INTERNSHIP TRAINING AT BENSUPS HOSPITAL, DWARKA, NEW DELHI

BY

COL MAAN SINGH GAHLOT

POST-GRADUATE DIPLOMA IN HOSPITAL & HEALTH MANAGEMENT
2012-14

International Institute of Health Management Research

New Delhi

INTERNSHIP TRAINING

AT

BENSUPS HOSPITAL, DWARKA

IMPROVEMENT OF DISCHARGE PROCESS

by

Col Maan Singh Gahlot

Under the guidance of

Dr A K Khokhar

Post Graduate Diploma in Hospital and Health Management

Year 2012-14

International Institute of Health Management Research

New Delhi

BENSUPS Hospital
Healing Touch
Cygnus Super Speciality Centre
PATIENT CARE WITH UTMOST CARE

The certificate is awarded to

Col Maan Singh Gahlot

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

Operations Department

and has successfully completed his Project on

Improvement of Discharge Process

From 01 Feb 14 to 30 Apr 14

Bensups Hospital, Dwarka

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

We wish him all the best for future endeavors

Dr Himanshu Shekhar
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Cygnus Super Speciality Centre

BENSUPS HOSPITAL * Sec-12, Dwarka, New Delhi-75 *

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Col Maan Singh Gahlot 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 Bensups Hospital, Dwarka, New Delhi from 01 Feb 2014 to 30 Apr 2014.

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

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal 26/5/2014
Dean, Academics and Student Affairs
IIHMR, New Delhi

Dr. A K Khokhar
Mentor
IIHMR, New Delhi

Certificate Of Approval

The following dissertation titled **"Improvement of Discharge Process"** at **"Bensups Hospital, Dwarka"** 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.

(Col M S Gahlot)

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr V K Singh	
Dr B S Singh	
Dr Preetha G S	

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Certificate from Dissertation Advisory Committee

This is to certify that **Col Maan Singh Gahlot,** a graduate student of the **Post-Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled " Improvement of Discharge Process" at "Bensups Hospital" in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

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

15/7/14

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Improvement of Discharge Process**" and submitted by Col Maan Singh Gahlot Enrolment No. PG/012/042 under the supervision of Dr A K Khokhar for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 01 Feb2014 to 30 Apr 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.

(Col Maan Singh Gahlot)

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TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Col. Mann Singh Gahlot,** a student at international institute for Health Management Research, has undergone an 12 weeks learning and dissertation placement in the Operations department, commencing from 1st Feb.'2014 to 30th April'2014.

During his training, **Col. Mann Singh Gahlot** exhibited a high level of professionalism and a tremendous enthusiasm for learning.

We wish him good luck in his future career.
With Best Wishes,

Puneet Khanna
Head HR

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FEEDBACK FORM

Name of the Student: Col Maan Singh Gahlot

Dissertation Organisation: Bensups Hospital, Dwarka, New Delhi

Area of Dissertation: Hospital Operations

Attendance:

Objectives achieved: Study, Analyse the Discharge Process in Bensups Hospital and suggest measures to improve the process and reduce the discharge time

Deliverables: Study the discharge process at the hospital in detail, Interact with hospital staff involved in discharge process, Analyse the process and find gaps/bottlenecks which delay the process, suggest measures to improve the process and to reduce time

Strengths: Administrative experience, maturity in interacting with staff, communication skills, leadership and team building, analytical skills

Suggestions for Improvement: Must try to gain experience in clinical subjects also

5/5/14.

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Date: 5 May 2014
Place: New Delhi

Table of Contents

List of Tables and Graphs

List Of Figures

List Of Abbreviations

1. EWS - Economic Weaker Section.
2. ENT – Ear Nose Throat.
3. IPD - Inpatient Department
4. HIS - Hospital Information System.
5. OPD - Out Patient Dept.
6. HK - House Keeping.
7. HK I/C - House Keeping In Charge.
8. ICU - Intensive Care Unit.
9. GDA - General Duty Attendant
10. TPA - Third Party Administrator
11. RMO - Resident Medical Officer
12. CGHS - Central Government Health Scheme
13. SOP - Standing Operating Procedure
14. DS - Discharge Summary
15. DO - Discharge Order
16. BPL - Below Poverty Line

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I convey my gratitude to D**r. Sudhir Gupta**, CEO Bensups Hospital who gave me the opportunity to learn the functioning of a multi-speciality hospital. I am also extremely grateful to Dr Himanshu Shekhar, the Medical Director, for his support to make this project possible. Words can never be enough to express my sincere thanks to the Operations department of Bensups Hospital, Dwarka, New Delhi specially Ms Neetu and Ms Anshu for their continuous support during my internship training.

In the end, I am thankful from the core of my heart to the Resident MOs and personnel of nursing, housekeeping, pharmacy and billing departments of Bensups Hospital, Dwarka for their support in providing the required information. I am grateful for their patience and kindness.

INTERNSHIP REPORT

Organisation Profile : Bensups Hospital

1. Bensups Hospital is a multi-speciality hospital which is located in Sector 12, Dwarka, New Delhi. The hospital in conveniently situated in near vicinity of Sector 12 Metro Station, in a clean and fresh ambience. It is part of Cygnus Medicare which has a significant presence in North India with ten hospital including Bensups.

2. The hospital has 138 beds including 14 beds reserved for EWS section, which consists of nine non-critical and five critical beds. Special attention has been given to the design and aesthetics of different categories of rooms for the patients with each spacious room being naturally well ventilated and well illuminated.

3. **Vision** To run centres for specialized surgeries in the population areas which lack in super specialty care. We aim to provide the International Standards in healthcare to masses at affordable prices.

4. **Mission** To provide bench marked quality at affordable coast with help of caring and efficient human resource. We believe that every individual has the right to finest quality healthcare at minimum possible cost and easy accessibility.

5. **Services Provided**. The hospital provides following medical services:-

a) Cardiology.
b) Obstetrics and Gynaecology.
c) Neurology and spine.
d) ENT.
e) Eye.
f) Gastroenterology and endoscopy.
g) General Surgery.

h) IVF.
i) Internal Medicine.
j) Orthopaedics.
k) Pathology.
l) Physiotherapy.
m) Dermatology.
n) Dental.
o) Cosmetic Surgery.
p) Radiology.
q) Urology.
r) Surgical Oncology.

DETAILS OF HOSPITAL DEPARTMENTS

House Keeping Department

6. **General Introduction**. Unlike many other hospitals, housekeeping in Bensups Hospital is not outsourced. A total staff of 50 including Ward boys (WB), Ayahs, and Housekeepers (HK) have been employed, which work in two shifts of 12 hours each (8 am to 8 pm and 8 pm to 8 am). The House Keeping In-Charge has three supervisors under him who supervise the functioning of above mentioned housekeeping staff. The House Keeping In-Charge in turn reports to the Medical Director.

7. **Employment of Staff**. The housekeeping staff is employed in following manner:-

		WB	Ayah	HK	Total
a)	**Morning Shift**	9	9	10	28
b)	**Evening Shift**	5	6	6	17
c)	**Relievers**	5 including all trades			

8. **Functions**. The role of housekeeping dept in a hospital is to create a clean, infection free and pleasant, homely atmosphere in the hospital to ensure speedy recovery of the patient. The functions are as follows:-

a) Cleaning of hospital, including infection control, sanitation.
b) Linen management including laundry.
c) Waste management and pest control.
d) Inventory management of items entrusted with housekeeping.
e) Assisting engineering dept in maintenance of the wards by timely intimation of any breakdowns/ repair requirements.
f) Administration of housekeeping staff.

9. **Observations**.

a) Twelve hour shift with minimum relievers leads to some housekeeping staff doing two or at times three shifts continuously. This leads to fatigue and inefficiency in the staff.
b) Training of the staff gets overlooked which is a very important aspect especially when there is attrition of staff and sometimes raw hands get employed in emergency.
c) A strong administration and good man management has enabled the hospital to manage housekeeping with minimal staff and save on expenditure.

Human Resource Department (HRD)

10. **General Introduction**. The HR Dept comprises of an HR Head and two HR Executives. However, for quite some duration the dept has only one executive after resignation by one of them. The HR Head is also entrusted with additional responsibility of looking after the general administration of the hospital, which includes engineering aspects, security, purchases etc.

11. **Functions**. The main role of HR Dept is to provide the organisation with structure and the ability to meet business needs through managing the hospital's most valuable resources -- its employees. Keeping this in view the main functions of the HR Dept are as follows:-

a) Determining the Job Description and Job Analysis for all the designation in the hospital.
b) Determining wages and salaries of the employees.
c) Selection and recruitment.

d) Training and development.
e) Performance Appraisal.
f) Employees' welfare and motivation.
g) Addressing employees' grievances.
h) Implementing organisational policies.
i) Dismissal and redundancy.

Additional Responsibilities

a) Maintenance of building, assets and infrastructure including engineering aspects.
b) Purchases.
c) Security.

12. **Observations.**

a) The HR Dept is entrusted with additional responsibilities which are being undertaken in a professional manner.
b) Being a small hospital with comparatively less number of staff (about 225) it is prudent to assign additional responsibility to HR Dept.

IT Department

13. **General Introduction**. IT Dept of Bensups Hospital comprises of two IT Executives. However, as the hospital is upgrading to a better IT software (Shivam HIS) four software engineers from the IT Company are also working in the for the implementation of the new software. The new software is Cloud based and can work on/off line. The hospital has about 30 desktop employed at various important work stations and four laptops are being used by the top management. The IT Dept is also responsible for maintaining internal communication and CCTV network for security.

14. **Functions**.

a) Implement and manage health information management system.
b) Ensuring safety, security and confidentiality of all medical records are maintained.
c) Ensuring back up of the data.
d) Formulate policies in consultation with higher management regarding storage, retrieval and sharing of medical data in the hospital and implementation of the same.
e) Maintaining internal communications.
f) Maintaining CCTV network in the hospital.

