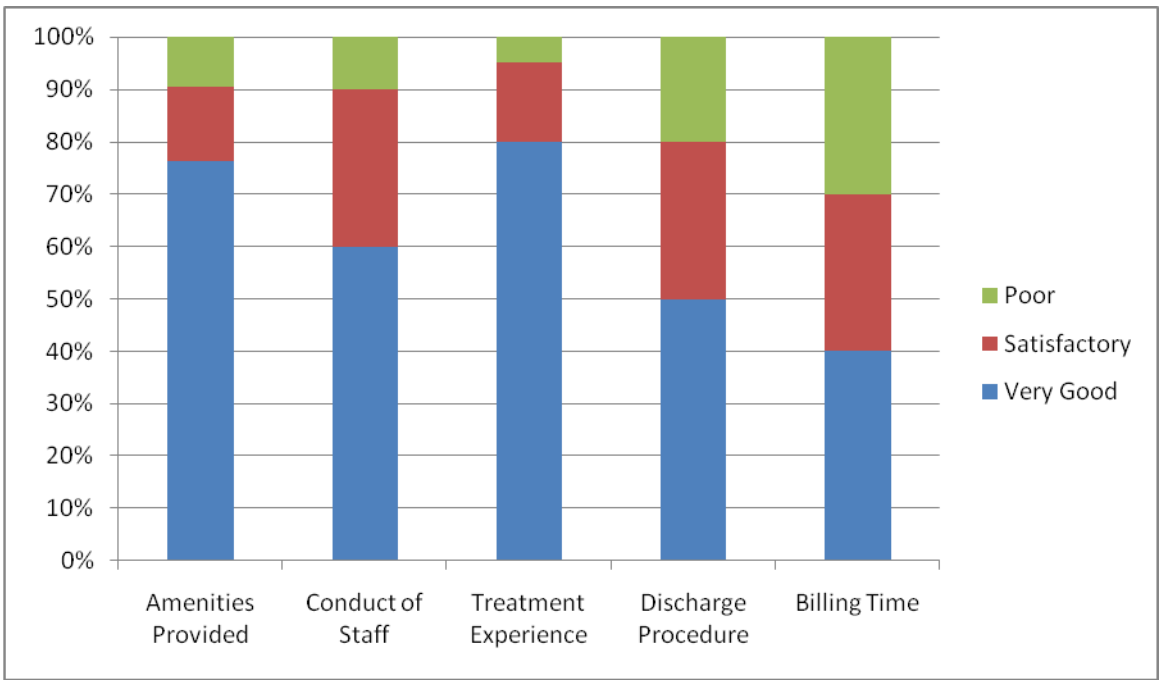
76. This fig depicts average times taken for entire discharge process up to settlement of bills (Refer Figure 2.8). It takes almost 17 hours 30 minutes to clear all dues related to a patient where payment are made by credit. For cash payments this time is even greater by 10 minutes.

PATIENT SATISFACTION RESULT

77. Patient satisfaction is an important indicator for analyzing the quality of care and hospital procedures. At any time there could be many satisfaction and non satisfaction areas of the hospital which largely depend on a large number of factors like amenities available, treatment experience, waiting time and the conduct of the staff.

78. A total of 100 IPD patients (awaiting discharge formalities) were questioned on various days / timings. This questionnaire was given at the Nursing Station as well as the billing area. The questionnaire had 20 questions comprising of two sections. In section 1 General Questions and Section 2, questions specific to feedback and the timings. The sample questionnaire I attached as per Appx 'A'.

LEVEL OF SATISFACTION - IPD PATIENT AWAITING DISCHARGE



Summary. The summary of the findings are as under :-

(a) 50% of the patients were satisfied with the time taken for file preparation (60 to 90 min) balance experienced a time lag of more than 90 min till they were finally able to leave the Hospital.

(b) Only 50% of the patients were satisfied with the discharge procedure and experience. According to them it was time consuming and lacked coordination between the Nursing Department and the Billing Department.

CASE ANALYSIS.

79. Cases were picked up at random on five different working days and followed from the beginning of marked for discharge by the physician till the final clearance of the bill. The aim was to get a holistic view of the discharge process and the time frame also this would help in corroborating the findings.

