Internship Training at IBS, Sunflag Hospital and Research Centre, Faridabad Delhi(NCR)

By

Dr. Vandana Yadav

PGDHM

2012-2014

International Institute of Health Management Research

Internship Training

Faridabad Delhi (NCR)

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TITLE

To study the patient discharge process in

IBS, Sunflag Hospital and Research Centre, Faridabad, Delhi (NCR)

By

Dr. Vandana Yadav

Post-Graduate Diploma in Hospital & Health Management
New Delhi
2012-14

International Institute of Health Management Research
New Delhi
2014

Sun Flag
INSTITUTE OF BRAIN AND SPINE
CURE CARE COMPASSION

INSTITUTE OF BRAIN & SPINE
(A Unit of Sri Neurocare Pvt. Ltd.)
Sunflag Hospital & Research Centre
Sector-16A, Faridabad-(Delhi NCR), Haryana -121002,
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The certificate is awarded to

Dr. Vandana yadav

In recognition of having successfully completed her
Internship in the department of

Medical Quality

and has successfully completed her Project on

Title

Study on patients discharge process

1st FEB/14 - 30 /04/**2014**

Institute of Brain & Spine
Basement Sunflag Hospital
Sector 16A Faridabad Haryana

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

We wish her all the best for future endeavours

Centre Head

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FEEDBACK FORM

Name of the Student: VANDANA YADAV

Dissertation Organisation: IBS, Sunflag Hospital and Research Centre, Faridabad, Delhi (NCR)

Area of Dissertation: Medical Quality and Medical Operations Dept.

Attendance: Met, 98%.

Objectives achieved: yes, handled project on patient discharge process

Deliverables: TAT for discharge

Strengths: Hard working, keen learner, perseverance & Optimistic

Suggestions for Improvement: focus on team work!,

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

Date:
Place:

Certificate from Dissertation Advisory Committee

This is to certify that **Dr. VandanaYadav,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled "Study of Patient Discharge Process at IBS, Sunflag Hospital and Research Centre, Faridabad Delhi (NCR)" 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.

Ms. Anupama Sharama,
Asst. Professor
IIHMR DELHI

Dr. Manoj Rawat
Consultant Neuro Physician,
IBS, Sunflag Hospital and
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Delhi (NCR)

Certificate Of Approval

The following dissertation titled "TO STUDY THE PATIENTS DISCHARGE PROCESS IN IBS, SUNFLAG HOSPITAL AND RESEARCH CENTRE, FARIDABAD DELHI(NCR)" at **"IIHMR** 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. A.K. Agarwal	
Dr. Ramteke	
Ms. Anupama Sharma	

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Vandana Yadav 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 IBS, Sunflag Hospital and Research Centre Faridabad, Delhi (NCR) from 1ST FEB 2014 to 30TH APRIL 2014.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical. The Internship is in fulfilment of the course requirements. I wish her all success in all her future endeavours.

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

Ms. Anupama Sharma
IIHMR, New Delhi

INTERNATION INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "TO STUDY THE PATIENTS DISCHARGE PROCESS IN IBS, SUNFLAG HOSPITAL AND RESEARCH CENTRE, FARIDABAD DELHI (NCR)" and submitted by Dr. Vandana Yadav Enrolment No- PG/12/103 under the supervision of Assit. Professor Ms. Anupama Sharma for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 1st February 2014 to 31st April 2014 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Vandana Yadav

Signature

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Abbreviations

- ICU Intensive Care Unit
- OT Operation Theatre
- RADIO Radiology
- LAB Laboratory
- MRD Medical Record Department
- TPA Third Party Administrators
- MO Medical officer
- DS Discharge summary
- DEPT. Department
- HRS Hours
- DR Doctor
- PT. Patient
- F.A Finance Assistant
- MED Medicine
- STD Standard
- IPD In patient department
- OPD Outpatient department
- HR Human resource

ABOUT HOSPITAL:

IBS is a world class neurosciences and trauma centre. With only a handful of such centres present in India, IBS located in Delhi National Capital Regions here to cater to the rising demands for such facilities.

A sound technological know-how, radiology services, well equipped ICU, blood bank, ambulance services at par with international standards sets IBS apart from other such centres.

Director's Message:

It gives me immense pleasure and satisfaction on introducing a Hi-Tech Holistic Care Centre that would offer the world's most advanced medical care to patients with specialization in neurology and Neurosurgery services.

Institute of Brain and Spine brings together the amalgamation of state-of-the-art infrastructure, cutting edge technology, experienced pool of doctors and a highly motivated and compassionate support team put together to deliver affordable yet world-class patient care services that are thoroughly supported by comprehensive and in-depth research carried out by the World's leading Scientific minds.

Being located in Faridabad, a bustling town in the National Capital region, we aim to become the best and the affordable healthcare destination available both nationally as well as internationally. We believe to go that extra mile to ensure a positive and unique patient experience.
- Dr. S. Dwiwedi

Vision:

IBS is directed under the regulatory moralities and ethics of providing affordable and high quality medical services to patient with devoted care, compassion and constant focus on excellence in patient care, continuing medical education and scientific knowledge.

Mission:

• To build a Centre of Excellence in Neurosciences and provide highest quality services to the entire
community.
• To convert it into Healthcare Hub and cater to the local population as well as take care of the
healthcare need of the International Patients.
• To make it a coveted destination not only for the patients but also for the physicians and other
healthcare workers.

Our Motto:

IBS strongly believes in the principle of 3Cs viz:
• **Cure**
• **Care**
• **Compassion**

Board of Directors:

1. Dr Sachin Kandhari
2. Mr Salim Tanwer
3. Ms Meghna Ambani
4. Dr Dewaker Sharma
5. Dr Manoj Rawat

LIST OF EMPANALED COMPANIES:

Table no- 5.1

S no	COMPANIES
1	Indian Oil Corporation Ltd.(IOL)
2	Yamaha Motors India Ltd.
3	National Thermal Power Corp.(NTPC)
4	Power Grid Corporation of India Ltd.
5	National Hydroelectric Power Crop. Ltd.(NHPC)
6	Badarpur Thermal Power Station (BTPS)

7	Indian Renewable Energy Development Agency Ltd.
8	Bharat Petroleum Crop. Ltd.
9	Fertilizer Crop. of India
10	Food Crop. of India (FCI)
11	Power Finance Crop. Ltd.
12	ABB Ltd.
13	National Institute of Financial Management (NIFM)
14	Unit Trust of India
15	State Bank of India (Retired Employees)
16	Housing & Urban Development Crop. Ltd.(HUDCO)
17	Engineering India Ltd.
18	Tata Steel & Iron co.
19	IBP Co. Ltd.
20	Ex-Servicemen Contributory Health Scheme (ECHS)
21	National Fertilizer Ltd.(NFL)
22	Hidustan Wire Ltd.
23	Jay Bharat Exhaust Systems Ltd.
24	Steel Authority of India(SAIL)
25	Hidustan Vidyut Products Ltd.
26	Faridabad Chamber of Commerce & Industry
27	Indication Instruments Ltd.
28	Showa India (P) Ltd.
29	Tecumseh Products India Ltd.
30	Hyderabad Industries Ltd.
31	Central warehousing Crop. (CWC)