15. **Observations**.

a) The full potential of the HIS is still not likely to be exploited as some important features like 'bed management' by HK staff is still not being utilized since there is no dedicated system for them.
b) The hospital can improve its efficiency manifold if an automatic SMS system can also be incorporated with the new IT software giving instant alerts to all concerned whenever an important event takes place e.g. admission/ discharge of a patient.

Inpatient Department (IPD)

16. **General**. The patients admitted in the hospital for more than 24 hours are referred to as IPD patients. The hospital has 138 beds including 14 beds for EWS. The ICU, NICU and CCU are located on first floor and have a total of 30 beds. Other IPD patients are housed on second, third and fourth floors. The hospital has deluxe rooms, single rooms, twin-sharing, semi-private and rooms with four and six patients. This department works under the Director, Medical Services and is supported by all departments, consultants, residents and Nursing staff.

17. **Functions**. The IPD is the most important department of the hospital as the treatment of patients is undertaken in wards under the physicians, ably supported by the Nursing staff. The primary functions of IPD include:-

a) Accommodate the patients in rooms/wards for treatment as per his needs.

b) Provide treatment till his full recovery or transfer to another facility.
c) Provide all life saving treatment and support systems to include monitors, bed, piped gases and diagnostic procedures.
d) Provide safe, secure and infection-free environment to the patient and attendants.
e) Low cost of treatment.

18. **Staffing.** Each patient is treated by a consultant and his team as per the diagnosis. Each ward has adequate number of nurses as per protocol. The wards other than ICU, NICU and CCU have a nursing station suitably located on each floor and all ultra-modern facilities have been provided to carry out nursing care. During day, there are four nurses on duty at each ward/floor to look after a maximum of 19 patients. In addition, housekeeping staff is provided for support. Consultants visit their patients twice or more as per the need and are available on call. Five RMOs are available in the hospital 24x7 to provide the necessary medical care and attend to emergency situations in IPD.

19. **Ward Facilities**. All facilities to include Nursing station, treatment room, doctors room, ward pantry, ward store, male and female staff changing room are provided.

20. **Observations**. The bed occupancy rate in the hospital is about 70% which is good. Following points were observed during the training :-

a) The nurses were allotted to patients and were responsible for all aspects of nursing care. However, it was noticed that all nurses were involved in administrative duties in case there were a number of discharges. Discharge coordinator can be nominated to carry this duty to relieve the nurses for their primary role.
b) Majority of the discharges are ordered during morning leading to extra load on the system which can be streamlined by ordering discharge in the evenings.
c) It was observed that all types of patients are admitted on each floor except Maternity cases (third floor) which may not be economical. The floors can be specifically allotted to departments/ specialties leading to economy in manpower, equipment and stores.

Outpatient Department (OPD)

21. **General.** The OPD is the first impression of the hospital. It provides primary as well as comprehensive healthcare for patients who come for diagnostic, treatment or follow-up care. Hospital OPD is located on the ground floor. There is a well lit comfortable lobby/waiting area which is used to accommodate patients, their family and friends.

22. **Functions**. The main functions of the OPD include:-

a) Ideal for early diagnosis.
b) Provides ambulatory care.
c) Route to inpatient admission.
d) Care & rehabilitation after discharge.
e) Preventive activities, Health promotion activities and epidemiological research.

23. **Layout and Staffing**. The OPD is located on the ground floor which is easily accessible from outside. There are eight consultant rooms and a nurse room for basic parameters to be recorded. The helpdesk, reception and billing are ideally located near the entrance with easy view of the complete lobby and all consultant rooms. Each consultation room is self contained with all facilities needed for examinations. The pharmacy is conveniently located near the OPD. The helpdesk and reception/registration is manned by two/three executives to cater for the load and assist the patients. Wheelchairs, stretchers and adequate staff are available to help the patients and attendants.

24. **Facilities Available**. The OPD provides following facilities for the convenience of patients and attendants:-

a) Seating arrangements, drinking water and toilets.
b) Guidance to diagnostics, specialists, lab and TPA office.
c) Reception and information desk, Registration counter.
d) Heath checkup room, health education room.
e) Display racks for promotion and educational materials.

f) It shares Emergency, Diagnostic services, Medical Imaging, Laboratory, and Pharmacy with all other departments.

25. **Observations**. The OPD is controlled by the Operations Manager through OPD manager. There is crowding at the Reception desk during peak time in the morning when more than five patients are waiting in the queue as is next to the entrance of the OPD. More and better signage will help patients to guide them to various places in the hospital. IPD billing and IPD reception are located at different places and hence certain resources have to be duplicated.

Emergency Department

26. **General**. The Emergency department is located on the ground floor of the building and has good access from outside. The entry to emergency is controlled and the ward has good connectivity to all important facilities.

27. **Functions**. The Emergency department is one of the most important links in the healthcare. The main functions are as follows:-

a) Prompt receptions for all emergency cases and assessment of their clinical conditions.
b) Immediate resuscitation and other life support treatment.
c) Investigations and treatment.
d) Admitting the patient.
e) Providing Ambulance services.
f) Filing FIR and calling the police in Medico-legal cases.
g) Briefing the patient/relatives.
h) Maintaining records.
i) Research, education and training of the medical and paramedical staff.
j) Management of Mass Casualties.

28. **Layout and Staffing**. The Emergency department is manned by one MO (24X7), two/three nurses and other HK staff for efficient functioning. There are six beds for treatment and examination with all life support equipment. Security staff is posted at the entrance for

crowd control and maintenance of peace. All requisites medical instruments, monitors and facilities have been provided. All specialists and anaesthetist are on call to attend to emergency cases.

29. **Facilities Available**. The hospital provides all facilities which are required for smooth functioning of Emergency department. These include Ambulatory services, beds, diagnostics, lab services, life saving and support services and drugs, medication and communications. Adequate privacy is ensured for the patients.

30. **Observations**. Major observations are as given below:-

a) The entry to emergency room is through a narrow corridor and is common with OPD. There is less space for attendants near the emergency room.

b) The reception desk/billing department cannot see the emergency department and hence have to be notified by Emergency. There are chances of patients leaving the premises without paying bills.

DISSERTATION

INTRODUCTION

31. Healthcare is one of the most essential needs and people require healthcare services from the moment they are born, in fact prior to their birth and the demand for these services varies during their life time. Therefore the volume of demand is almost the size of the human population. The complex nature of the human body and the potential ailments it might suffer, add to the complexity of what is expected from healthcare service providers.

32. A healthcare system can be defined as a set of facilities and organizations that participate in providing services that relate to individuals' health and wellbeing. The structure and functioning of the healthcare system is largely shaped by the country or territory it is serving.

33. It is the ultimate goal of any acute care hospital to provide the highest quality healthcare, while effectively restoring its patients to optimal health and efficiently returning them to their normal daily routine. Decreasing the average length of stay in an acute care hospital is both satisfying to patients and keeps medical costs per patient at a minimum. For any hospital, this goal can be quite challenging considering the unique health conditions and socio-economic status of its patient population.

34. "An "inpatient" is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. A person is considered an inpatient if formally admitted as an inpatient with the expectation of remaining at least overnight and occupying a bed, even if it later develops that discharge or transfer to another hospital is possible and a hospital bed actually is not used overnight". In the simplest form possible, and for any inpatient, their total hospital experience can be divided described into three distinct phases; admission,

intervention, and discharge. Even though they occur in that sequence, these phases do tend to overlap.[1]

35. 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 another nursing home. Discharge involves the medical instructions that the patient will need to fully recover. Discharge is usually the happiest moment for the patient and their family. As soon as the doctor says “Discharge” on the rounds, most people find it irritating to wait for any extra time taken for paperwork. However, it involves process and lengthy paperwork for cashless patient.

36. Discharge from hospital is a process and not an isolated event. It involves the development and implementation of a plan to facilitate the transfer of an individual from hospital to an alternative setting where appropriate. Components of the system (family, carers, hospitals, primary care providers, community services and social services) must work together. Activity and performance standards should be frequently monitored and the system and the organization should be open to innovative solutions.

37. Discharge planning is the critical link between treatment received by the patient in hospital and transitional care provided in the community. Effective discharge planning enables a seamless transition from hospital to home (or residential care), thus enabling better health outcomes for the patient and reducing the likelihood of readmission to hospital. This will ensure that the whole systems approach to admissions and discharges is positively reflected in the patient’s experience. All hospitals should have their own operational policies for discharge planning. Staff should to be involved in the development and regular review of these policies. As with admissions, the standard of discharge management impacts on patient satisfaction, hospital efficiency, quality and safety of patient care.

38. **Discharge Process.** The discharge process in almost all the hospitals is executed in the following manner:-

a) Consultant/treating physician assesses the clinical condition of the patient on a daily/periodic basis as per the progress of the patient. On finding the patient fit to be discharged, the consultant will order discharge by writing the "discharge order" in the case-sheet of the patient. This order will trigger the discharge process to be put into effect by all the functionaries/stake-holders.

b) The RMO will prepare the discharge summary of the patient which will incorporate all the necessary details as required. This will broadly include complaint/condition of the patient on admission, treatment given/administered, diagnostic/lab tests carried out and their results, condition of the patient presently and prescriptions for home care/treatment.

c) The RMO sends the draft Discharge Summary to the transcriptionist for preparing the file/notes which become the basis for further action. The transcriptionist types the discharge summary and sends it back to the RMO and the consultant for their signatures.

d) The nursing department will take all actions to complete the process i.e. return of balance medicines and get all pending reports if any and file them in the patients' case-file. Photocopy of original reports for TPA patients are prepared and filed.

e) Pharmacy will take all medication return and prepare the final bill and return the file back to Nursing station or the IPD billing (in case of hospital functioning with networked software).

f) Completion of file of patient and forwarding it to IPD billing is the responsibility of concerned Nursing station.

g) IPD billing will prepare final bill of the patient and handover to the attendant for cash patients. In case of TPA, CGHS and Corporate patients, the procedure laid is followed.

h) Payment/ clearance of bill is done by the patients' attendant or the TPA/Corporate.

i) The bed or the room is vacated by the patient after clearance of bill and the nursing station informs the HK staff who will take over the room/bed and prepare the bed/ room for the next patient after necessary cleaning/ disinfection.

