"A Study on the Discharge Process of JEEVAN JYOTI HOSPITAL , ALLAHABAD U.P"

A dissertation submitted in partial fulfillment of the requirements
For the award of

Post-Graduate Diploma in Health and Hospital Management

By

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Certificate of Internship Completion

Date:.....

TO WHOM IT MAY CONCERN

This is to certify that Mr./Ms./Dr. Sathya Kumari has successfully completed his 3 months internship in our organization from January 2013 to April 2013. During this intern he has worked on Patient Care ....(task performed) under the guidance of me and my team at .....(organisation). .....(any positive/negative comment)

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Certificate of Approval

The following dissertation titled "**STUDY OF DISCHARGE PROCESS**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory 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.

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Name	Signature
DR. BRIJENDER SINGH DHILLON	3/5/13

Certificate from Dissertation Advisory Committee

This is to certify that SadhnaKumari, 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 "Discharge process" 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.

Faculty Mentor	Organizational Advisor
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FEEDBACK FORM

Name of the student :- Sadhna Kumari

Summer Training institution :- Jeevan Jyoti Hospital, 162, Bai Ka Bagh, Allahabad.

Area of Summer Internship :- Patient Care

Attendance :- 88%

Objective met :- Achieved Target

Deliverables :- up to the mark.

Strengths :- Cooperative.

Suggestion for improvement :- —

Date:- 11-4-13

Place:-

Signature of the officer-in charge(training)

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Abbreviation list

JJH	**:**	**Jeevan Jyoti Hospital**
PCC	**:**	**Patient Care Coordinator**
CGHS	**:**	**Central Government Health Scheme**
ESI	**:**	**Employee State Insurance**
ECHS	**:**	**Employee Contributory Health Scheme**
TPA	**:**	**Third Party Administrator**
OPD	**:**	**Out Patient Department**
IPD	**:**	**In Patient Department**
ICCU	**:**	**Intensive Coronary Care Unit**
GDA	**:**	**General Duty Assistant**

INTERNSHIP REPORT

HOSPITAL PROFILE

Jeevan Jyoti Hospital Allahabad began its seemingly quixotic quest in 1988 October -From 20 beds in 1988 to 500 beds of 2008 having almost all facilities under one roof, with an advanced multispeciality hospital, diagnostic centre, IVF centre and a research centre along with paramedical & Nursing School with different charitable ventures, training centre for various government projects and dream to set up a Medical University very soon.

- JJH has engaged in charitable endeavors across Uttar Pradesh regularly and frequently, through free medical camps, free distribution of medicines in rural areas, training of birth attendants in different blocks and reaching out to those who find it difficult to reach us.

- The assisted reproduction unit at Jeevan Jyoti Hospital, namely Arpit Test Tube Baby Centre (ATTBC), consists of highly skilled and experienced reproductive specialists. The team provides international standard services in IVF/Andrology/Endocrinology making every effort to let the infertile couples conceive and fulfill their dream of having their own baby. It offers a complete range of facilities for investigation of male and female infertility. Treatment is coordinated with the best scientific and medical practice with the highest level of care and consideration for each couple.

- It service capability is universally acknowledged as the most effective in the medical profession in Global scenario, especially in surgeries and test tube baby centers. It has also started Nursing and Paramedical education in our centre. The combination of research and education distinguishes Jeevan Jyoti Hospital .
-

  JJH is planning to make health care hub to create a global talent pool of medical professionals and start a new era in health care at ALLAHABAD -UP -INDIA.

- **INFRASTRUCTURE**

- **Reception:**
- The reception is mannaged by trained staff with full of hospitality, who are keen to facilitate the patient visit to various services of the hospital round the clock.

- **OPD Services:**
- The hospital has modern and spacious OPD with senior consultants available from 8 am to 8 pm for consultation. This ensures minimal waiting period and increased choice to the patients. There is separate cafeteria, public utility services, PCO and waiting area for the

Patients & attendents.

- **Kitchen pantry:** Kitchen pantry is also available for the convenience of patients and meals are provided to indoor patients free of cost. This service is run under able supervision of the consultant of department of dietetics.