Table no-5.2

LIST OF TPA's		

S.No	TPA Name	STATUS
1	Family Health Plan	
2	Paramount Health Care Ltd.	
3	United Health Care	
4	Bajaj Allianz	
5	Medi Assist	
6	Star Health	
7	I Care	
8	Chola Mandlam	
9	Genins	
10	DHS	
11	East West	Only for Corporate Employee
12	Alankit	Only for Corporate Employee
13	Good Health Plan	
14	Max Bupa	
15	TTK	Only for Corporate Employee
16	Raksha TPA	Only for Corporate Employee
17	Safeway	
18	ICICI Prudential	

Medical Services:

1. Neurosurgery & Spine surgery
2. Trauma Services- Ortho & Neuro
3. Neurology
4. Stroke Clinic
5. Psychiatry
6. Geriatric Care
7. Neuro diagnostics
8. Sports Medicine Unit
9. Rehabilitation

Introduction:

Discharge planning is "A process used to decide what a patient needs for a smooth move from one level of care to another." It is the development of an individualized discharge plan for the patient prior to leaving the hospital, to ensure that patients are discharged at an appropriate time and with provision of adequate post-discharge services [1]. Such planning is a mandatory part of hospital accreditation [2].

Discharge planning is a complex process that seeks to determine the appropriate level of services required by the patient and then match the patient to an appropriate site of care [3]. This process ideally begins at the start of the hospitalization. An estimated discharge date and a provisional discharge destination (for example, home with home care, a rehabilitation facility, or a long-term-care home) should be established for every patient within 48 hours of admission. The hospitals indicated that the estimated discharge date is generally based on the patient's diagnosis.

In general, the basics of a discharge plan are:

- Evaluation of the patient by qualified personnel
- Discussion with the patient or his representative
- Planning for home coming or transfer to another care facility
- Determining if caregiver training or other support is needed
- Referrals to home care agency and/or appropriate support organizations in the community
- Arranging for follow-up appointments or tests.

The objectives of this internship project are: a) to study the patient discharge process in Sunflag hospital Faridabad b) to analyse the opportunity if available to reduce the time.

The findings of this project will help to determine the discharge process for the Sunflag Hospital Faridabad New Delhi, and will be used to modify the existing policies to reduce the turnaround time for the discharge of the patient and to minimize the risk for the patient and will help in providing the excellent services on time that in turn will increase the patients satisfaction.

Literature review:

The hospital discharge process is initiated on the recommendation of a physician. The process may vary from hospital to hospital as hospitals have their own policies regarding discharge. Patients should make sure they understand any follow-up instructions before leaving the hospital and, if not, they should ask for clarification.

Effective discharge planning can decrease the chances of readmission to the hospital, help in recovery and ensure medications are prescribed and given correctly. Not all hospitals are successful in this. Although both the American Medical Association and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) offer recommendations for discharge planning, there is no universally utilized system in US hospitals.

Studies have shown that as many as 40 percent of patients over 65 had medication errors after leaving the hospital, and 18 percent of Medicare patients discharged from a hospital are readmitted within 30 days. This is not good for the patient, not good for the hospital, and not good for the financing agency, whether it's Medicare, private insurance, or your own funds. On the other hand, research has shown that excellent planning and good follow-up can improve patients' health, reduce readmissions and decrease healthcare costs. Delayed discharge or 'bed blocking' are terms used to describe the inappropriate occupancy of hospital beds. Delay in discharging surgical patients from hospital is a long-standing and common problem [4]. Delayed discharges have an impact on hospitals' ability to cut waiting lists and deliver healthcare effectively and efficiently. In acute care hospitals, prolonged length of stay (LOS) not only increases cost, but is also associated with increased rates of complications.

In previous studies in this area has proven that some of the confounding factors like age, severity of illness, complex co morbid physical health problems, poor mobility and informal status [5] also leads to delay in the discharge process.

1. Two approaches to discharge planning became prevalent in the U.S. following introduction of a new payment system based upon diagnosis related groups. The nursing approach, or medical model, involves specialized knowledge of illness, understanding of medical terminology, ability to instruct patients and families on the use of technical equipment, ability to provide instructions on general home health care procedures and close working relationship with physicians. The social work approach focuses on non-medical aspects of hospital care; it includes the use of clinical skills, assessment techniques, advocacy, problem-solving abilities and community resource identification. The organizational environment of the hospital greatly affects the discharge planning process. Organizational policies and legislative policies are determining how discharge planning is carried out. A 1988 survey of discharge planners in 229 California hospitals found 52.4% of hospitals located discharge planning services within the social work department, 31.4% in an administrative department and 16.1% in a nursing department. The most frequently mentioned criteria for selecting patients to receive discharge-planning services were social situation, medical condition, age, mental condition and referral from another professional. Progress notes were the most frequently used assessment tool, followed by the nursing care plan and activities of daily living scales. More than half (58%) had a procedure for evaluating the quality of services to which a person is discharged; follow-up telephone calls were mentioned most frequently, while audit at readmission and questionnaires ranked second and third, respectively. Home-visits

were the least-used evaluation method. The author suggests that hospital's structure, goals, technology, ideology and adherence to the medical model may be more powerful than the professional perspective in defining discharge-planning services. All discharge-planning models include: screening, assessment and diagnosis, planning, implementation, and evaluation and follow-up. The author cites studies suggesting the then prevalent screening procedures may not have been sufficiently accurate to target patient's post-discharge needs. The author also cites research suggesting indicators need to target a broad range of post-hospital needs rather than those primarily related to delayed discharge. The author expresses the view that the use of progress notes and nursing care plans for assessment and screening does not reflect adherence to a comprehensive model of discharge planning, and notes the importance of evaluation in a comprehensive model (Inglehart 1990).

2. An interpretive study contrasted the discharge experience in a rural and an urban Ontario setting (McWilliam & Sangster 1994). The authors found that in the rural setting, the efficiency of bed utilization was compromised by democracy and professional autonomy, resulting in the overuse of hospitalization and learned helplessness among patients. Family involvement was limited in the urban setting; communication between the hospital and home care agencies was kept to the minimum, focusing on efficiency. The process differed in the rural and the urban setting, while the patient experience of the process was similar. In both settings, patients deferred to the professional management of discharge care. Rural professionals took a collegial approach, whereas those in the urban setting focused on their own area of specialization to avoid stepping on each other's toes. The urban approach resulted in fragmentation, adversely affecting patient-centeredness, continuity and effectiveness. Home-care professionals noted the challenges created by the hospital's focus on efficient bed utilization. They were also uncertain of which physician to contact for which concern. Variations in physician practice style were identified as a complicating factor in the urban setting. Challenges common to both settings included communication and coordination, and lack of information. In the urban setting, family physicians and home-care professionals often faced delays of several weeks post-discharge in receiving details of care requirements. Potential solutions are identified, including systematic approaches to written correspondence, face to face communication, interdisciplinary planning meetings that include patients and families as well as hospital and community-based professionals; continuous family physician involvement; improvements in discharge teaching; better understanding of the roles of all health professionals; and interdisciplinary clinical education. The authors conclude that approaches to discharge care should be evaluated for their impact on accessibility, coordination, continuity, comprehensiveness, patient-centeredness, and the effectiveness of overall patient care, and they note the importance of teamwork.