Magnitude of the Problem

39. In view of the importance of an effective discharge planning system in both acute and sub-acute care policy and practice, many countries have launched a series of guidelines for good practices in hospital discharge planning process. In the United Kingdom (UK), the National Health Services (NHS) Plan included a commitment to ensure that by 2004, every NHS patient should have a discharge plan starting from hospital admission. The Department of Health's guidance for England also said that discharge planning from a hospital is a process, instead of an isolated event, which should start at the earliest opportunity. Effective discharge has also been a priority area in Australia since 1998. The Victoria Government has set an "Effective Discharge Strategy," a five-year initiative from 1998/99-2002/03 for all Victorian public hospitals. In the US, discharge planning is a legally mandated function for hospitals.[4]

Rationale of the Study

40. This present study aims to identify current discharge planning practices of health professionals working in Bensups Hospital, Dwarka, determine the barriers in executing the discharge planning of the existing system, and suggest components in developing an effective patient discharge planning system. The findings will provide information critical for the development of a discharge planning policy in Bensups Hospital. The present study will also provide additional information for further research into this important issue.

41. The main reasons for focussing on a streamlined, smooth and fast discharge process in our context can be summarised below:-

a) Restlessness/ eagerness of patient to go home and/or to a familiar (friendly) environment after stay in hospital. After consultant orders discharge, patient and attendant want to go home immediately even though the patient may have spent several days or weeks in the hospital.

b) The patient may have been hospitalized for days and has received quality treatment; he/she is not keen to wait for a few hours after the discharge has been confirmed. This may manifest in giving poor feedback in the Patient Satisfaction Feedback Form, due to some perceived delay at the time of discharge.

c) Most of the new admissions take place during morning OPD hours. Early availability of beds is one of the challenges faced by the management in most of the hospitals.

d) Housekeeping staff will get time to prepare rooms/beds and disinfection of rooms can be undertaken during turnover.

e) Smooth discharge process will improve feedback on waiting time (during discharge).

f) The Discharge process policy will help in Accreditation process.

g) Loss of revenue may result in the long run due to verbal feedback (word of mouth).

REVIEW OF LITERATURE

42. **Timely Discharge.** Timely discharge is when the patient is discharged home or transferred to an appropriate level of care as soon as he/she is clinically stable and fit for discharge.[2]

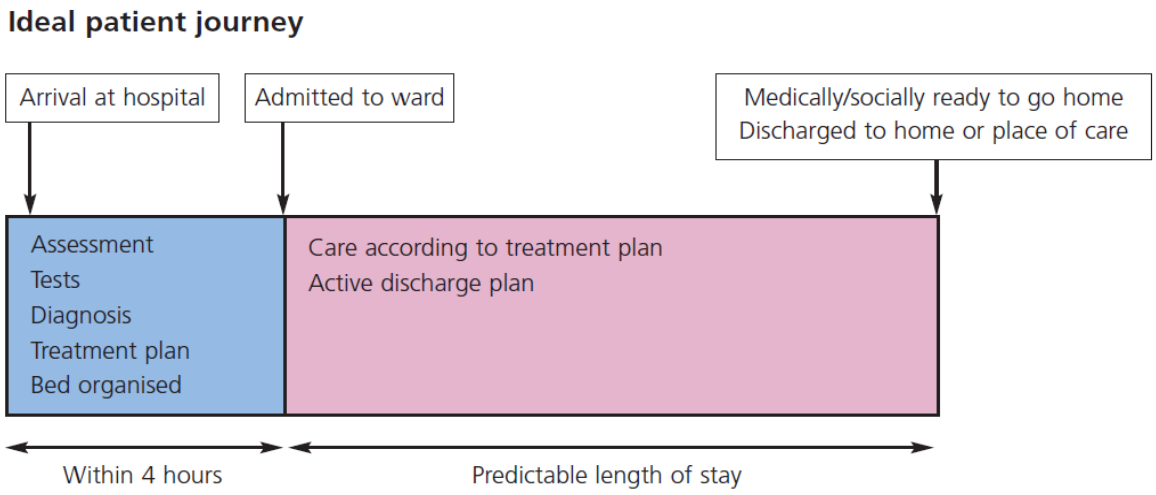


Figure 1. Figure showing ideal patient journey in a hospital

43. **Definition of Clinical Stability.** The terms clinical stability and medical stability mean the same thing. The patient can be defined as clinically or medically stable when tests such as bloods and investigations are considered to be within the normal range for the patient. 'Fit for discharge' however has a different meaning.[2]

44. **Criteria for Patient To Be "Fit for Discharge".** The patient is 'fit for discharge' when physiological, social, functional, and psychological factors or indicators have been taken into account following a multi-disciplinary assessment if appropriate. It is safe for the patient to be discharged or safe to transfer from hospital to home or another setting. The patient who is 'fit

for discharge' no longer requires the services of acute or specialist staff within a secondary care setting, and where:

a) Review of the patient's condition can be shared with the GP including adjustments to medication.
b) Ongoing general, nursing, and rehabilitation needs can be met in another setting at home or through primary/community/intermediate/social care services.
c) Additional tests and interventions can be carried out in an outpatient or ambulatory care setting.[2]

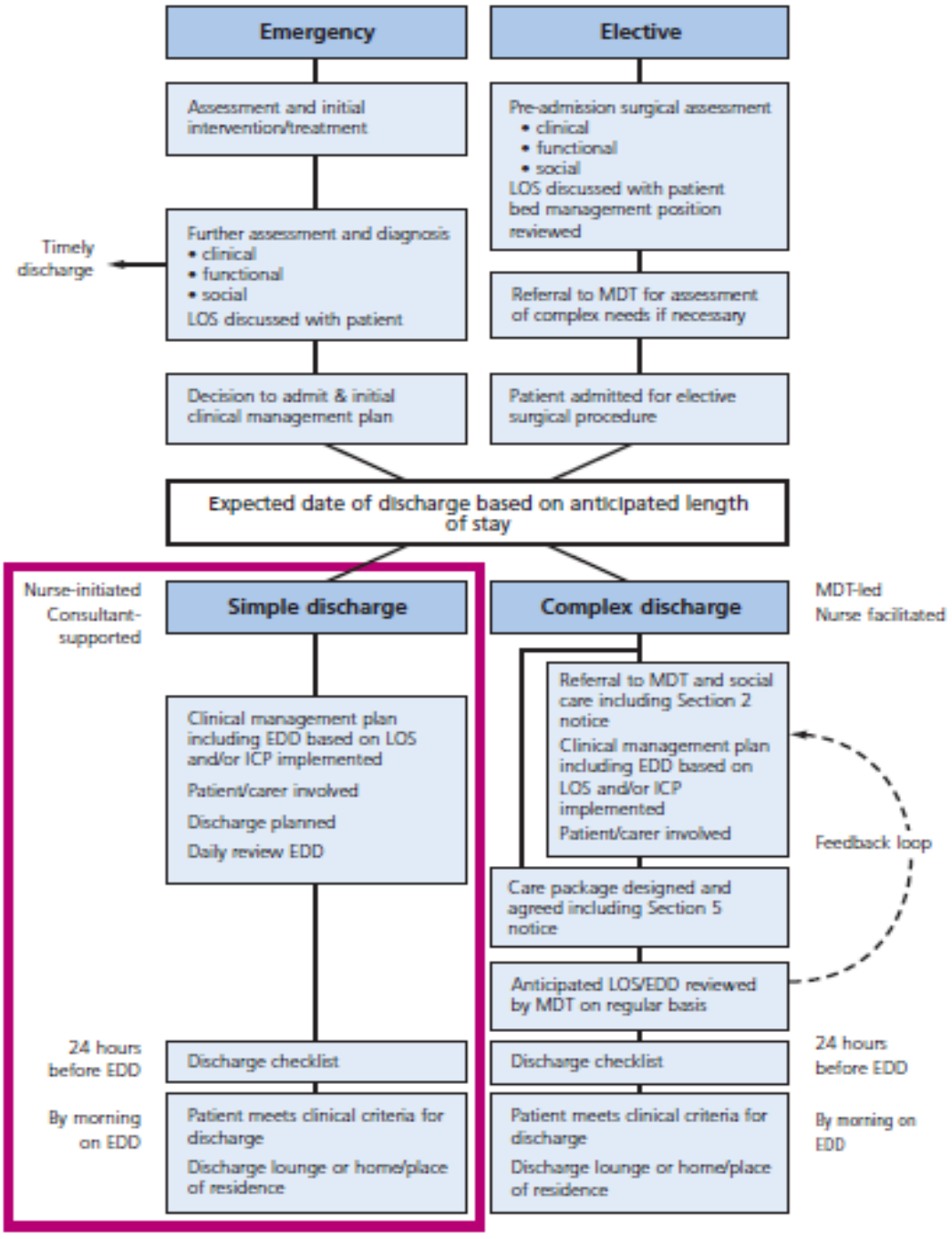


Figure no. 2. Figure showing discharge process of a patient in a hospital

EDD: Expected date of discharge

LOS: Length of Stay

MDT: Multi-disciplinary team

ICP: Integrated care pathway

45. **Key Players In The Discharge Process.** As already discussed, discharge is a process and not an isolated event. There are a large number of people including healthcare professionals who are involved in the discharge process. Key players in the discharge process are:[2]

a) **The Patient** The most important person in the discharge planning process is the patient. The care team will typically respect the patient's preferences during the discharge process. Recent studies have demonstrated that recovery at home is comparable to, and in some cases more favourable than recovery at a facility. However, every individual has his or her own preferences when it comes to discharge. This is why it is critical to establish open lines of communication as early as possible during the hospitalization. Clear communication allows the patient to voice personal desires and concerns and allows the discharge team and family members to share their thoughts and recommendations.