The sequence of the activities and the timings taken are depicted as under :-

Ser No	Activities	Time Mkd for Disch	Docu sent to Billing	Prep of Bills	Negotiation	Clearance of Bills	Delay/Remarks
1.	Case 1	0830h	1000h	1030h	1130h	1400h	3 hr
2.	Case 2	0930h	1100h	1145h	1300h	1430h	3 hrs, 30 min
3.	Case 3	1930h	0900h	1030h	1130h	1200h	On next day
4.	Case 4	2130h	0900h	1030h	1145h	1200h	-do-
5.	Case 5	1200h	1400h	1500h	1630h	1630h	4 hrs, 30 min

What has been attempted to answer through this analysis is nothing more and nothing less than finding scope for improvement in discharge process which may result is better efficiency of hospital.

CHAPTER – V : RECOMMENDATIONS

General

80. The recommendations on the study are covered in two phases. In phase I recommendations on the procedural aspects are discussed and in phase II specific to identification of the training needs. It is felt that rectification of procedural errors by the top mgt is a prerequisite which should be followed by the inclusion/deletion of the training needs. This will go a long way towards the improvement and streamlining the discharge process and ultimately would lead to quality enhancement and better patient satisfaction.

Phase I.

81. The procedural flaws in the discharge process needing deliberation and rectification are enumerated in the succeeding paragraphs.

82. **Discharge Decision.**

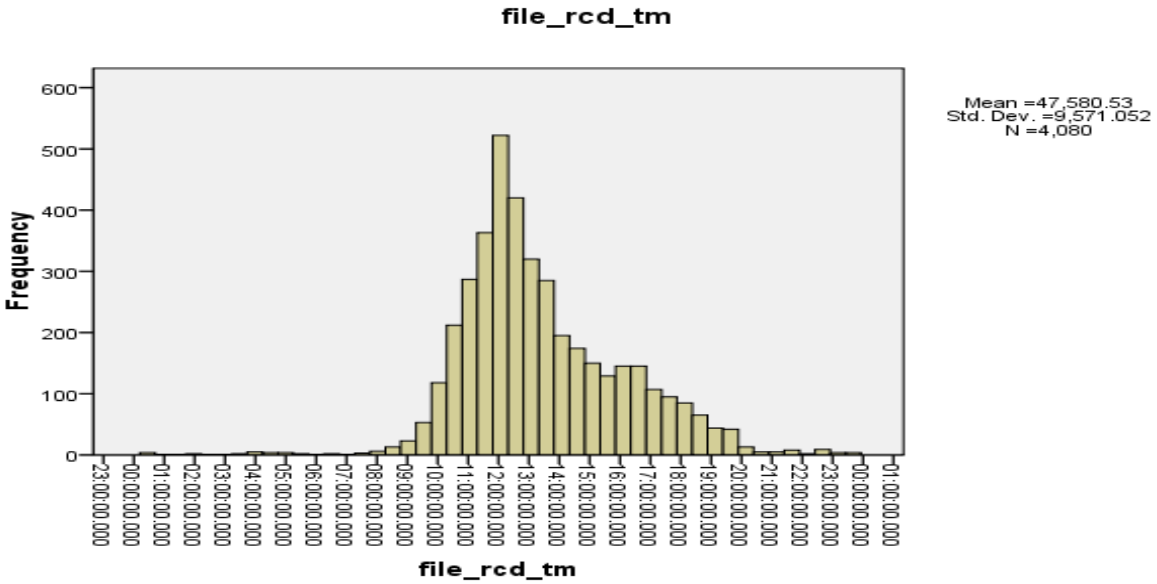


Figure 14 : Timings of Patient Marked For Discharge in Ward

83. A very small number of discharge decisions are taken in non-working hours of the day. There are very few decisions taken to discharge patients in window of 1930hr to 0730hr. Since maximum decisions of discharge are taken in period of 1000hr to 1200hr the discharge process inevitably spreads to billing cycle of the next day. This leads us to draw two inferences for hospital one is to prepone the decision making of discharging a patient and other is to postpone timings of billing cycle from already existing time of 1200hr to the altered time of 1500 hr. This change of time will have its impact on other functions of the hospital therefore a balanced decision by the mgt needs to be arrived at with diligence and deliberation.