Dressing Room:

- There are fully equipped dressing rooms on the OPD floor for minor dressings and small procedures that can be done under local anesthesia.

Operation Theatre Complex:

- JJH a sophisticated ultramodern operation theatre complex with latest state of art technology, including one laminar OT, equipment and instruments. Depending on the work load, it has up to 6 operations theatres functional at one time. Each theatre has a team of nursing and technical staff trained in various subspecialties.

Power Back Up:

- The hospital has two sets of stand by generator for use in case of power failure.

Lifts:

The hospital has 3 functioning lift round the clock for the patient convenience.

Wards:

- 1. The rooms are well ventilated with proper light, full care of hygienic, central oxygen supply.
  2.Equipped with telephone operating system and extensions have been provided the rooms.
  3.Each room is equipped with separate toilet,bath & cupboard.
  4. Almost the entire hospital is air condition except the general ward which are connected to central cooling system,

Room/Ward Categories:

1. **General ward**
2. **Economy ward**
3. **Private ward**
4. **Deluxe ward**
5. **Suites**
6. **Pediatric ward**
7. **Neonatal ward**
8. **Emergency ward**
9. **Intensive care wards**
10. **Surgical ICU**
11. **Pre- labour ward**

12. **Trauma unit**
13. **Burn unit**

Additionally it has facilities for:

- Education & Research

DEPARTMENTAL OVERVIEW

Inpatient" means that the procedure requires the patient to be admitted to the hospital, primarily so that he or she can be closely monitored during the procedure and afterwards, during recovery. An inpatien**t** is "admitted" to the hospital and stays overnight or for an indeterminate time, usually several days or weeks (though some cases, like coma patients, have been in hospitals for years). All the patient occupancy areas are well light and ventilated, and equipped with Pipe Line Oxygen, Central Suction etc. to minimize patient discomfort and for the immediate availability of the life saving systems. A quality service from the nurses is available round the clock.

Basic services including breakfast, lunch, evening tea and dinner are provided. Provision of special diet for patients like diabetic, cardiac, pregnant etc is available.

- ❖ An attendant is allowed to stay only with private room patients, but in general wards the attendants are discouraged to stay except in case of pediatric ,geriatric patients.
- ❖ There is a visiting hour to in patient department. Every patient is given one attendant pass.
- ❖ Children below the age of 12 are not allowed to visit the patients.
- ❖ Visitors are allowed only at the notified Visiting Hours

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

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

Patient Care Coordination (PCC) Department:

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

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

- PCC is focused on clinical content and workflows

- PCC profiles are championed by clinicians to support clinical integration

TASKS PERFORMED

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

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

- Discharge decision with timings.
- Discharge summary preparation, its timeliness and improvement if any.

- Discharge timings
- Monitor of discharge timings from discharge decision to departure of patient.

- Co-ordination with Quality Cell to provide quality indicators and patient discharge timing analysis.

3.Scrutiny of patient feedback forms and information captured thereby. Coordination with Quality Cell as regards to capturing quality indicators pertaining to patient satisfaction..

4.To monitor Housekeeping services in patient care including Biomedical Waste clearance from patient care areas.

5. Monitor dietary services and related patient complaints

- Take round of Kitchen and observe functioning of the same.

- Turnout of serving boys.

- Round of patient pantry.

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

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

REFLECTIVE LEARNING:

- Coordination between different departments (nursing, typing & Housekeeping etc.)
- Effective discharge management is when both individual and staff are satisfied knowing that adequate plans have been made for discharge, with the outcome of the individual's discharge taking place without unforeseen difficulties.
- Analysis of the feedback forms & communicating the results to the respective departments
- Learning about Improving balance between bed supply and demand during peak demand hours

- Man power management
- Waste Management.
- To streamline the Discharge process of hospitals through customer focus and optimum utilization of the resources.
- Customers' satisfaction is the main factor. A new and more effective method has to be adopted to ensure customers' satisfaction.
- Patient education must occur throughout the hospitalization, not only at the time of discharge.
- Information should be captured throughout the hospital stay, not only at the time of (or after) discharge.
- Waiting until the discharge order is written before beginning the discharge process is likely to increase the risk of errors.
- All patients should have access to their discharge information in their language and at their educational level.