b) **Patient's Family Members and Caregivers** Family members and caregivers are a vital part of the discharge planning process because they are the ones who will help manage the patient's care in the home or post-hospitalization facility. They can provide valuable input to the discharge team that the patient may not have fully considered. It often falls to the family to ensure that the best possible decisions are made for a successful recovery and for the patient's wellbeing.

c) **Discharge Planner** The discharge planner, usually a nurse or a social worker, coordinates a patient's discharge from the hospital. The discharge planner wears several hats. She/he has to consider cost effectiveness for the hospital while also considering the family's wishes and the wellbeing of the patient.

d) **Nursing Team** Nurses who have taken care of the patient throughout the stay in hospital are an extremely valuable resource during the discharge planning process. They are able to comment, for instance, on a patient's mental status, stamina, ability and willingness to follow directions. They will also be able to provide valuable advice to the family based on their experience and their understanding of the patient's time at the hospital.

e) **Physician** The physician signs off on the final discharge plan and is responsible for prescribing medications which can have a direct bearing on the patient's comfort and mood. The physician's primary goal is the patient's physical and mental wellbeing.

f) **Social Worker** The social worker has three responsibilities: (1) to assess the patient for psychosocial factors that could impact discharge plans, (2) to help connect families with relevant community resources and (3) to provide emotional support and guidance to patients and their families. Social workers can be a tremendous resource, especially if the patient has spent significant time in the hospital or is at risk of depression or other emotional issues during the transition home. This issue is not given full significance since all hospitals donot have the Social workers working closely with the patients.

g) **Skilled Therapists (OT/PT/ST)** Occupational therapists, physical therapists and speech therapists can play a role in the discharge planning process by communicating the patient's capabilities and deficits to the discharge planner. These skilled therapists will also play an important role in the post-hospitalization care process.

46. **Key Principles for Effective Discharge**. The key principles for effective discharge and transfer of care are that[3]:

a) Unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes and the commissioning and delivery of services;

b) The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge;

c) Discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across the primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate;

d) The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'. This involves liaison with the pre-admission case co-ordinator in the community at the earliest opportunity and the transfer of those responsibilities on discharge;

e) Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process;

f) Effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately and individuals achieve their optimal outcome;

g) The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights and receive advice and information to enable them to make informed decisions about their future care.

47. **Discharge Planning.** Discharge planning is a process that begins with early assessment of anticipated patient care needs. Effective discharge planning requires input from numerous disciplines i.e. physicians, nurses, case managers, dieticians, educators, therapists and social workers. Hospitalization is often a short-term event, so planning for discharge may begin shortly after admission. The physicians, nurses, and case managers involved in a patient's care are part of an assessment team that keeps in mind the patient's pre-admission level of functioning, and whether the patient will be able to return home following the current hospital admission. Information that could affect the discharge plan should be noted in the patient's medical record so that it will be taken into account when discharge is being scheduled. While a person has been in the hospital, physicians other than the primary care physician have been in charge of the patient's care. Good discharge planning involves clear communication between the hospital physician(s) and the primary care physician. The information to be conveyed includes:

a) Summary of the hospital stay.

b) List of test and surgeries performed, with results and list of test results still pending.

c) List of tests needed after discharge, such as a repeat chest x ray.

d) List of medications for the discharged patient, including the dosage and frequency.

e) Copy of the patient's discharge instructions.

f) When the patient should see the physician for a follow-up appointment.

g) Discharge instructions to the patient on activity level, diet, and wound care.

48. Before leaving the hospital, the patient will receive discharge instructions that should include:

a) Explanation of the care the patient received in the hospital.

b) List of medications the patient will be taking (the dosage, times, and frequency).

c) Prescription for any newly prescribed medications and their potential side effects.

d) When to see the physician for a follow-up appointment.

e) Home care instructions such as activity level, diet, restrictions on bathing, wound care, as well as when the patient can return to work or school, or resume driving.

f) Signs of infection or worsening condition, such as pain, fever, bleeding, difficulty breathing, or vomiting.

49. **Benefits of Effective Discharge Planning.** The benefits of effective discharge planning are:

a) **For the Patient** Patients' needs are met and they feel part of the care process, an active partner and not disempowered.

b) **For the Carer** They feel valued as partners in the discharge process and consider their knowledge has been used appropriately. They are aware of their right to have their needs identified and met and feel confident of continued support in their caring role and get support before it becomes a problem. They have the right information and advice to help them in their caring role and understand the whole process.

c) **For the Staff** The staff feels their expertise is recognised and used appropriately, they receive key information in a timely manner and understand their part in the system. They can develop new skills and roles and have opportunities to work in different settings and in different ways as they work within a system which enables them to do so effectively.

d) **For the Organisations** Resources are used to best effect and service is valued by the local community. The staff feels valued which, in turn, leads to improved recruitment and retention and meet targets and can therefore concentrate on service delivery. There are fewer complaints and avoidance of blame and disputes over responsibility for delays. Positive relationships with other local providers of health and social care and housing services are maintained.

Important Studies

50. **Caregiver Perceptions of the Reasons for Delayed Hospital Discharge.**[5] (Tracey M. Minichiello, Andrew D. Auerbach, Robert M. Wachter)

a) This study was done to identify caregiver's perceptions of reasons for discharge delays at an academic medical centre. There were total 171 respondents including house staff, attending physicians and nurses.

b) The result of the study suggested that nurses were more likely to attribute delays in discharge than house staff and physicians. Also, caregivers at the same institution perceived different barriers to discharge and believed that discharge related activities occurred at different times.

c) The conclusion was communication gaps should be addressed to facilitate hospital discharges.

51. **Barriers to Effective Discharge Planning: a Qualitative Study Investigating the Perspectives of Frontline Healthcare Professionals.**[6] Wong EL, Yam CH, Cheung AW, Leung MC, Chan FW, Wong FY, Yeoh EK.

a) The aims of this present study were to explore the perceived quality of current hospital discharge from the perspective of health service providers and to identify barriers to effective discharge planning in Hong Kong.

b) Focus groups interviews were conducted with different healthcare professionals who were currently responsible for coordinating the discharge planning process in the public hospitals. The discussion covered three main areas: current practice on hospital discharge, barriers to effective hospital discharge, and suggested structures and process for an effective discharge planning system.

c) Participants highlighted that there was no standardized hospital-wide discharge planning and policy-driven approach in public health sector in Hong Kong. Potential barriers included lack of standardized policy-driven discharge planning program, and lack of communication and coordination among different health service providers and patients in both acute and sub-acute care provisions which were identified as mainly

systemic issues. Improving the quality of hospital discharge was suggested, including a multidisciplinary approach with clearly identified roles among healthcare professionals. Enhancement of health professionals' communication skills and knowledge of patient psychosocial needs were also suggested.

52. **Factors Contributing to the Process of Intensive Care Patient Discharge: An Ethnographic Study Informed by Activity Theory.**[7] Lin F, Chaboyer W, Wallis M, Miller A

a) The aim of this study was to explore the factors that influence intensive care patient discharge. This study was undertaken in an Australian metropolitan tertiary hospital that had a 14-bed level 3 intensive care unit. Intensive care and acute care unit medical and nursing staff, and other hospital staff who were involved in the intensive care patient discharge process participated in this study. A total of 28 discharges were observed, and 56 one on one interviews were conducted.

b) Data collection techniques including direct observations, semi-structured interviews, and collection of existing documents were used.

c) Three patient activity systems were identified: intensive care patient discharge activity, acute care unit accepting patient activity, and hospital bed management activity. Analysis of the interactions among these activity systems revealed conflicting objectives (goals), communication breakdowns, and teamwork issues.

53. **Framework and Components for Effective Discharge Planning System: a Delphi Methodology.**[8] Yam CH, Wong EL, Cheung AW, Chan FW, Wong FY, Yeoh EK.

a) This study was a 3-staged process to develop, pre-test and pilot a framework for an effective discharge planning system in Hong Kong.

b) Delphi methodology was adopted to engage a group of experienced healthcare professionals to rate and discuss the framework and components of an effective discharge planning. The framework was consisted 36 statements under 5 major themes: initial screening, discharge planning process, coordination of discharge, implementation

of discharge, and post discharge follow-up. Each statement was rated independently based on 3 aspects including clarity, validity and applicability on a 5-point Likert-scale.

c) The findings of this paper provide a reference framework helping policymakers and hospital managers to facilitate the development of a coherent and systematized discharge planning process. Adopting a Delphi approach also demonstrates the values of the method as a pre-test (before the clinical run) of the components and requirements of a discharge planning system taking into account of the local context and system constraints, which would lead to improvements to its applicability and practicability.

OBJECTIVES

54. **General Objective.** To study the activities/events involved in the discharge process and average time taken in the process and factors responsible for the delay in the discharge process (if any) at Bensups Hospital, Dwarka, New Delhi.

55. **Specific Objectives.**

a) To observe the events involved in patient discharge process at Bensups hospital.

b) To observe the work flow and responsibilities of various departments involved in discharge process.

c) To calculate the average time taken in discharge of each patient from the hospital.

d) To find out the events causing delay in discharge process and factors responsible for it.

e) Formulate an SOP for Discharge Process at Bensups Hospital.

RESEARCH METHODOLOGY

56. The researcher employed quantitative and qualitative approach to data gathering. The data collection source for the study is primary and secondary data source. The primary data was collected through the use of observation and Discharge tracking tool that include, Patient information, timings of various events occurring in the process of discharge. Interviews were conducted with staff nurses, resident physicians, floor managers, pharmacists, patient flow coordinators, executive administrators and housekeeping supervisors. Interviews with floor nurse managers helped identify patient flow issues and complete a flow chart of the entire patient discharge process. In order to recognize and understand the complexity of the patient discharge process, a root cause analysis was performed to identify roadblocks and determine reasons for delays in the process. The other details are as follows:-

a) **Study design** Descriptive cross-sectional study (Time motion study).

b) **Study area** Bensups Hospital , Delhi.

c) **Study population** Patients discharged from the hospital from 16 Feb to 31 March 2014.

d) **Sample design** Non probability- convenience method. Three/four patients discharged in the morning per day were included in the sample. Patients admitted in the Inpatient department situated on the second, third and fourth floors of the hospital only, were taken into consideration while sampling.

e) **Sample size** 100

f) **Study duration** The study duration was of 45 days from 16 Feb to 31 March 2014. Three-four patients per day were tracked.

g) **Data collection tool and technique** Observation and Discharge tracking tool.