Prepone Decision Making

84. This can be achieved through selective delegation of decision making authority by the involvement of subordinate doctors and the nursing staff. It is suggested that prelim recommendations on discharge of a patient can be made by the nursing staff attending the patient and same may be concurred / averred by resident doctors. The consultant/physician treating the patient may be posted of such recommendations that may help him in early decision. The discharge process can be halted if consultant opines further stay. Ideally discharge decisions must be finalized prior to 1000hr for all patients requiring discharge on that given date.

Reduce Delay in Communication

85. During the round of consultant in the ward decision to discharge a patient are made by assessing physiological condition but same is not recorded/communicated on HMIS for others in real or near real time. This avoidable delay can be reduced by making use of Wi-Fi devices and the HMIS software. The current protocol of restricted access to the HMIS also needs deliberation.

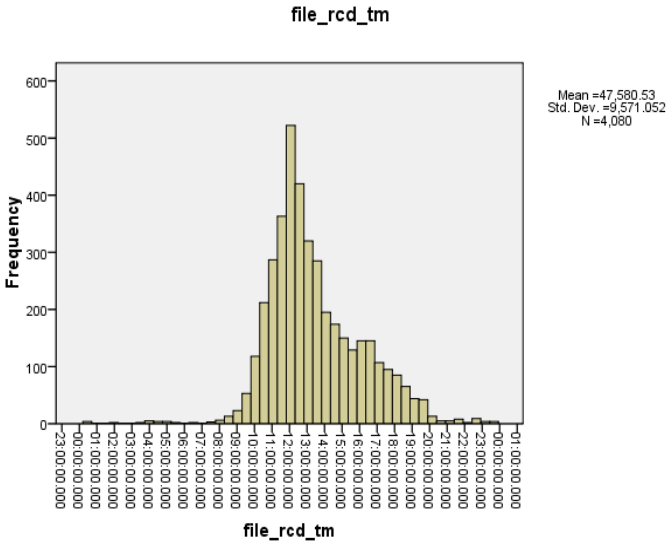
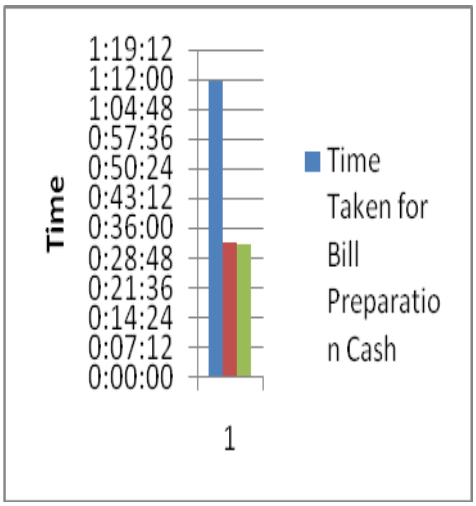


Figure 15 : Timings of receipt of Patient Files at Billing Office.



Movements of Patient File

Figure 16 : Time Taken for Move of File Preparation of Cash / Credit Bill

86. There is considerable time lag between decision taken to discharge a patient and receipt of his case file at billing office. Once decision has been marked on system (HMIS) the requirement of sending file to billing office is purely a wasteful activity which consumes precious time and also fritters away valuable resources of the hospital. On an average there is a delay of more than 45 minutes in initiation of the billing process after discharge decision is marked / recorded. To reduce this time relevant information can be shared with billing office on HMIS. Physical movement of the file is fraught with risks of its misplacement and it falling into hands of unauthorized person. (in some cases , the patient file had over writings, related to treatment administered to patients. Such files were within easy accessibility of relatives of patient approaching to avail concession. Photographs taken of such over writings have great potential of causing insurmountable

embarrassment to hospital by inviting legal suits of negligence against the hospital or its employees).

87. There are avoidable delays in processing and preparation of cash as well as credit bills. Considering average delay in receipt of files at billing office to be 45 min it takes more than an hour for a credits bill to be prepaid. In case of cash bills it takes even more up to (average) 1hr 45 min. Ideally these timings can be reduced to 15 to 30 min by correct application of software and refining of discharge process and protocols.