PROJECT REPORT

Chapter 1

Introduction

Discharge

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

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

DISCHARGE PROCESS (IPD)

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

Types of discharges:-

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

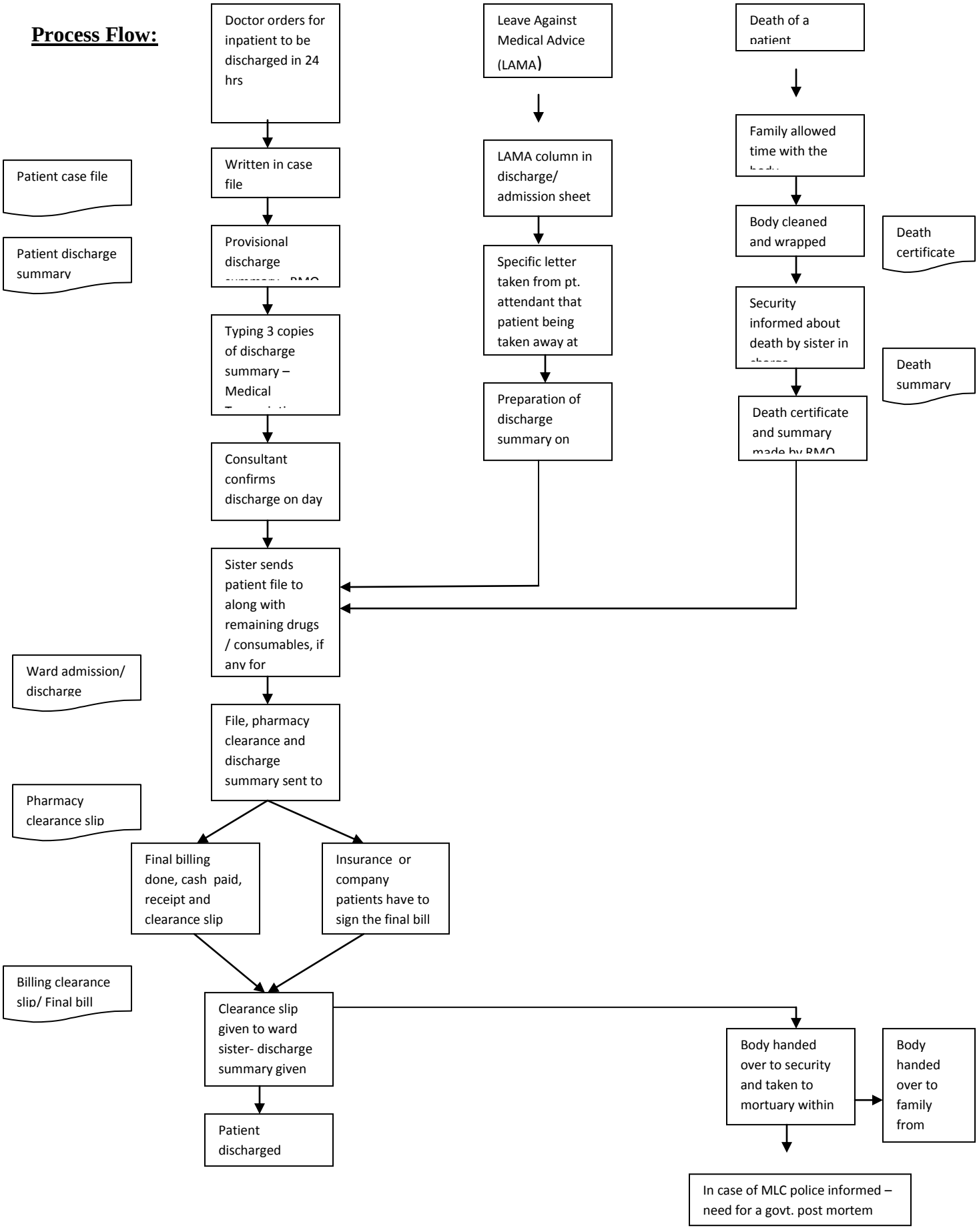
Sound admission and discharge processes are essential for quality health care delivery and are one of the important areas of practice that requires constant review, evaluation and development to keep abreast with the constantly changing demands of health care delivery. The discharge process can have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