57. The work process of every concerned department is divided into various events to monitor the time taken in the completion of each event. Time of every event which is followed by the departments was documented over a period of 45 days and 100 patients were monitored. Time taken by each event was noticed. Then, total time taken in the completion of whole discharge process was calculated. The average time taken in the completion of each event was calculated and average time taken in the discharge process of all 100 patients was calculated.

ABOUT THE HOSPITAL

58. Located as a pioneer group in Dwarka Sub-city in the walk able proximity to Sector 12 metro station, Bensups Hospital gives a clean and fresh ambiance. The hospital aims to provide a seamless healthcare delivery system encompassing tertiary, secondary and primary care. Special attention has been given to the design and aesthetics of different categories of rooms for the patient with each spacious room being naturally well ventilated and well illuminated. Bensups Hospital is a 138-bedded hospital. 14 beds are reserved for economically weaker section. It consists of 5 critical beds and 9 non critical beds.

59. Bensups Hospital endeavors to redefine and bring healthcare within the reach of every individual at an affordable cost. The motto 'Healing Touch', is the guiding principle for the entire Bensups family. Today Bensups Hospital is a multi-specialty hospital, with focus on specialization with perfection. A diligent team of professionals and highly qualified doctors renowned in their respective fields of specialty are a part of the Bensups family.

Bensups Hospital - Healthcare Excellence with a Healing Touch

60. The Bensups Hospital has created a niche for itself in a short span of time both within the medical fraternity and patients. It has been set up as a multi-specialty hospital with tremendous latitude of growing into a super-specialty hospital & as a major center to cater to affordability of various economic segments. The ultra modern, technically advanced operation theaters with laminar airflow and pneumatic instruments are well equipped to carry all sorts of sophisticated surgery. Post-Operative and Intensive-Care beds connected to a centralized gas supply and an advanced monitoring system are supervised by experienced and trained nursing staff. Strategically designed health packages are a noteworthy feature of the hospital services. They have been planned keeping economy and the highest standards of quality under consideration, with an aim to benefit each and every stratum of society.

The Visionary and Promoters

61. The visionary behind Cygnus Bensups Hospital, Late Mr. B R Dhawan relentlessly strived to contribute to the growth and development of society keeping the cultural traditions intact. The idea behind starting Cygnus Bensups hospital was to provide affordable quality services to society at all times and today Cygnus Bensups is the hospital for the people, a gift by Late Mr. B R Dhawan for all to cherish. The Hospital is being promoted by B R Dhawan Memorial Charitable Trust. The trustorial board of the organization consists of experienced professionals. The trustees are first generation entrepreneurs having business interests in fields such as Hospitality, Healthcare & Consultancy. The Group has achieved continuous growth in their ability to care for its patients, right from inception in year 2006.

About Cygnus

62. Cygnus Medicare is a company formed by a group of highly skilled doctors with a vision to open centers for specialized surgeries throughout north India. The endeavor would be to provide latest technology with advance skills in the backdrop of desired infrastructure of international standards. Cygnus Medicare is providing its expertise in management, specialized surgeries and internationally renowned faculty at Bensups Hospital with great success to the satisfaction of the patients coming not only from Dwarka but from all across North India and different parts of the world.

63. **Services Provided At Bensups Hospital**

a) Cardiology
b) Cosmetic Surgery
c) Dental Department
d) Dermatology
e) ENT
f) Gastroenterology and Endoscopy
g) General Surgery
h) Neuro & Spine

i) Obstetrics and Gynaecology

j) Physiotherapy

k) Radiology

l) Surgical Oncology

m) Pathology

n) Orthopaedics

o) Eye Institute

p) Urology

STUDY FINDINGS

64. The events involved in discharge of a patient from the hospital can be divided into following heads according to the department involved:

a) Nursing
b) Pharmacy
c) Billing

NURSING

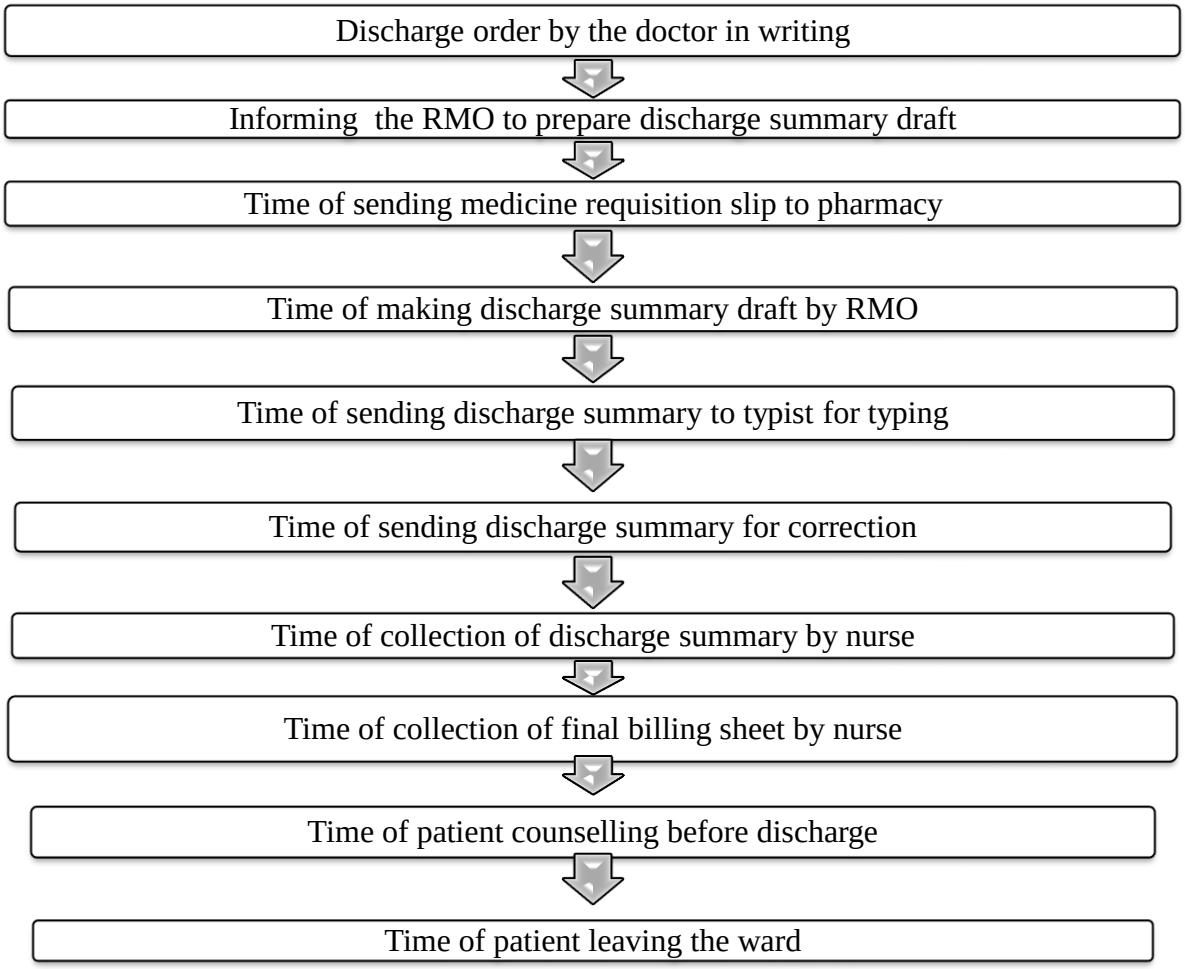


Figure No. 3. Figure showing workflow of Nursing department during discharge

PHARMACY

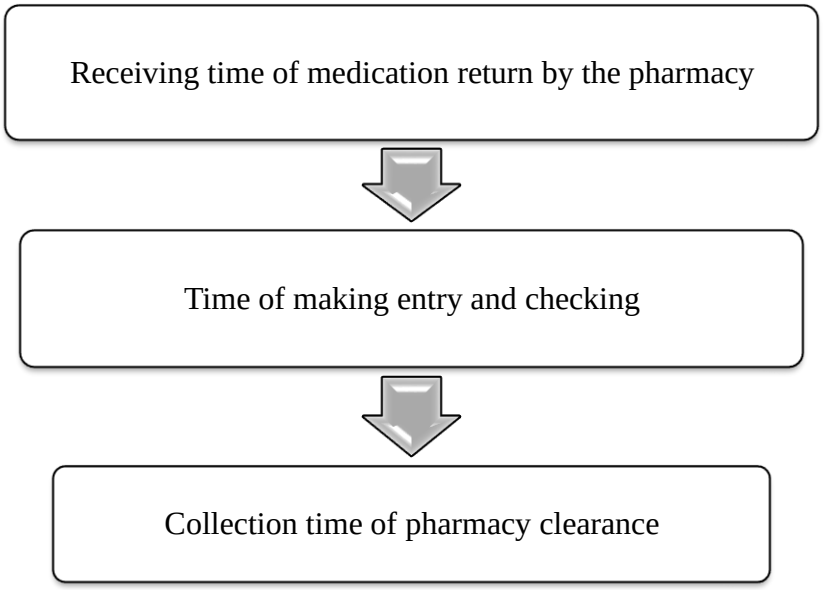


Figure No. 4. Figure showing workflow of Pharmacy department during discharge.