Clientele Categorization

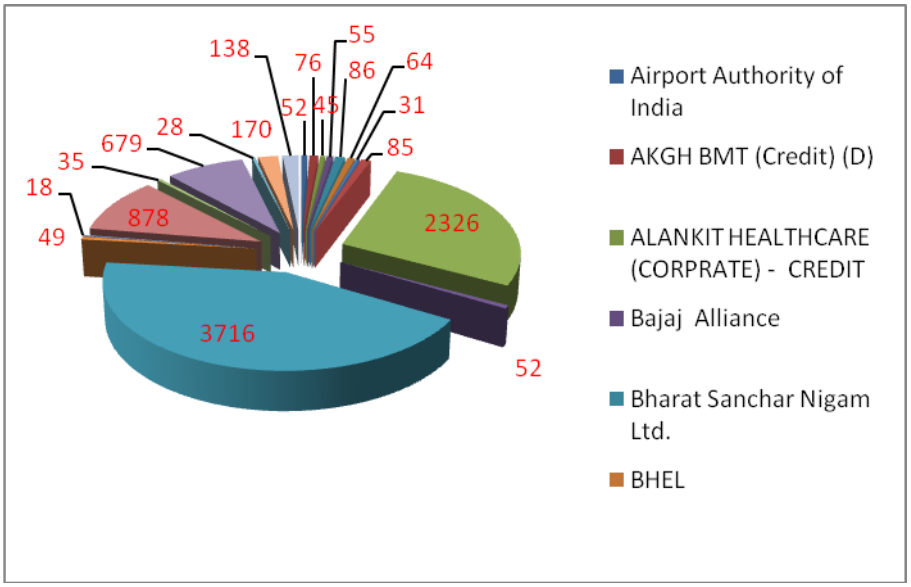


Figure17: Categories of patients admitted

88. It depicts share of clientele proportion getting admitted/discharged from the hospital. Major proportion is taken by departments/organization of government (incl CGHS/ECHS) followed by cash patients. The data can be sorted and filtered as per requirements and can help draw the billing strategy / correction validation of same.

Death Rate

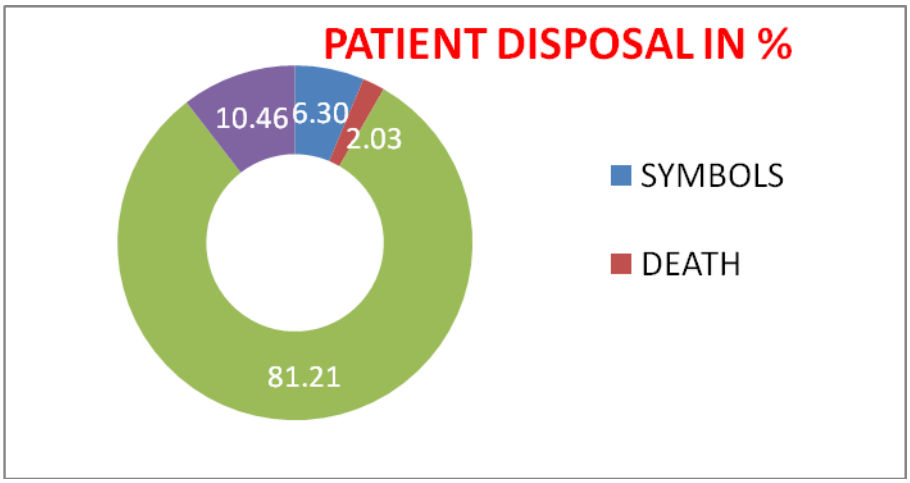


Figure 20 : Disposal of Death Cases

89. There are 2% death cases in the hospital on an average; these are mostly patients undergoing tertiary care. The billing proc needs redefining for these cases. Compassion, urgency and conduct of the staff is important considering the emotion and trauma of the relatives.

Summary of Recommendations in the Procedure.

90. The recommendations are based purely on analysis of data, supplemented with personal observation and interaction with the patients and their relatives. These are intended to bring greater efficiency in the management functions towards improving the discharge proc and likely to translate to better patient satisfaction.