3. In the U.K., 82% of acute trusts have a discharge coordinator and two-thirds have a discharge team. One quarter have a [paper] system of joint records with social services and of these most have seen a positive impact on discharge rates. On any given day, 4,100 older patients in NHS acute care beds are the equivalent of ALC. Factors contributing to discharge delays for older patients on elective admissions include: the absence of alternatives to acute care; poorly coordinated or tardy

discharge planning; delays in starting or completing needs assessments; bottlenecks in post-acute hospital care; delays in preparing packages of care due to funding or workforce constraints; poorly coordinated or tardy preparation for day of discharge; and lack of capacity in post-acute care in all health, social services and independent sectors. In September 2002, 26% of patients experiencing delays in discharge were awaiting placement in a residential or nursing home and a further 10% were awaiting placement in a home of their choice. Lack of capacity in alternate care facilities is the leading cause of delayed discharge in England. Recommendations are made for NHS Trusts, including wider circulation of their discharge policies (outside the Trust); early commencement of discharge planning and assessment; mapping older people's pathways through hospital care to identify bottlenecks; involving patients and their caregivers in the discharge process; monitoring the rate and cause of emergency re-admissions; and enhancing the organization of equipment services (National Audit Office 2003).

4. In a Cochrane Database Systematic Review of discharge planning from hospital to home, Shepperd et al (2003) report than nearly 30 per cent of all hospital discharges are delayed for non-medical reasons. The causes of such delay, reported by the U.S. Department of Health in 2003, include inadequate assessment resulting in, e.g., poor knowledge of the patient's social circumstances; poor organization, e.g., late booking of transport; and poor communication between the hospital and providers of services in the community. Readmissions account for one-quarter of Medicare inpatient expenditure in the U.S. The review failed to detect a significant impact on length of stay or readmission rates for elderly patients with a medical condition for discharge planning compared to usual care. Some trials found higher patient satisfaction to be associated with discharge planning. The impact of discharge planning on health outcomes is uncertain. One study found hospital total costs were significantly lower with discharge planning for patients with a medical condition (e.g. readmission at two weeks), but no different for surgical patients. Another found lower costs for laboratory services for patients receiving discharge planning. In one study of discharge planning for stroke patients, a quicker improvement in quality of life and activities of daily living was found for the control group; this surprise finding might indicate there are benefits arising from a less structured, more flexible approach to continuing patient assessment. The reviewers note in their conclusions that a high level of communication between the discharge planner and the providers of services outside hospital is important. They also note in the review that even a small reduction in length of stay or readmission rates could free up capacity where there is a shortage of acute hospital beds.

5. In the study conducted by LAMBOURNE, P., ASHAYE, K. & LAMBOURNE, A. (2005) on the impact of delays in discharging patient has proved that Delayed discharge not only exposes the patient to health risks such as infection, social isolation, increased dependency and loss of skills [6] but also affects the health and well-being of those awaiting hospital admission and their carers. Delayed discharges have an impact on hospitals' ability to cut waiting lists and deliver healthcare effectively and efficiently. In acute care hospitals, prolonged length of stay (LOS) not only increases cost, but is also associated with increased rates of complications [7].

6. Research among adult patients in two Midwest U.S. hospitals found that, of 24 variables examined, only age, disability, living alone and self-rated walking limitation were jointly predictive of using specialized discharge planning services. A screening tool using a limited number of characteristics was found to be highly predictive of using specialized discharge planning services. Early identification allows for the timely coordination of services required for complex discharges. The variables are identifiable early in the hospital stay and easy to measure. Co morbidities and severity of illness were not predictive of specialized hospital discharge planning services. The authors of this study suggest these variables may be more related to the outcomes of the discharge plan, e.g., institutionalization (Holland et al 2006).

7. An Intervention study on Evaluation of discharge summaries, E-Discharge was conducted by O'Leary, Leibovtz, Feignlass, Liss, Evans, Kulkarnii,Landler, Baker, (2009). This paper describes a pre and post evaluation of an intervention study designed to evaluate the effectiveness of an electronic discharge summary system. As a part of the intervention, an electronic discharge summary template was implemented that included key variables/elements of discharge summaries as indicated by a survey of outpatient physicians. The outcome measure for this study was an outpatient physician survey, which measured satisfaction with the discharge summary. Results from the intervention demonstrated that physician satisfaction with the timeliness and quality of the discharge summary after the implementation was significantly higher than for dictated discharge summaries. After implementation the number of dictated discharges dropped from 47.5% to 10.5%. Results from the study also demonstrated that completeness of the discharge summary improved. For example, information about follow-up tests was included in 52.0% of dictated discharge summaries, and in 75.8% of electronic discharge summaries.

8. In January 2010, Sterling Hospital, Ahmadabad, volunteered to participate in National Demonstration Project (NDP) for Lean Six Sigma, and was sponsored by QCI. Two projects prioritized by the hospital for NDP were :
   - Project 1- Improving TAT for patients discharge
   - Project 2- Improving TAT for inpatients lab reports

   Patient satisfaction survey was conducted by the patient care department, to study the perceptions of TPA (Third Party Administrator), corporate and cash patients revealed that TPA patients were particularly dissatisfied by the extensive time required for discharge. On an average, TPA patients accepted a norm of three hours for discharge, post consultant instructions. However, the reality is that the discharge process typically takes five hours. Patient dissatisfaction with the discharge process is further magnified because approximately 40% of the Sterling Hospital, Ahmadabad, and revenue traceable to TPA and corporate patients. The results were gratifying. The overall **TAT for the patient discharge process was compressed from 300 minutes to 150 minutes**. This enhanced the capacity of the hospital for **admitting additional patients by 80**. The hospital **increased its profitability by approximately Rs 32 lakhs per annum**.

9. In "Discharge from Hospital Literature Review" Prepared for the discharge Planning and ALC Policy Task Team November 2006: Discharge planning is critical to

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

Root Cause Analysis:

Table no - 8.1 Major bottlenecks preventing timely discharge and their root causes

Bottleneck	**Root cause**
Delay in start of discharge process	Care plans with the expected length of stay and discharge date were not created at time of admission. The discharge process began unpredictably only when the consultant determined the patient to be ready during rounds
Delay in completion of discharge card	Cards are handwritten and activity begins after consultant signoff on the day of discharge
Delay in completion of final case file	Case file not checked each day to update services ordered with services and reports received
Delay in preparation of final bill	Wards waited for a stack of billing files to accumulate before sending them to the billing counter for processing
Delay in financial clearance	Attendants were not immediately informed that the final bill was ready. Late entry of charges led to a substantial hike between the interim and final bill that was often questioned during settlement.