BILLING

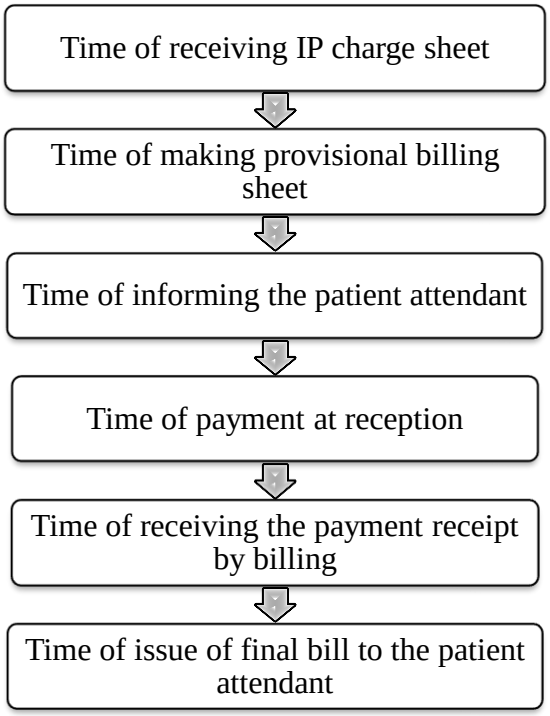
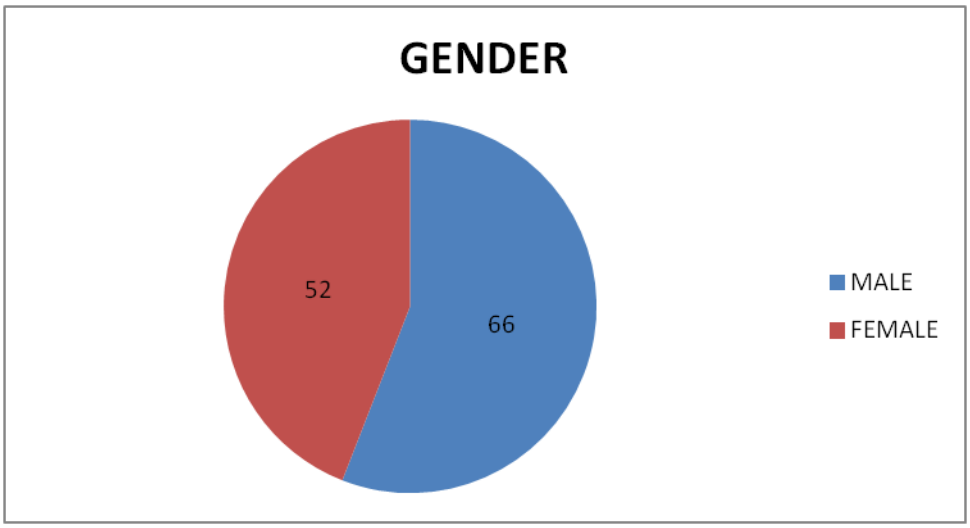


Figure No. 5. Figure showing workflow of Billing department during discharge

ANALYSIS

1. Table and graph showing number of gender of selected sample.

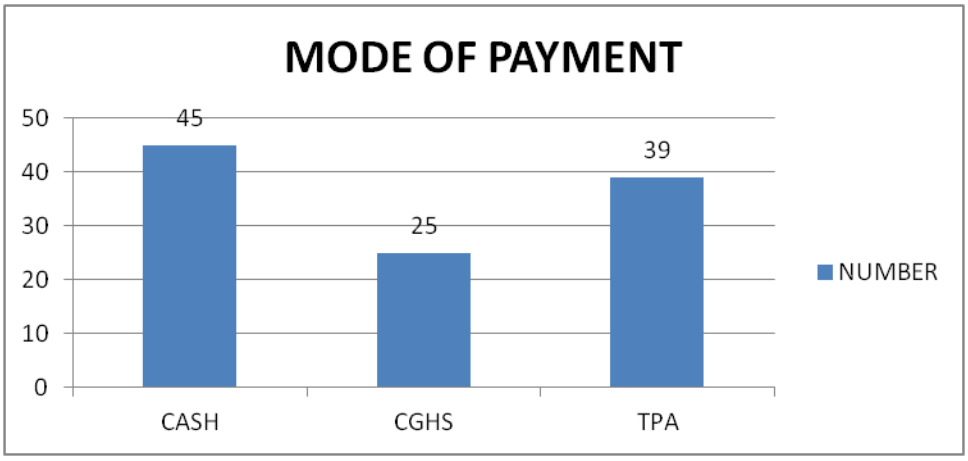
GENDER	NUMBER
MALE	66
FEMALE	52
TOTAL	118



65. Out of 118patients, 66 patients (approximately 55%) were males out of the selected sample and others were females.

2. Table and graph showing number of category of selected sample according their mode of payment.

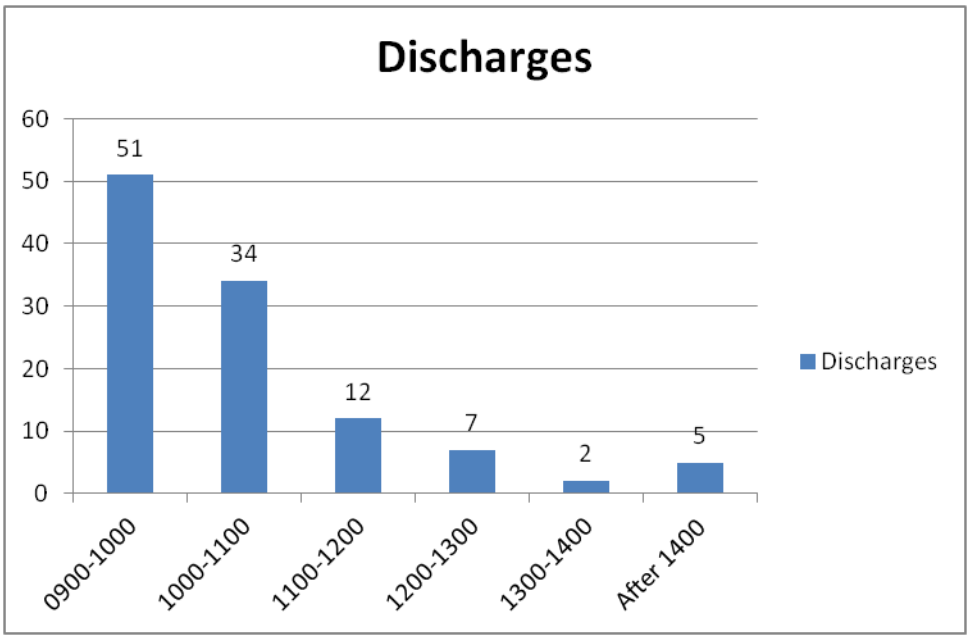
CATEGORY	NUMBER
CASH	45
CGHS	25
TPA	39
TOTAL	109



66. Out of 118 patients taken in the study, 45 patients were Cash patients, 25 patients were CGHS credit patients and 39 patients were TPA patients. Balance nine patients were BPL and international patients who were not included as the procedure followed for them was different.

3. Table and graph showing timings of discharge of patients.

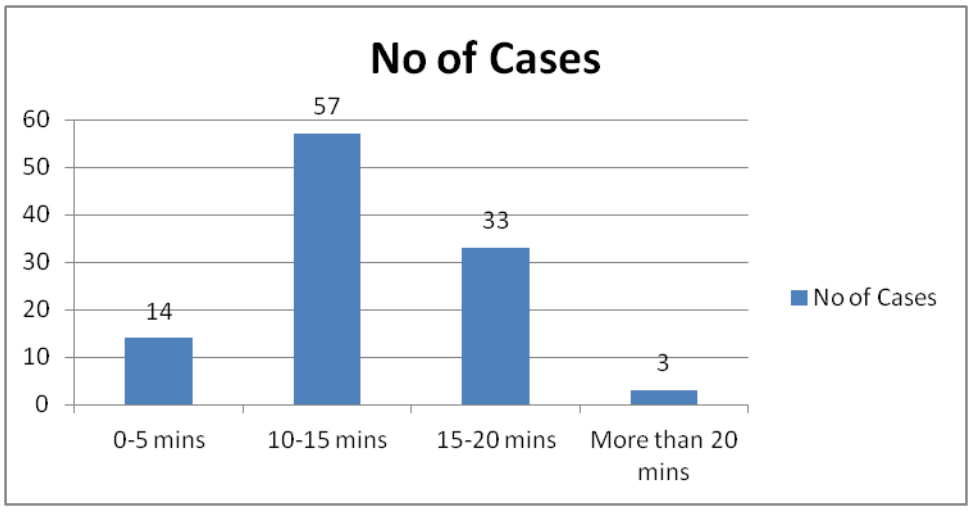
Time range	No of Discharges
0900-1000 hours	51
1000-1100 hours	34
1100-1200 hours	12
1200-1300 hours	7
1300-1400 hours	2
After 1400 hours	5
Total	111



67. It was noticed that maximum discharges were ordered by the consultants during morning rounds primarily between 0900 hours to 1100 hours. 85 discharges (77%) were ordered uring the peak hours (0900 – 1100 hours). The consultants are not using the evening rounds to order and plan discharges. There were two cases of night discharges but they were transfer cases only.