Discharge of individual should not take place until the responsible clinician is satisfied, following consultation with the multi-disciplinary team, individual that the individual can be safely discharged. Delayed discharges lead to : Bed control does not have enough bed options to meet incoming demand Critical care units become challenged with moving patients into step-down areas

- Directly impacting inpatient admissions from the Emergency department

Delayed discharges are particularly problematic because of their significant impact on hospital admissions and patient throughput. As a result of delayed discharges, bed control does not have enough bed options to meet incoming demand. Critical care units become challenged with moving patients into step-down areas, which then directly impacts inpatient admissions from the Emergency department. Preoperative services also experiences back-ups in the PACU, waiting for beds to become available. In effect, discharge delays create an upstream tidal wave of patient flow constraints which negatively impacts patient satisfaction, safety, hospital capacity, and financial performance.

Process Flow:



Objectives:-

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

2. To study the patient satisfaction after discharge .

3. To provide recommendations for improving the quality of the discharge process

Limitation Of the Study :-

- Time duration of the study was only 3 months i.e data collected and analysed is very short period of time.

NEED FOR THE STUDY:

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

CHAPTER-2

Review Of Literature

PAUL PETERS et al (1997) A project employing a liaison none has been started in the

Dutch Zaandam region. The liaison projects will discuss on the experience of problems in preparing for hospital discharge and on continuity between hospital and home care. This article discusses the effect of the liaison nurse on the quality of the discharge planning process. The Investigation included a pre-test and a main test for which data were collected using questionnaires. These were sent to patients who had received after-care on being discharged from hospital. To measure the quality of the discharge process and after-care continuity, use was made of explicit quality criteria, targeting discharge planning. The results show mat discharge planning in hospitals has improved. No significant improvement was detected with respect to continuity of care. It may be concluded that the discharge process requires more attention. The quality criteria used here could function as points of departure.

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

David Anthony et al (2005) The transfer of patient care from the hospital team to primary care and other providers in the community at the time of discharge is a high-risk process characterized by fi-agmented, nonstandardized, and haphazard cares that leads to errors and adverse events. The development of interventions to improve the discharge process requires a detailed evaluation of the process by a multidisciplinary team. Methods used are the resources of the Boston University- Morehouse College of Medicine AHRQ Developmental Center for Patient Safety Research (funded by the Agency for Healthcare Research and Quality), multidisciplinary teams have been assembled to identify and address the sources of error at discharge. To better understand the current hospital discharge process, the researchers have applied a battery of epidemiologic and quality control methods taken from industry. These include probabilistic risk assessment, process mapping, qualitative analyses, failure mode and effects analysis, and root cause analysis. The researchers describe each of these methods and discuss their experience with them, displaying concrete tools that have arisen from their application. The conclusion of the study was a detailed, multifaceted process analysis has provided us with powerful insight into the many patient safety issues surrounding the discharge process. The generalizable methods described here have produced the re-engineering of the discharge process, allowing for the planning of a clinical trial and significant improvements in patient care.

Sima Ajam et al (2006) The hospital discharge process is a basic bottleneck in hospital management. Improved discharge process is the main strategy that covers many hospital activities. Discharge process is the last patient's contact with hospital system. Therefore, it is the most important stage affecting patient's satisfaction. If this process takes long, not only it makes patients dissatisfied but it also will not be beneficial for the hospital. The main objective was determining average waiting time of patient discharge process at Beheshti Hospital in Esfahan, Iran in the spring of 2006. This study was a case study in which data were collected by questionnaires, observation and forms. The statistical population was all personnel involved in

discharge process and patients discharged throughout the spring of 2006. To analyze data SPSS and Win QSB (Windows Quantitative Systems for Business) were used. Results According to the personnel's views, the main factors affecting average waiting time were patients' financial problems and un-accessibility of interns to complete the summery sheets. The longest patient's waiting time for discharge was 345 minutes and the least was 35 minutes. Average time for patients in discharge process was 197 (±65) minutes. This study concluded that Discharge planning is a routine feature of health systems in many countries. Hospital information system should be implemented at least between wards, Para-clinics stations, accounting and cashier station. It causes many stages in manual patients' discharge process will be omitted.