Because of the above mentioned causes delay in administration of first dose of medicine take place , to overcome the issues recommendation are given to make the process more efficient and to enhance the patient satisfaction .

Reasons for delay:

1. **Due to physician and nursing staff :**
   - Late physician rounds
   - Late preparation of discharge summary [DS]
   - Knowledge and experience determines the decision taking capability of the physician
   - Lack of communication and coordination among physician and nursing staff
   - Failure to follow established protocols/procedures, motivation and attitude, and physical, mental health

2. **Teamwork factors** :
   - Including verbal or written communication during handover,
   - Routine care and crisis,
   - Supervision and seeking help
   - Team structure and leadership

3. **Working conditions :**
   - Including staffing levels
   - Workload and skill mix
   - Availability or maintenance of equipment
   - Administrative and managerial support

4. **Organisational and management factors :**
   - Including financial resources
   - Time pressures
   - Physical environment.

5. **Patient factors :**
   - Patient and family not adequately informed about the discharge date
   - Including clinical conditions
   - Language
   - Social factors

6. **Task factors :**
   - Including availability
   - Use of protocols
   - Test results and accuracy of test results

1) Late physician round:

- Main reason for delay in planned discharges.
- Dr. is busy in OPD consultation.

- Advice on discharge (prescription) gets delayed due to late physician round and in turn the whole process of discharge gets delayed.

2) Late DS Preparation

- One MO is preparing DS for medicine and surgery patients both.
- Most often MO is not having the complete list for the planned discharges and gets late confirmation for the discharges.
- Medical officer indents the medicines for TPA patients.
- At times MO is busy with emergency patients.
- MO answers the TPA queries at the same time.

3) Lack of coordination (nursing staff)

- Nurses busy with patients.
- Don't get timely information.
- Delay in sending the file to finance.

Objective:

The study aim is to identify the patient discharge process and to analyse the opportunity if available to reduce the time.

Specific Objective:

1) To evaluate the time taken at each step in the process of patients discharge
2) To check the compliance of discharge policies followed in Sunflag Hospital Faridabad
3) To identify the delay and the reason of delay in the patient's discharge process

Methodology:

This evaluation study examines patient's discharge process in IBS, Sunflag Hospital and Research Centre Faridabad Delhi (NCR). This is the case study used cross-sectional study, exploratory method of direct observation to analyse the work flow process and to identify and examine the barrier in the work processes involved in patients discharge process. The focus of observation was on the doctors and nursing tasks, material and information flows, communication, variations and staff developed work- around associated with patients discharge.

Study Area:-

As per the requirement of the study on turnaround time for patient's discharge process the sample area taken is the In-Patient ward in IBS, Sunflag Hospital and Research centre Faridabad Delhi(NCR).

Sample Size :-

As it is tracer audit sample size is kept small, after screening of 60 patients 40 patients were eligible for the study because study is based on the new admission of the patients.

Recruitment of the Patients:-

For the study, followed the patients till the time discharge process was complete and patient left the hospital, for each patient it took approximately 3-4 hrs.

Study Period:-

Sample collection was done during 1st February to 20 February 2014 so per day data was recorded for 3 patients and out of which after screening 40 patients were taken.

SAMPLE POPULATION:-

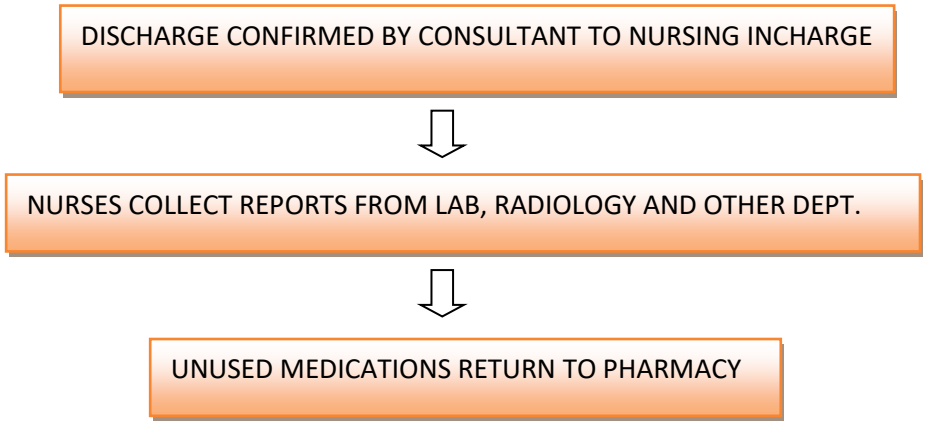
Table no- 10.1

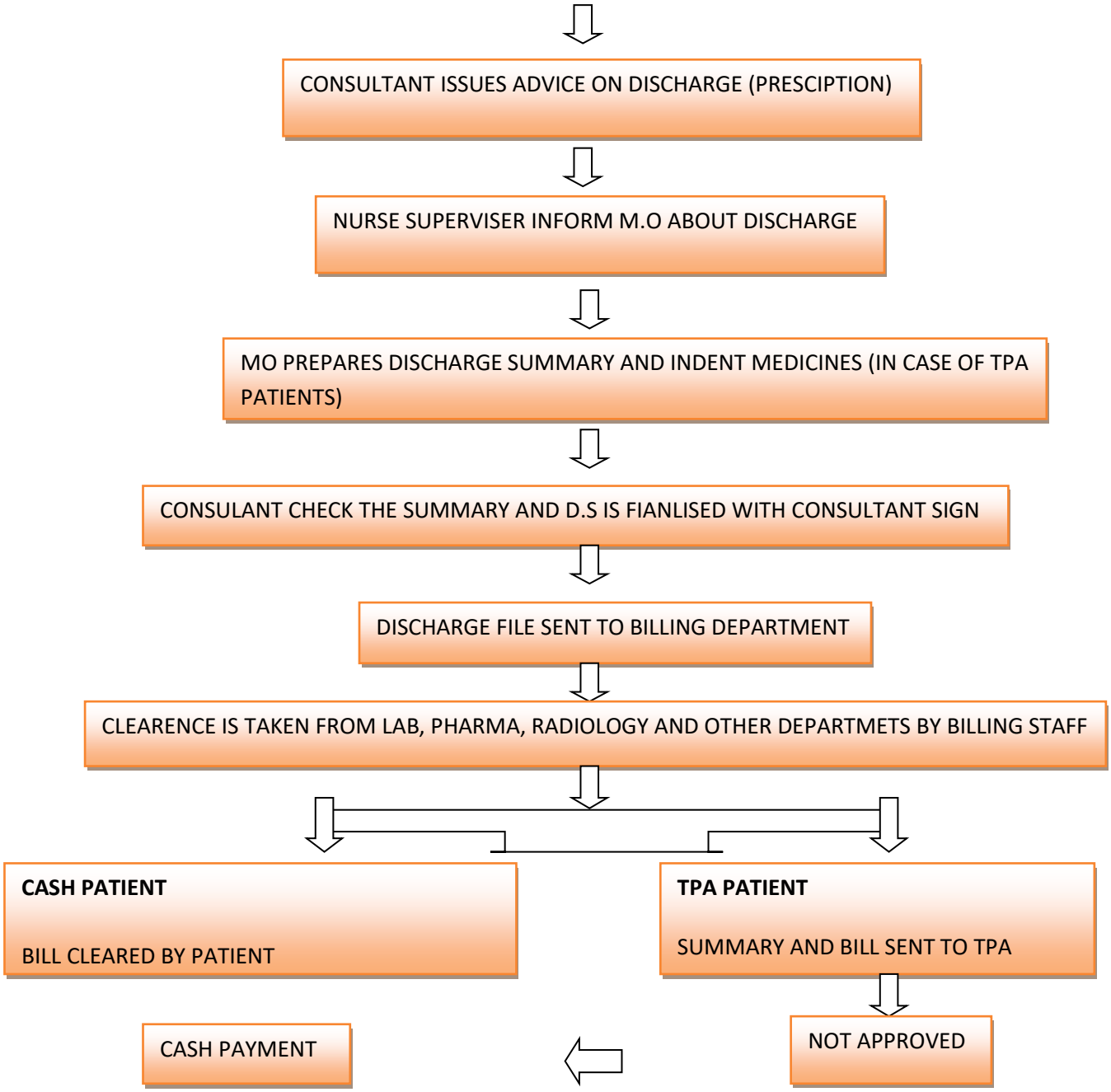
In-Patient ward in basement	Initially no of patients screened for the study	No of patients eligible for the study
Total	60	40