4. Table & graph showing time taken by RMO to prepare discharge summary.

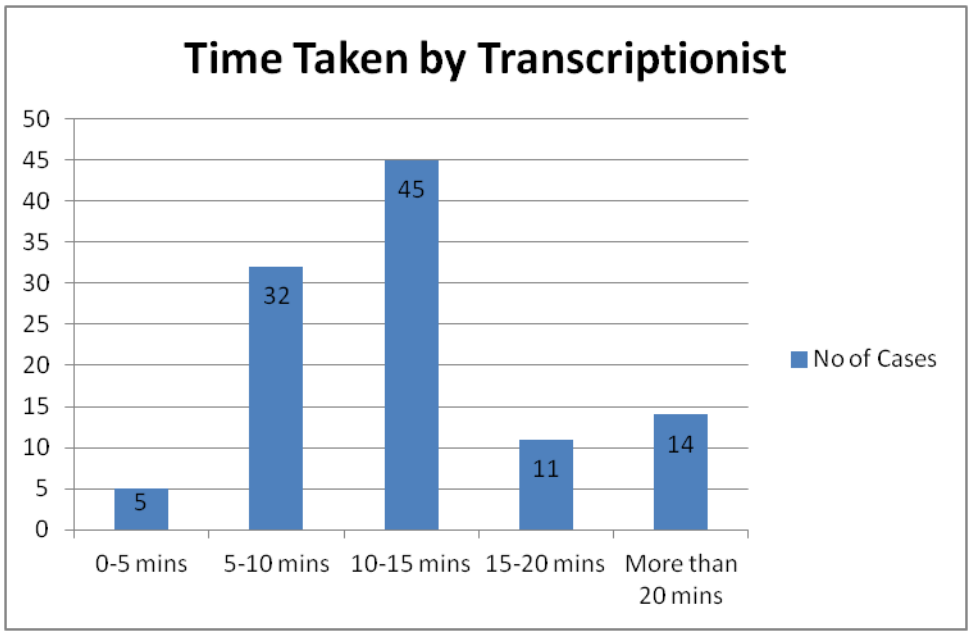
Time Taken by RMO to prepare DS	No of Cases
05-10 mins	14
10-15 mins	57
15-20 mins	33
More than 20 mins	3



68. There are five RMOs in the hospital who are available 24x7 in the hospital. to prepare discharge summary. Writing the discharge summary is the first step in the process of discharge. The average time taken by RMO to prepare discharge summary draft was 15 mins. However, in some cases more than 1 hour time was also observed. The maximum time taken was 1 hr 10 mins in case of one of the sample patients taken.

5. Table & graph showing time taken by Transcriptionist to type the discharge summary.

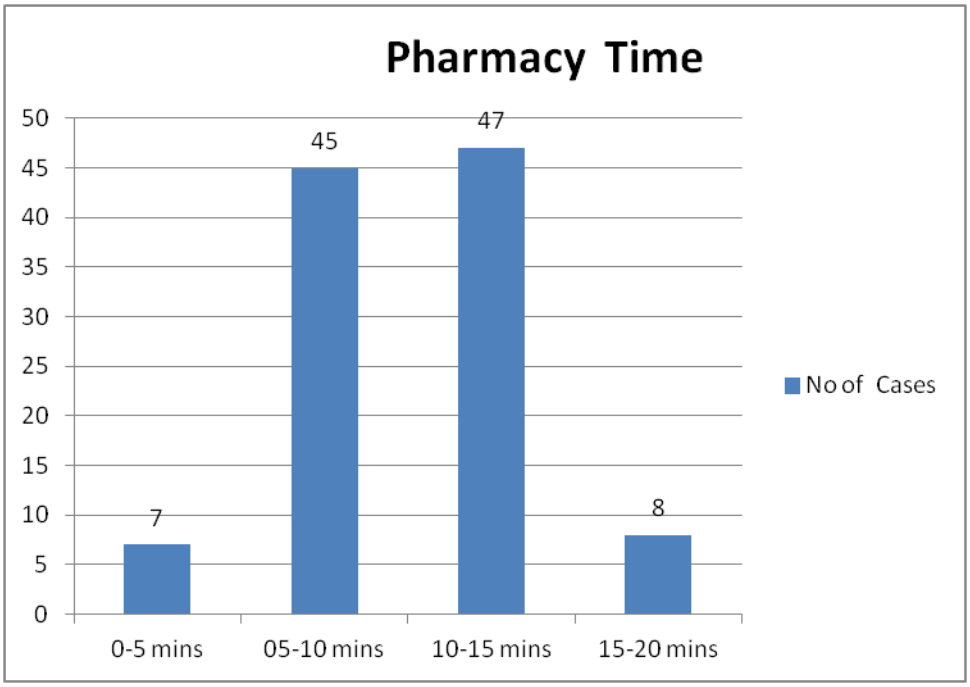
Time Taken by Transcriptionist	No of Cases
0-5 mins	5
05-10 mins	32
10-15 mins	45
15-20 mins	11
More than 20 mins	14



69. It was noticed that average time taken by the typist to type the discharge summary was 16 mins. However, in two cases it was more than 1 hour also. In the cases which were completed in less than five mins the RMO was on the same floor and was sitting with the typist. The delays took place where amendments had to be carried out in the DS.

6. Table & graph showing time taken by Pharmacy for medication return and preparation of pharmacy bill.

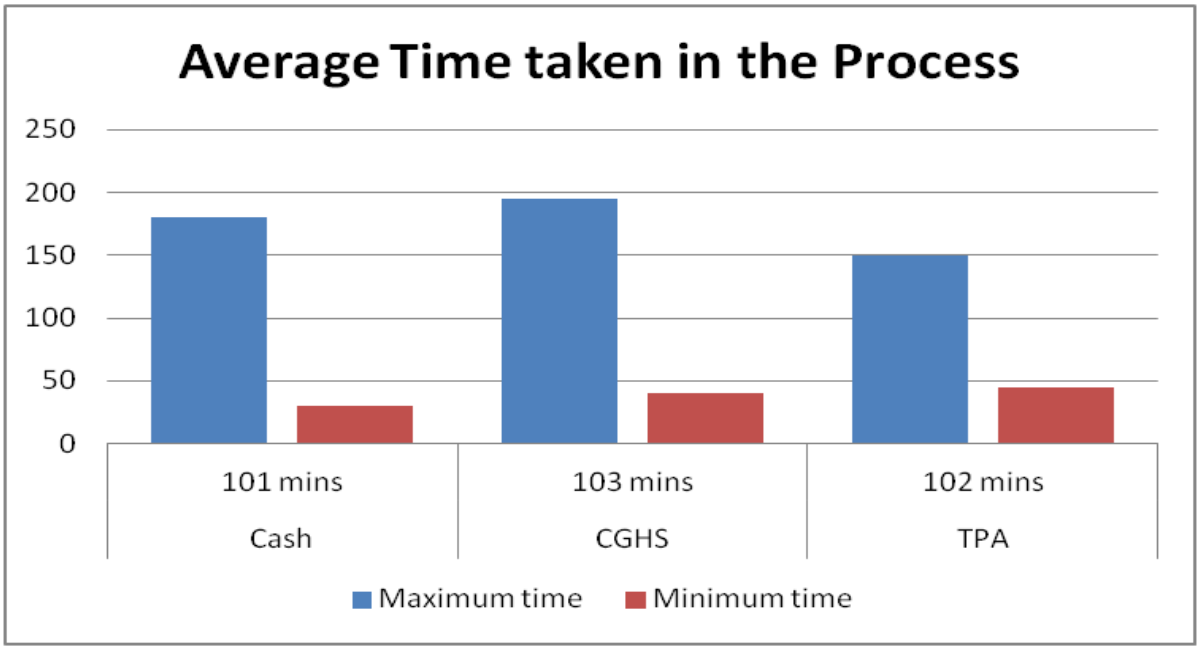
Time Taken by Pharmacy	No of Cases
0-5 mins	7
05-10 mins	45
10-15 mins	47
15-20 mins	8



70. Average time taken by the Pharmacy to return the medications and prepare the final bill was noticed to be 11-12 mins. It was also noticed that the GDA who had come for medication return and collection of Pharmacy bill was not available at the pharmacy immediately to pickup the file and return it to Nursing station. On enquiry I was found that more tasks were also allotted to him, like dispatch of samples/collection of lab or diagnostic reports. This led to delays at the pharmacy counter and was attributed accordingly.

7. Table showing average time in process of discharge in case of all types of patients.

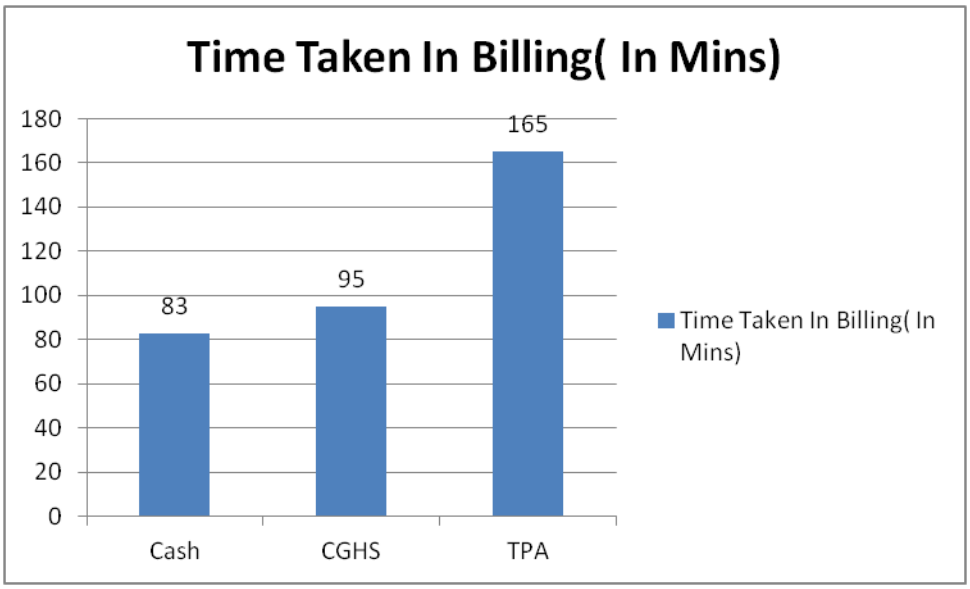
Type of Patient	Average time in Process	Maximum time	Minimum time
Cash	101 mins	180	30
CGHS	103 mins	195	40
TPA	102 mins	150	45



71. Having seen all the timings taken by the activities involved in the discharge process, average time taken in the discharge process was101 mins to 103 mins for all three types of patients. There is not much of difference in these cases as the steps followed are the same. It was also observed that type of patient has no effect on the process. Although, international patients were not part of the study, but the time taken was 87 mins in their case.