Charity Mukotekwa et al (2007) had done a study aiming that the complexity of the discharge planning process is such that it is often difficult to achieve in a totally efficient and effective manner. In this paper a systems approach is adopted in analyzing the discharge planning process in a general surgical ward in order to understand better the nature of this complexity. Adopting a soft systems methodology it is shown that the major issues to be addressed relate to the need for a more seamless service provision and more effective utilization of resources. Conceptual models are formulated which enable comparison to be made between current provision and the issues that need to be addressed. This in turn results in the creation of an agenda of items for change, from cultural, organizational and technological perspectives, which can be considered in terms of their feasibility and desirability. Key proposals highlighted, so as to improve discharge planning, include: the need for greater co-operation between the many healthcare professions involved; the adoption, particularly on the part of nursing staff, of a more holistic approach with regard to the needs of their patients; enhancing the utilization of nursing staff; and moving towards a greater adoption of information and communication technologies as a means of achieving more effective communication. More generally, the paper provides an example of the role that soft systems analysis can play as an aid in dealing with the complexities of healthcare processes and their management.

Chapter – 3

Data and Methods

METHODOLOGY

Area:

JEEVAN JYOTI HOSPITAL ,ALLAHABAD,U.P

Study Design:

The study design is cross-sectional analysis in nature.

Research Methods:

The research method used was quantitative & qualitative analysis.

Type of data collected:

- Primary data was collected by using a discharge monitoring tool

Sample size:

Sample size taken for the study is 105.

Duration of the Study:

3months (10th January to 10th April)

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

- Bed No.
- Patients Name
- Consultants Name
- Category of the patient
- Discharge order time
- Bill Book sent for billing time noted
- Time when patient is finally discharged
- Time taken in the whole process
- Discharge summary given to the patient or not
- Reasons for delay if any

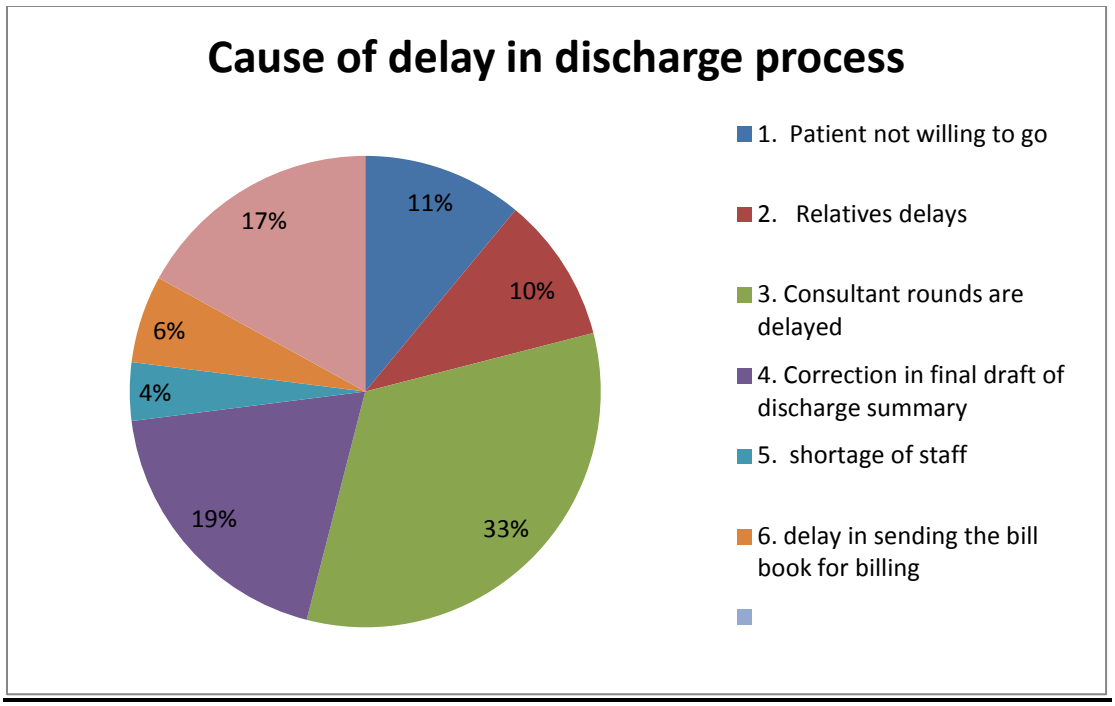
Data Analysis: Data was analyzed using excel.