Prepone Discharge Decision

(a) A preliminary discharge decision by doctors subordinate to the treating physician may be taken to initiate the billing process. Involvement of nurses will help in better decision process.

Physical Movement of Patient Records

(b) These be replaced by sharing information on HMIS which will be near real time and translate into net saving of 30-60 min and also eliminate the duplication of work and resources committed in physical handling of patient files.

(c) **Improvement In Communication Of Discharge Decision** This can be made near real time by imaginative use of technology available in the hospital.

(d) **Review Staffing Pattern In Billing Office** This can be made commensurate to work load.

(e) **Bill Preparation** The preparation time can be reduced to below 15 minutes by exploiting software of HMIS.

(f) **Seperate Strategy** By analysis of quarterly data of Government / corporate/TPA patients, separate billing strategy can be reviewed or validated.

Phase II

91. The recommendations for inclusions in the trg curriculum for stream lining the discharge proc are discussed as trg initiatives/actions to be taken to meet the organization level trg needs and the indl trg needs. The organization level trg initiatives/needs recommended are as under :-

Preparatory Activities.

(a) At the organization level a trg team is recommended to be set up under the Manager L & D as part of the over all '**Staff Development Programme'.** This team will comprise of a trg cell and a databank/library. The existing trg hall near the HR department could be converted into the trg team cell/library.

(b) The trg should be organized at par with the hospitals vision, mission, be patient centric and be under the gambit of the NABH guidelines. A six monthly trg

cycle pgme should be prepared, documented and budgeted well in advance by the HR deptt.

(c) The focus of the trg should shift from the current 'better management' to 'better patient care'.

Activities

92. The following trg may be organized at the organization level :-

(a) **Inter departmental Coordination** :-

(i) Lay down the qualitative requirements and the time schedules to be adhered in the SOPs.

(ii) Develop a "Simulated CBT package" with real time HMIS platform, depicting of patient movement and document movement.

(iii) Incorporation of HMIS (which will be doctored in the package)

(iv) Conduct of joint IT eqpt and HMIS classes for the billing staff and the nursing staff.

(v) Joint mock trg of the deptt with the trg team as the control.

(vi) Contin plg trg for situations like patients leaving the hospital with his docu and confrontation like situation during bill clearance. These situations should be incl in the contin plg trg.

(b) **Reporting Procedure**

(i) Trg on generation of real time reports at the end of each shift.

(ii) The med supdt, nursing supdt, nursing supr, billing mgr, front desk and IT deptt should be part of online reports addressees.

(iii) The existing HMIS platform needs improvement/updation in auto generation of reports and auth of access to the staff involved in the process

(c) Laying down a well defined evaluation procedure as part of monthly appraisals and yearly appraisal done on 31 March every year. The level of education and trg stds achieved and levels of patient satisfaction (after taking oral and written feedback) should from part of evaluation process.

(d) Patient feedback drop boxes at nursing stn and billing deptt may give insight into genuine problems faced by the patients.

(e) **Evaluation Indicators** Certain evaluation indicators which could be part of the appraisal process are :-

(i) Education and trg levels achieved

(ii) Practical skills (IT skills, handling telephone, HMIS, Communication).

(iii) Patient handling and satisfaction.

(iv) Coordination with other deptt and team work.

(v) Handling of difficult situations.

(vi) Adherence to standards protocols, proc and laid down timings.

(f) The duration of organization level trg should be of one day duration with first half devoted to refresher modules, talks, experience sharing and second half to a simulated exercise on the CBT platform

Individual Level Training

93. At the individual level the trg in small groups for respective deptt can be organized for short modules of 1-2 days. This trg may be organized as induction trg (on induction of new employee). The recommended actions are as under :-

(a) **Induction trg**. The aim of this trg should be

(i) To bring an agreement between the org goals and the pers goals of the employee.

(ii) To build the employees confidence in himself, the org and the org system/ tools.

(iii) To give an insight into the patient centric responsibilities and challenges.

(iv) To promote “espint de corps”, belonging, loyalty, adherence to rules, regulations and time schedules.