The main reasons for exclusion during the screening process were:

- Patients that were transferred from OT to the different wards
- Patients that were transferred from ICU to the wards
- Patients who were coming from the emergency department
- Referral cases from other departments

Discharge Process flow:





Data collection:

Source of data collection:-

Primary Data: Data were obtained from the CPRS, HIS, BCMA and by the direct observation of the work flow process.
Secondary Data: data is collected from the internet about the previous studies done on turnaround time for Patients Discharge Process.

Tool and technique:

Tool: table is formulated and all the data was entered in an Excel spreadsheet and analyzed.

Table no- 12.1

Id no	T1	T2	T3	T4	T5	T6	T7	T8	R

Variable:

Time is the variable
T1- Total time by which discharge process was delayed
T2- In time pharmacy department
T3- Out time for pharmacy department
T4- Total time taken in clearance from pharmacy department
T5- In time for lab
T6- Out time for lab
T7- Total time taken in clearance from lab
T8- Total time taken at cash counter
R- Reason for delay

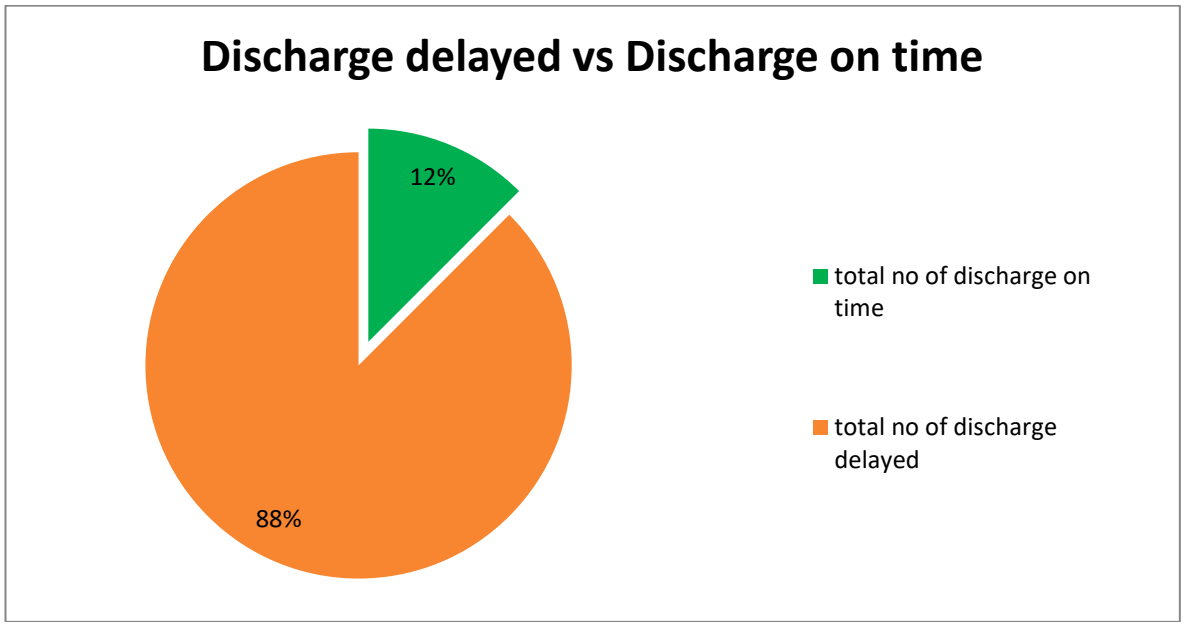
Technique:

By direct observation of work flow process.

Study findings:

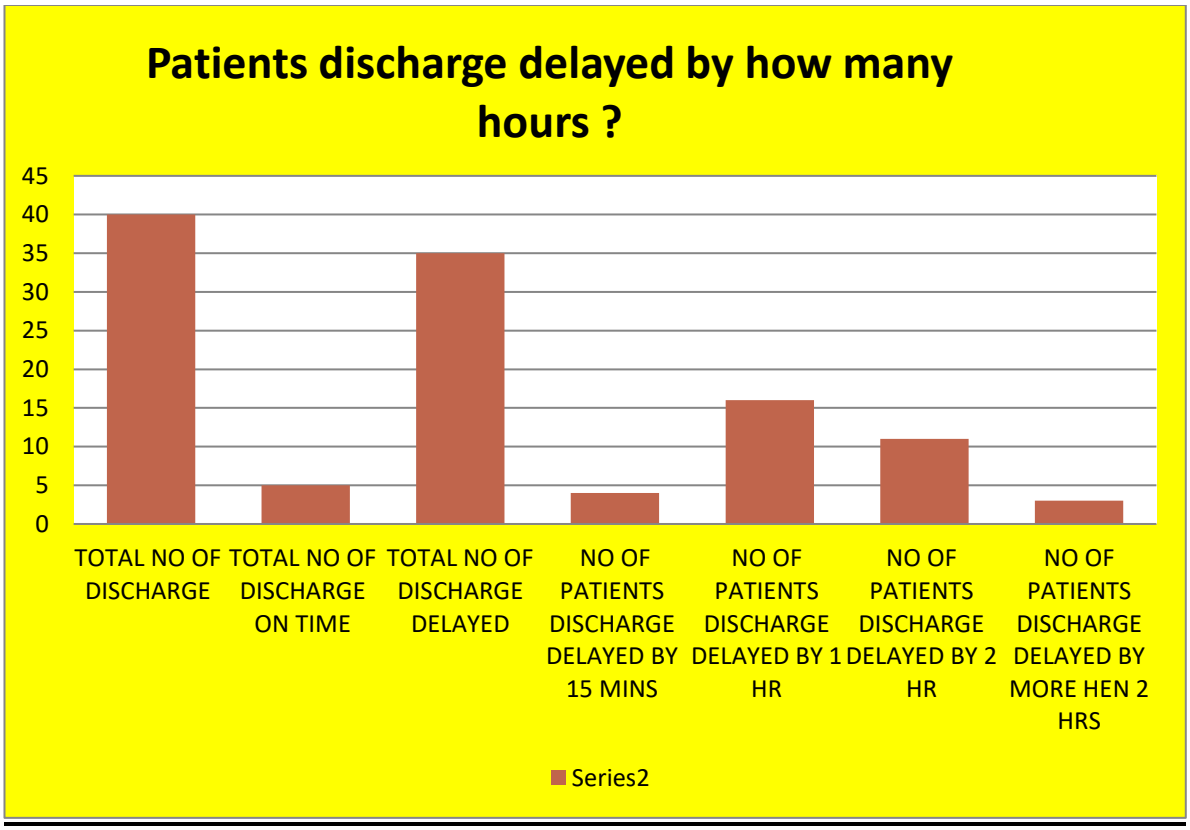
Total no of patients discharged on time = 5
Total no of patients discharged late = 35
So the patients discharge process was delayed in 88% of cases which contributes a very high figure and attracts attention towards itself. Discharge time needs to be reduced to achieve patient's satisfaction and to bring delightment factor in service delivery.

Figure -13.1



Total no of discharge delayed on hourly basis from data recorded

Figure -13.2

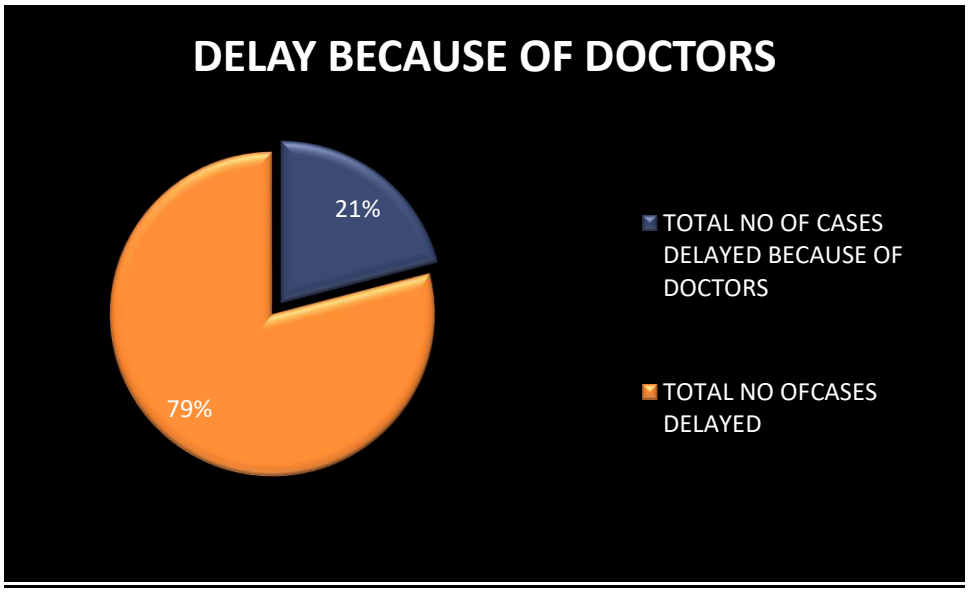


According to IBS, Sunflag Hospital and Research Centre Faridabad

- Data collection is started at the first point of patient contact by any care provider, and is ongoing throughout the continuum of care.
- Patients will have regular assessment and follow-up for discharge needs.
- The Nurse in charge as well as the Resident Doctor is responsible for coordinating the discharge with the other team members.
- Discharge planning should begin early during the stay of the patient and discharge plan should be documented at least 24 hrs before the actual discharge process is initiated.
- Clinical criteria for discharge must be documented and note of patients functional, medical and other systems status should be made.
- The treating doctor must record that the patient is **'fit for discharge'** and record the condition on discharge.
- Each Patient will be provided with a discharge summary on the day of discharge.
- Routinely anticipated patient and family discharge needs are to be documented in the Patient Discharge Summary.
- A copy of the discharge summary will be kept in the medical record.
- In case of a death the death summary **must** contain the cause of death.
- Discharge before 11am.

Total no of patients discharged delayed because of physician:

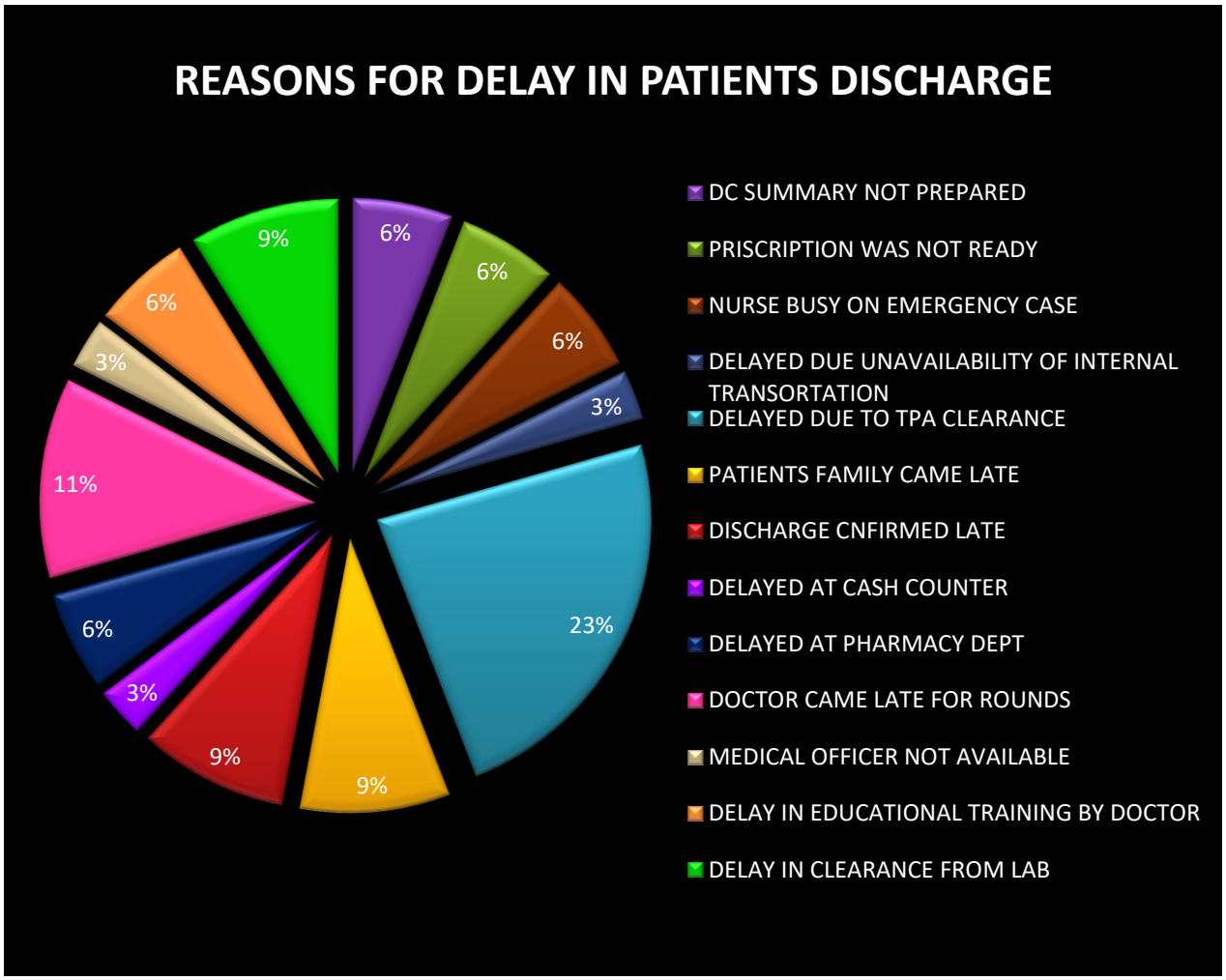
Figure- 13.3



21% of the discharges were delayed because of doctors which is again a very huge number and attention.

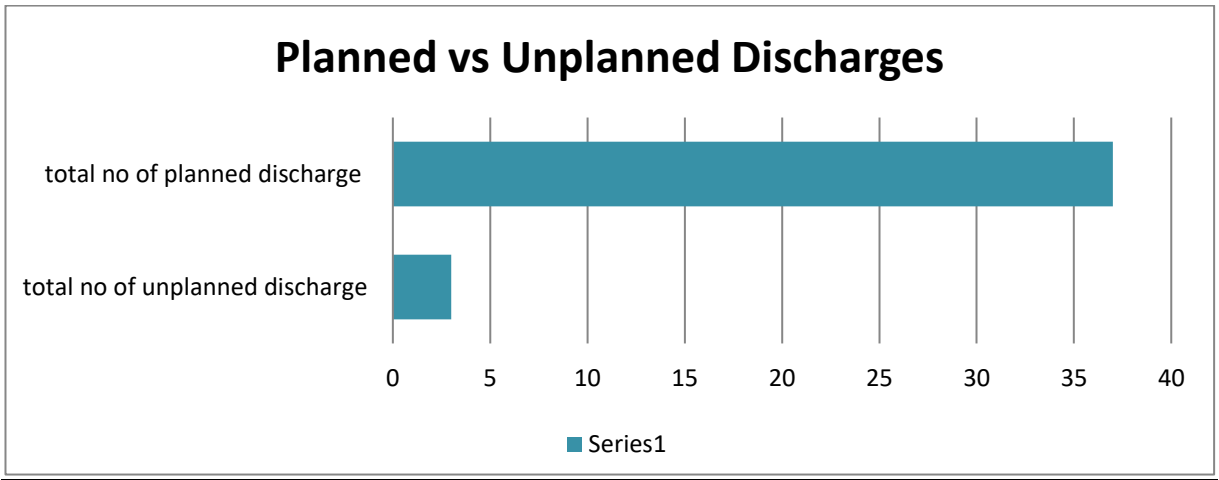
Reason for delay in patients discharge process:

Figure-13.4



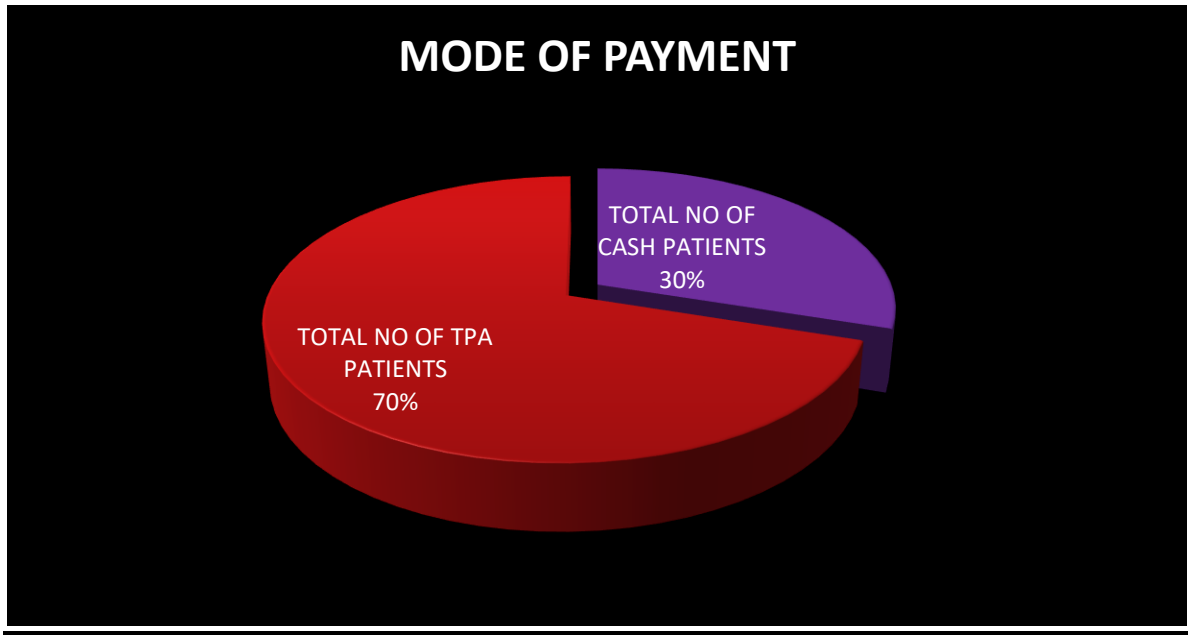
Total no of planned vs total no of unplanned discharges:

Figure-13.5



MODE OF PAYMENT:

Figure- 13.6



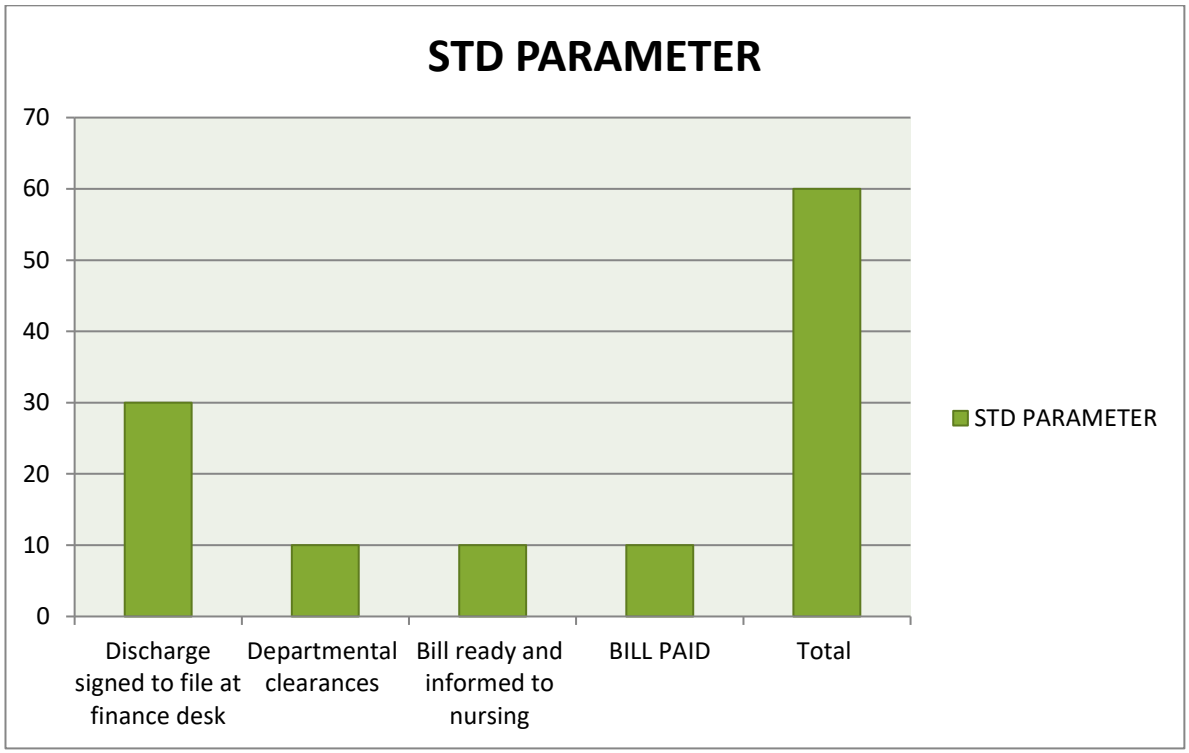
Cash discharges:

Table no- 13.1

S no.	Activity	Average time taken	Standard parameter
1	**Discharge signed to file at finance desk**	60mins	30mins
2	**Departmental clearances**	28mins	10mins
3	**Bill ready and informed to nursing**	15mins	10mins
4	**BILL PAID**	12mins 42 sec	10mins
5	**Total**	1:56:10	60mins

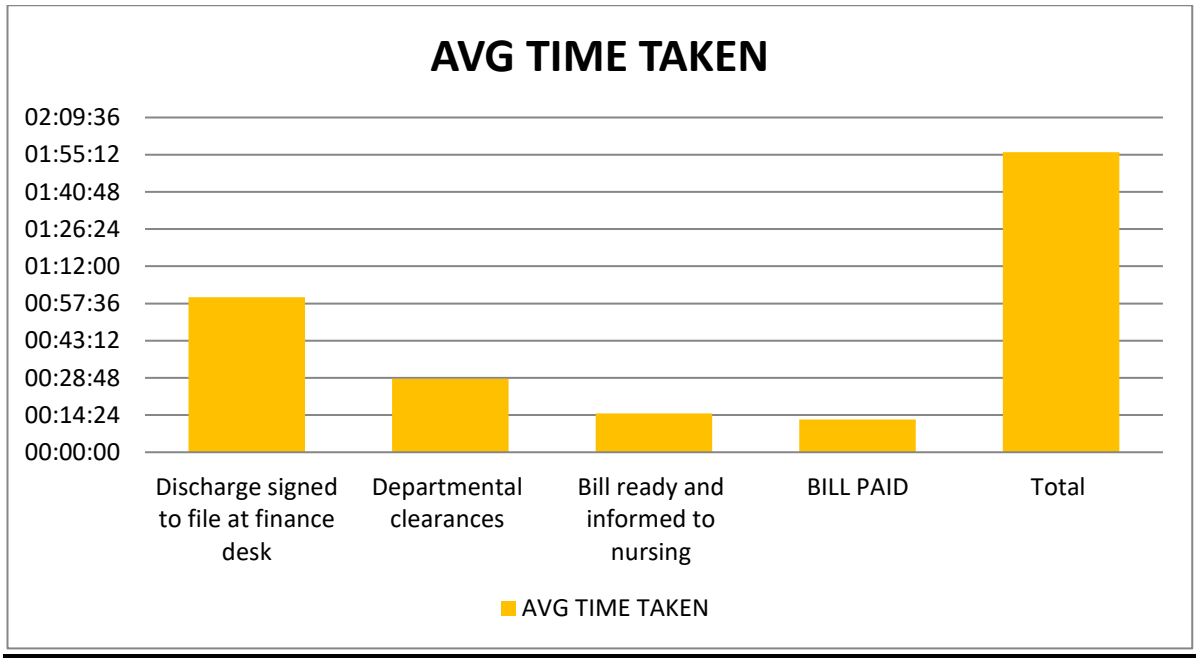
Time taken as per Hospital Policy and Standard's:

Figure- 13.7



As per the data recorded average time taken to discharge the cash patient is:

Figure-13.8



Suggestions:

1. After discussion with the IT department planning to introduce tablets that will help in reducing the tot for discharge process.
2. Round timings of the doctors should be fixed preferably in the morning before 10 am.
3. Nurse should know the expected discharge date so that she can complete her notes the night before the discharge and return left medicines to the pharmacy.
4. Clearances from the radiology and lab should be taken by financial assistant the night before the discharge is planned.
5. Discharge summary should be written by the night duty MO's.
6. Effective and timely discharge can only be attained by interdepartmental coordination and proper communication between all the team members involved in the discharge process.
7. If possible, more and more cases should be planned discharge. As in following cases:
8. Patient shouldn't be discharged immediately on request. He could be planned for evening discharge so that it should also turn out as an appropriate discharge otherwise , not only case in itself will be delayed but also shackles the strength of other planned discharges.
9. Discharge coordinator/ nurse should coordinate for parallel work flow which is seen absent in many cases, such as to, inform to dietician or physiotherapy, or should inform the house keeping department for wheel-chair (if required) as intimated by treating physician during the time she is preparing DS, for smooth process.
10. In cashless patients, documents should be collected with the time so that the nurse doesn't have to rush to collect reports or summary at the time of discharge.
11. Patient should be well informed about the time the whole discharge process will take.

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