Chapter – 4

Results and Findings

TABLE: 2 Delay mostly occur in discharge process

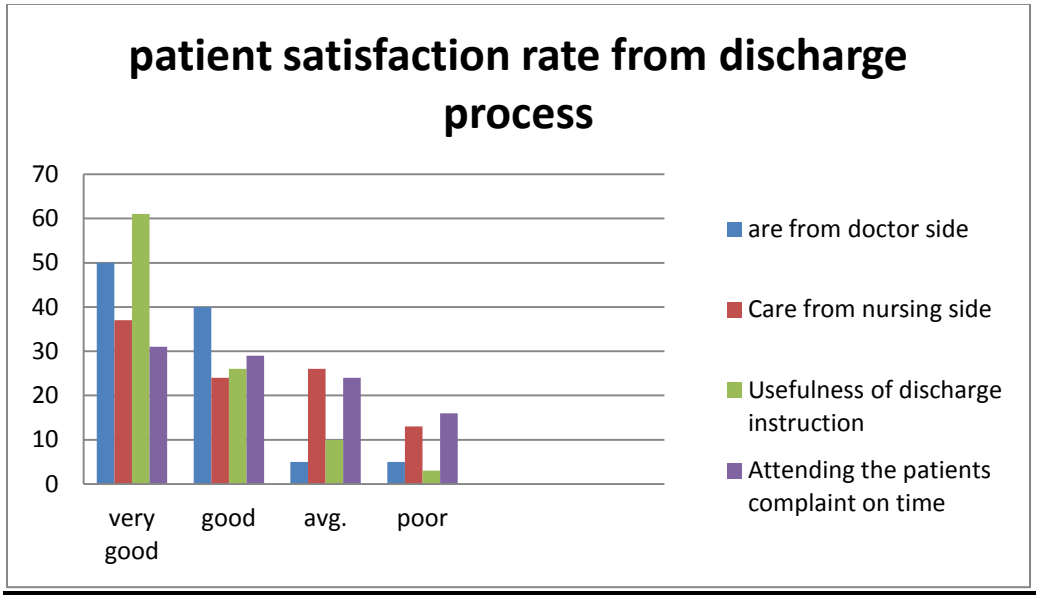
Cause	Percentage of delay
Patient not willing to go	**11**
Relatives delays	**10**
Consultant rounds are delayed	**33**
Correction in final draft of discharge summary	**19**
Shortage of staff	**4**
Delay in sending the bill book for billing	**6**
TPA patients approval delay	**17**



Above chart shows that maximum discharge delay33%s due to consultant round delays ,19% delay due to cause of correction in final draft of discharge summary., 17% due to TPA patients approval delay,11% discharge due to Patient not willing to go.4% due to Shortage of staff.

TABLE 3: Patient satisfaction after discharge proces

	CARE FROM DOCTOR SIDE	Care from nurse side	Usefulness of discharge instruction	Attending the patient complaint on time
Very good	**50**	**37**	**61**	**31**
Good	**40**	**24**	**26**	**29**
Average	**5**	**26**	**10**	**24**
Poor	**5**	**13**	**3**	**16**



Above graph shows that Patient satisfaction after discharge process regarding

Care from doctor side :- 50% says very good way, 40%says good way, 5% says average & 5%says poor.