(v) To foster relationship between new and the old workers as part of the introduction pgme and the detailment of an ‘over study’.

(vi) The trg should be organized by hiring expert trainers and conducting of cl by the managers/ experienced billing staff themselves for leaving a lasting impression on the new employees.

(b) **Refresher trg** To be organized at regular intervals in two six monthly trg cycles.

(i) This trg should be of one day duration catering for the high attrition rates of the employees leaving the hosp/economics in the conduct of this trg should be worked out.

(ii) The refresher trg could cover proc aspects, IT(HMIS), comd and cont, protocols, stds, timings and reporting proc.

(c) **Continous Trg**

(i) To be conducted at the deptt level as a continuous process covering OJT, proc requirement for managing daily challenges, management of stress, intervention trg and managing difficult customers.

(ii) This could be org in form of short cl/demo of 30-45 min duration (once a week) during lean pd in rotation for the staff by the mgr/dy mgr/nursing supr at the deptt itself.

(iii) Record of such trg should be kept at the deptt itself and produced during deptt audit. The onus for selection of the topics for continuous trg should be with the mgr/dy mgr. This trg should be separate from the trg on technical and functional aspects being org at the deptt.

(d) **Billing Trg Module.** Should be conducted quarterly specifically for the employees of the billing deptt by the HR deptt as per laid down schedule, the detailment of employees for this trg should be done by the various deptt heads. The trg should be pro active towards defining/redefining the key competencies which may change in a fast mov competitive environment.

The key trg competencies currently identified along with the measurable expectation are as under :-

	Competency	**Measurable Expectation**
(i)	Communication Skills	**.**The employee should be soft spoken •The employee should be able to communicate effectively •The employee should be able to demonstrate empathy effectively Lateral and vertical comn using software Reporting and recording proc
(ii)	Working with others	•The employee should be able to handle different kind of patients/relatives •The employee should be able to adapt as per the environment . Work as a team member . Inter deptt coordination
(iii)	Managing Emotions	•The employee should be able to control and manage his/her emotions during the interaction with patients Should be considerate as per different type of patients (like old pers, ladies, death cases)
(iv)	Handling Customers	•The employee should be able to handle difficult situations tactfully •The employee should be able to handle irate/difficult customers and relatives
(v)	Proactive approach	•The employee should be willing to take ownership and accountability •The employee should plan his/her actions in accordance with organisational goals Patient Centric Apch
(vi)	Trg on HMIS	•Employee should be able to work efficiently •Knowledge of software/updation

(e) **Training Proposed.** Broadly the imp trg areas proposed to be incl by the HR deptt for the indl level trg of billing deptt should incl key competencies of communications skills, working with others, managing emotions, emotional intelligence, handling of customers, HMIS trg with a proactive approach towards quality delivery and patient satisfaction.

(f) **Nursing Trg Module** The str of the nursing staff in the hosp is almost 700 hundred nurses therefore the plg and the frequency of the nursing trg module should be monthly with strength of 20-25 nurses in a module. The duration should be of one day, the work at the nursing stn should not get affected. The key trg competencies should incl soft skills, patient centricity, business communication, service excellence, team spirit, initiative

taking, delegation, working with colleagues, subordinates and the operation of the HMIS. These are also listed as under :-

	Competency	**Measurable Expectation**
(i)	Communication Skills	. The nurse should be soft spoken and . be able to communicate effectively and clearly . The nurse should communicate laterally and vertically . Inter deptt comn
(ii)	Telephone Skills	. Handle phone calls effectively and confidently . Should be able to enhance customer experience over the phone . Should be soft spoken and courteous
(iii)	IT Skills	. Should be able to handle IT eqpt and be aware of the HMIS soft ware
(iv)	Handling difficult situation	. Should be calm and composed . Should be reassuring . Crisis management
(v)	Team Activity	. Work as a team . Feedback within the team
(vi)	Grooming Skills	. Should project professional image in line with the organization image
(vii)	Patient Centricity	. Should have patient centricity attitude . Should take initiative for patient satisfaction . Should take personal accountability and ownership for work
(viii)	Saving Orientation	. Should be sensitized about the need for patient savings

(g) **Training Proposed.** Broadly the imp trg areas proposed to be incl by the HR deptt for the nurses trg should incl key competencies of communications skills, working with others, managing emotions, emotional intelligence, handling of customers, HMIS trg, reporting proc with a proactive approach towards quality delivery, patient satisfaction and savings orientation.