Care from nurse side- 37% says very good way, 24% says good way,26% says average ways,13% says poor.

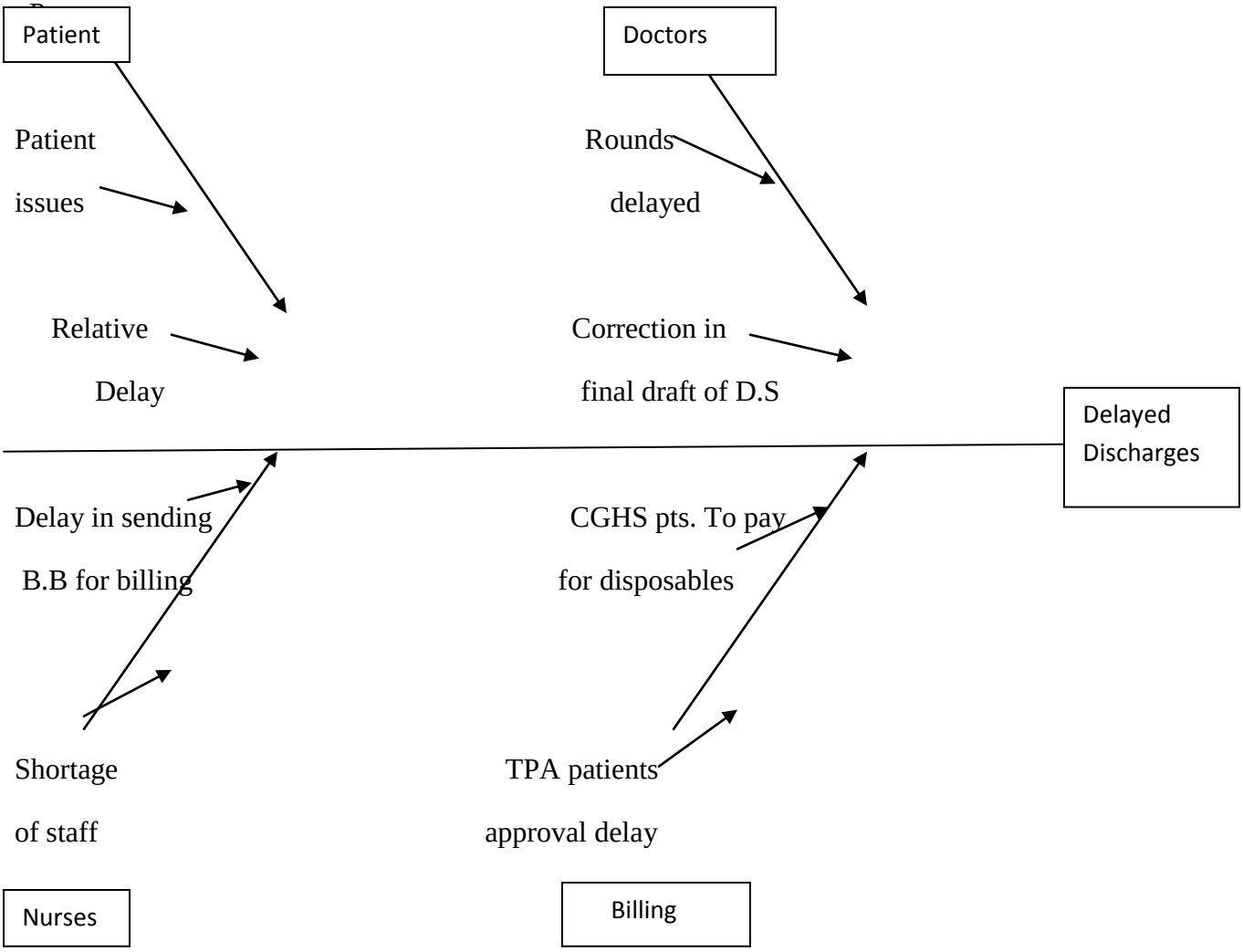
Usefulness of discharge instructions- 61%says very good,26% says good, 10% says good, 3% says poor.

Attending the patient complaint on time- 31%says very good,29% says good, 24% says good, 16% says poor.

REASONS FOR DELAY IN DISCHARGE:

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

Fig.4.4 Cause and Effect Diagram



It was observed that maximum no. of delays in the discharge process were occurring in a particular area of the hospital.. The reasons for the delay are :-

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

CHAPTR-5

DISCUSSION

Discussion:-

The study findings also showed that the delay of discharge is due to 33% consultant rounds,19% due to correction in final drafts of discharge of summary,17% TPA patient approval delay,11% not willing to go,10% due to relatives delay & shortage of staff & delay in sending the bill book for the billing respective 4 & 6 %

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

Patient satisfaction after discharge process are:-Care from doctor side :- 50% says very good way, 40%says good way, 5% says average & 5%says poor. Care from nurse side- 37% says very good way, 24% says good way,26% says average ways,13% says poor. Usefulness of discharge instructions- 61%says very good,26% says good, 10% says good, 3% says poor. Attending the patient complaint on time- 31%says very good,29% says good, 24% says good, 16% says poor.

IMPORTANCE OF QUICK DISCHARGE PROCESS

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

Chapter 6

Conclusion

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

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

CHAPTER-7

RECOMMENDATIONS:

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

16. Every discharge must have a written discharge plan that is comprehensive in scope and that addresses medications, therapies, dietary and other lifestyle modifications, follow-up care, patient education, and instructions about what to do if the condition worsens.

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

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Annexure

A. Delay mostly occur in discharge process ?

1. Patient not willing to go

2 Relatives delays

3 Consultant rounds are delayed

4. Correction in final draft of discharge summary

5 Shortage of staff

6. Delay in sending the bill book for billing

B. Prep of discharge summary

a. Fast b. Average c. Cumbersome/Difficult d.Poor e. No answer

2. Typing of Discharge Summary

a. Fast b. Average c. Cumbersome/Difficult d.Poor e. No answer

3. Checking for unused medication

a. Fast b. Average c. Cumbersome/Difficult d.Poor e. No answer

4 Compilation & Photocopy of reports

a. Fast b. Average c. Cumbersome/Difficult d.Poor e. No answer

5 Briefing by Nurse

a. Fast b. Average c. Cumbersome/Difficult d.Poor e. No answer

Please indicate your view/suggestion with the following statements about your unit by tick marking one of the following:

a. Very good b. Good c.Avg. d. poor

1. Are you received over all care from your doctor

a. Very good b. Good c.Avg. d. poor

2. Are you received over all care from nursing dep.

a. Very good b. Good c.Avg. d. poor

3. Usefulness of discharge instruction is beneficiary for you?

a. Very good b. Good c.Avg. d. poor

4. Taking action on patient complaints

a. Very good b. Good c.Avg. d. poor

TABLE SHOWING ACTIVITIES OF THE NURSING STATION DURING A DISCHARGE AND TIME TAKEN FOR THE SAME.

Time **Patient**	**Prep of discharge summary**	**Typing of Discharge Summary**	**Checking for unused medication**	**Compilation & Photocopy of reports**	**Briefing by Nurse**	**Visit by Dietician**	**TOTAL TIME**
A	14	93	13	8	5	5	138
B	31	238	10	10	5	5	299
C	30	105	55	15	30	5	240
D	60	102	38	25	10	5	240
E	60	80	25	20	5	5	195
F	15	30	15	5	10	5	80
G	20	180	20	65	10	5	300
H	30	115	15	25	10	5	200
I	50	70	15	10	15	5	165
J	60	150	10	15	5	10	250
K	30	170	20	5	7	10	239

- Average time for discharge is found to be **213.27 minutes**, which is approximately equal to **3hrs and 33 min.**

- The main cause in the delay in discharge was found to be the **Preparation and Typing** of the Discharge Summaries.