(h) At the end of any trg module either for the billing deptt or the nursing deptt (be it induction trg, refresher trg, and deptt oriented) the employee should give feedback and design an action plan to apply the learning at the work place. This action plan should be shared with his manager/deputy manager/supervisor. This feedback is also to be studied at the HR deptt and midcourse correction taken.

(j) The nursing supervisors and the managers should remove the fear of mistakes from the employees minds. However the good work and performance should be re awarded with avenues of advancements and promotion. The sample audit sheets for telephone skills, grooming and communication skills in respect of the employees are attached from Appx ‘B’ to Appx ‘E’ respectively

94. The role of Manager (L & D) in the Skills Development Programme for the deptt should incl .

(a) Assess the trg needs (in consultation with HODs)
(b) Set Priorities
(c) Develop objectives
(d) Develop trg calender and issue trg schedule to all concerned.
(e) The conduct of different types of trg under the SDP.
(f) Develop and maint records of all participants
(g) Review functioning of the trg team
(h) Establish files on major topics/trg library
(j) Evaluate/take corrective measures
(k) Develop reporting proc laterally and vertically till the Med Supdt and the Vice President.
(l) Follow a “Pull and Push Model System” for detailment of trainees.

Conclusion

95. In the present competitive world, quality of health care plays an important role in the modern society. Amongst the various factors affecting the health care system, discharge process is one of the important factors related to patient satisfaction. It is the process that occurs when the patient leaves the facility and is his final step in his hospital experience. The discharge process is likely to be well remembered by the patient. Even if everything else went satisfactorily, a slow, frustrating discharge process can result in low patient satisfaction. It is an important area which touches the patients’ emotions and influences the image of the hospital in his mind.

96 Discharge planning is a centralized coordinated effort by the staff of the billing deptt, the nursing deptt and the GDA,s. All of these employees play a vital role in the discharge process, which involves a methodical approach, ingenuity, decision making and clerical work to be done in the billing office. Continuous training and up gradation of the employees is required to streamline the procedure. There is a need to take regular feedback through the patients, their relatives, supervisors, observations and the appraisal process to make midcourse modifications and rectifications in the training curriculum prepared by HR deptt. The key trg competencies require identification, defining and re-defining at regular intervals so as to achieve the quality standards, NABH guidelines and better patient satisfaction.

Appx 'A' (refers to para 78)

Questionnaire

The questionnaire consists of two Sections, covering General Aspects, Feedback, Timings and Experience of the IPD patients awaiting discharge and billing formalities.

Section 1. - General

1. Coordination between the staff.
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Poor

2. Availability of Amenities / Facilities
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Poor

3. Doctors / Consultants Availability
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Poor

4. Treatment Experience
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Not upto the mark.

5. Behavior of Nursing Staff.
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Not upto the mark.

6. Response of Billing Staff.
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Not upto the mark.

7. Time taken for file prep after marked for discharge.
   (a) Less than 30 min
   (b) 30 to 60 min
   (c) 60 to 90 min
   (d) More than 90 min

Questionnaire (Contd)

8. Time taken for final clearance after discharge order.
   (a) Less than 60 min
   (b) 60 to 90 min
   (c) 90 to 120 min
   (d) More than 120 min

9. Time taken for transit of file.
   (a) Less than 30 min
   (b) 30 to 60 min
   (c) 60 to 90 min
   (d) More than 90 min

10. Overall Discharge Experience.
   (a) Very Good
   (b) Good
   (c) Satisfactory
   (d) Poor

Appx 'B' (refers to para 93 (J))

TELEPHONE SKILLS-AUDIT SHEET

Employee ID	
Audit Date	
Trainer's Name	

Ser No	Statement	Yes	No	NA
1.	The employee started the call with "Thank you for Calling" "Name of Nursing Station" or "BLK Super Speciality Hospital"			
2.	The employee offered assistance in the beginning of the call by saying, "How may I Help You?"			
	Placing the call on Hold			
3.	The employee sought customer's permission before placing the call on hold.			
4.	The employee mentioned the amount of time it would take to be on hold and offered the option of calling back whenever appropriate			
5.	The employee thanked the customer on retrieving the call			
	Ending the Call			
6.	The employee thanked the caller at the end of the call			
7.	The employee greeted the caller by saying, "Have a good day"			
	Soft Skills			
8.	The employee avoided long silences and dead air during the call			
9.	The employee spoke in a clear and pleasant tone			
10.	The employee used the phone effectively for feedback and daily procedures			
11.	The Employee had hesitation in using the phone			

Areas of Strength of the Employee (Manager / Supervisor)

What could have been done better (Areas of Improvement) (Manager / Supervisor)

Appx 'C' (refers to para 93 (J))

GROOMING SKILLS-AUDIT SHEET FOR LADIES

Employee ID	
Audit Date	
Trainer's Name	

Ser No	Statement	Yes	No	NA
1.	The hair was nicely tied into a bun of French knot and did not cover the face or forehead			
2.	The hair was neatly brushed/combed and did not appear too oily/dry			
3.	The design of the shoes was formal and shoes were well polished			
4.	Uniform was clean and well ironed			
5.	Uniform fitted the employee well and was not too loose or too tight			
6.	The nails were well trimmed and clean			
7.	The employee had worn no or at the most one ring and the jewellery worn was appropriate			
8.	The skin was clean and did not appear too oily/dry			
9.	Make up if worn was appropriate (Mild and matching the skin tone)			
10.	There employee did not have any body odour or bad breath			
11.	The overall appearance of the employee was pleasant			

Areas of Strength of the Employee

(Nursing Supervisor / Head Nurse)

What could have been done better (Areas of Improvement)

(Nursing Supervisor / Head Nurse)

Appx 'D' (refers to para 93 (J))

GROOMING SKILLS-AUDIT SHEET FOR MEN

Employee ID	
Audit Date	
Trainer's Name	

Ser No	Statement	Yes	No	NA
1.	The hair was cut short and the sideburns were of appropriate length			
2.	The hair was neatly brushed/combed and did not appear too oily/dry			
3.	The design of the shoes was formal and shoes were well polished			
4.	Uniform was clean and well ironed			
5.	Uniform fitted the employee well and was not too loose or too tight			
6.	The nails were well trimmed and clean			
7.	The employee had worn no or at the most one ring and there was no visible jewellery or accessories			
8.	The skin was clean and did not appear too oily/dry			
9.	The employee had a clean shaven look without any stubble/missed spots			
10.	There employee did not have any body odour or bad breath			
11.	The shirt/tunic was well tucked in			
12.	The overall appearance of the employee was pleasant			

Areas of Strength of the Employee

(Manager / Supervisor)

What could have been done better (Areas of Improvement)

(Manager / Supervisor)

Appx 'E' (refers to para 93 (J))

COMMUNICATION SKILLS-AUDIT SHEET

Employee Name	
Employee ID	
Audit Date	

Ser No	Statement	Yes	No	Remarks
1.	The employee was able to communicate clearly in a way that the message was well understood.			
2.	The employee was able to effectively manage the difference in dialect/language and culture (if any).			
3.	The employee checked the understanding by asking relevant questions to ensure that the patient/relative has understood him/her.			
4.	The employee spoke clearly at an appropriate pitch and volume.			
5.	The employee had a warm and courteous tone of voice.			
6.	The employee depicted a positive body posture and avoided closed hand gestures.			
7.	The employee maintained the eye contact while talking to the patient/relative?			
8.	The employee had pleasant facial expressions and smiled whenever appropriate?			
9.	The employee maintained correct tone and expressions while interacting rather than appearing/sounding assertive/annoying.			
10.	The employee documented the conversation in simple, precise and correct manner.			
11.	The employee communicated timely to his superior and other departments.			

What did the employee do well? (Areas of Strength)

(Nursing Supervisor) (Ward Manager)

What could have been done better? (Areas of Opportunity)

(Nursing Supervisor) (Ward Manager)

Exhibit One

TRAINING PHOTOGRAPHS

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