8. Table showing time taken at IPD Billing as per category of patients.

Type of Patient	Average time in Billing Process
Cash	83 mins
CGHS	95 mins
TPA	165 mins



72. The time taken by the patients/their attendants to clear the bills depended on the mode of payment for the services. Average time taken by cash patients was 83 mins, CGHS patients bills were cleared in 95 mins while average time taken by TPAs to clear the bills/ authorize the payment was 165 mins. The time taken at billing is on the higher side in case of cash and CGHS patients. Sometimes patient's attendants are also responsible for delayed discharge. The reasons were non availability of patient attendant at the time of bill clearance and avoidable delayed payment of bill by patient attendant.

9. Table showing time taken in the Discharge process as per timings of Discharge.

Time of Discharge	**Cash**	**CGHS**	**TPA**
0900-1000	120 mins	115 mins	107 mins
1000-1100	99 mins	102 mins	100 mins
1100-1200	80 mins	93 mins	85 mins
1200-1300	92 mins	105mins	100 mins
After 1300	101 mins	115	105 mins

73. It was seen that time taken in the discharge process when the discharge was ordered in the morning between 0900-1000 hours was the maximum. This could be attributed to peak load of work for Nursing, GDA/HK staff due to discharges, admissions, surgeries, diagnostics tests, management rounds and OPD.

DISCUSSION

74. In Bensups hospital the average time taken in the patient discharge is 3 hours 6 mins. According to the Operations department of the hospital (Bensups hospital), the discharge of a patient should be completed within two hours of signing of the discharge order by the consultant, in case of Cash and CGHS patients.

75. The average time taken for discharge of cash patients is less than that of CGHS and TPA patients. In case of TPA patients, it takes more time to get the clearance from the company. This is the main reason due to which it takes around 4-5 hours to discharge a TPA patient.

76. Some of the other causes for delayed discharge of TPA patients include:

a) Delay in finance clearance in the hospital.

b) Medical records are not filled completely by the treating doctors.

c) Discharge summary not signed by the treating doctor.

d) Remarks not mentioned in the discharge summary.

e) Final bill of the patient is more than the approved amount and hence corresponding delay in enhancement approval.

f) 'Delayed response' from the TPA on 'final authorisation approval'- TPAs generally take two to three hours to finally authorise a claim whereas the hospital internally takes around two hours to complete the administrative formalities that encompass discharge summary, collection of reports, billing and other relevant documentations.

77. The main cause of delay is poor communication between the doctors, nurses, personnel of pharmacy and billing department and patient’s attendant. The responsibilities of each functionary in the chain of discharge process are not well articulated to them.

78. While the workflow is known to each employee, the maximum time for each activity in the workflow is not known to them. Hence everyone wants to do their action fast but at their convenience.

79. The GDAs are one of the most ‘scarce’ commodities in the hospital and hence all employees specially the Nursing staff does want to send them for individual files/tasks and tend to club tasks outside the floor. This activity/tendency leads to bunching/piling of files at various stations and leads to consume time and slow down the process.

80. In IP pharmacy, the pharmacist generally takes 11-12 minutes for clearance of each file. At the Pharmacy, it takes long time sometimes because of following reasons:

a) In view of sending the GDA only once, nurses send pharmacy return of 2-3 patients together which take longer time for clearance.

b) Nurses send medical requisition for the prescribed drugs without checking that the patient has already got enough of them. This sometimes increases the amount of medication return to pharmacy. The reason behind this is poor communication between nurses during handling over of patient after shift change.

c) Sometimes GDA is not available for handling over of the medication return after preparation of pharmacy return by the nurses.

d) The GDA at times leaves the medication return at the pharmacy and perform other tasks and do not collect the files on time.

81. The IPD billing department workflow is streamlined and they are not very hard pressed with high workload. There is not much delay at the billing station in case all the files are complete in all respects.

82. Billing also takes longer time in case of incomplete documents submitted by nurses. According to hospital’s policy Billing department receives the document of the patient only when it is complete specially of TPA patients.

83. Sometimes patient’s attendants are responsible for the delay. The possible reasons are:-

a) Non availability of patient attendant at the time of bill clearance

b) Delayed payment of bill by patient attendant.

c) Transport for the patient is not available for journey to his home.

10. Table showing Suggested Time for Activities

S No	Station/ Person	Actions	Time taken	Running Time	Remarks
1	Ward	DO by consultant	-----		
2	RMO	Discharge summary /notes	15-20	20	Should be available readily
3	Typist	Typing of notes	10	30	
4	Nursing	Return medicines Compile all reports	Concurrent 15	45	
5	Pharmacy	Prep final bill	15	6	
6	Nursing	Check correctness, Dispatch file to billing	15	75	
7	IPD Billing	Prep final bill	30(cash)	105	
8	HK	Check room/bed for inventory	concurrent		Prior to move of patient
9	Floor Mgr	Obtain feedback, Prep for new patient	concurrent		After ordering discharge

Table 11. Table showing Suggested Time Check-sheet

S No	Activity	Person Responsible	Time In	Time Out	Total Time	Running Time	Coord by
1	Discharge ordered	Consultant	0930	0945	00.00	15	
2	Discharge summary	RMO (name)	0945	1005	20 min*	35	Floor
3	Transcription	Neha	1005	1015	10*	45	
3	File prep	Nurse IC	1015	1030	15	60	
4	Return medicines	Nurse & GDA	1015	1025	10*	-	
5	Pharmacy Bill	Pharmacy	1025	1045	15*	75	
6	Check & dispatch file	Nurse	1040	1050	15*	90	
7	IPD Billing	Billing Exec	1120	1150	30	120	

The above check-sheet is a sample. There is a need to monitor activities as per timings laid down by the hospital. Floor managers and Operations manager must keep a close watch on the activities of various functionaries to follow the procedures.

RECOMMENDATIONS

84. Consultants/Doctors should plan for discharge of the patients after the patient is stable, possibly within 48 hours of his admission. He should provide the information to the assigned nurse about the tentative discharges during the evening rounds (1 day prior to discharge). This procedure will provide adequate time to each stake-holder to prepare for the discharge of the patient including the patient himself.

85. Presently, the peak hours of ordering discharge are between 09:00 am to 11:00 am. Hence, the consultant's morning round should be completed by 9:00 am. "To be discharged" patients should be examined /seen by the consultant/doctor first.

86. Tentative discharge summary should be prepared by the resident medical officer and transcriptionist (discharge typist) during the night time preceding the day of discharge. This can only happen only if the discharge is ordered or planned previous day.

87. In case of planned discharges, all functionaries must commence their actions a night before only.

88. Medications return should be conducted and completed during the night time, one day prior to discharge. Morning dose of all medications should be kept separately for administration to the patient.

89. Nursing staff must complete the documentation of the patients' files after the consultant orders discharge. In fact it should be continuous process and the documents and reports should be filed every day. Photocopying of documents where necessary should be done in advance. All pending Lab/Radiology reports should be collected during night time and filed in the patient's records.

90. Inter departmental communication between wards, lab/diagnostic services pharmacy, floor managers and communication between nurses and patient attendant need to improve.

91. Nurses should properly check the medication before sending requisition pharmacy to avoid extra accumulation of drugs. This needs to be emphasised on all nurses and should become part of the work culture.

92. Nurses should not send the pharmacy return of many patients in bulk. It leads to wastage of time at all levels- at wards and at Pharmacy. The GDA is also engaged at the pharmacy for longer time leading to avoidable delay.

93. IP Billing section should keep a track of outstanding balance of the patient and remind the attendant/patient.

94. Smooth discharge process is a function of efficiency of personnel involved and their commitment and dedication. However, it is felt that that number of GDA should be increased to cater for the needs of the departments and the floors.

95. A Discharge co-ordinator should be appointed who would facilitate the discharge process by acting as a mediator to increase inter-departmental communication.

96. Automated system for the whole discharge process can be implemented. HMIS will ensure that work processes are uniform and easily accessible to all those who need it.

97. There should be uniformity in the billing model for all the hospitals so that there is transparency between the hospital and the TPA groups. With this practice the chances of delay is reduced and it also smoothens the claim process.

98. The 10 steps which can be followed by each healthcare institution where patients are admitted for treatment are given below:-

a) Start planning for discharge or transfer before or on admission.

b) Identify whether the patient has simple or complex discharge and transfer planning needs, involving the patient or carer in your decision.

c) Develop a clinical management plan for every patient within 24 hours of admission.

d) Coordinate the discharge or transfer of care process through effective leadership and handover of responsibilities at ward level.

e) Set an expected date of discharge or transfer within 24-48 hours of admission and discuss with the patient or carer.

f) Review the clinical management plan with the patient each day, take any necessary action and update progress towards the discharge or transfer date.

g) Involve patients and carers so they can make informed decisions and choices that deliver a personalised care pathway and maximise their independence.

h) Plan discharges and transfers to take place over seven days to deliver continuity of care for the patient.

i) Use a discharge checklist 24-48 hours before transfer.

j) Make decisions to discharge and transfer patients each day.

99. Responsibilities of various functionaries in the chain of discharge process are enumerated at Appendix A for strict compliance and for better inter-departmental communication and coordination.

CONCLUSION

100. Hospital discharge is a complex and challenging process for healthcare professionals, patients, and carers. Effective discharge planning could significantly improve a patient's health and reduce patient readmission. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan. Planning for hospital discharge is part of an ongoing process that should start prior to admission for planned admissions, and as soon as possible for all other admissions. This involves building on, or adding to, any assessments undertaken prior to admission.[4]

101. Effective and timely discharge requires the availability of alternative, and appropriate, care options to ensure that any rehabilitation, recuperation and continuing health and social care needs are identified and met.

102. The average time taken for discharge of a patient was 3 hours 06 mins which is much higher than the estimated target of the hospital i.e. 2 hours. Various reasons for delayed discharges include longer time taken in the process, improper nursing activity, longer time in clearance of bill in case of TPA patients.

103. Hospital management should set an aim to decrease the discharge time to 2 hours and increase the inter-departmental co-ordination so that the aimed timing is achieved. Also, some automated system could be implemented so as to facilitate overall discharge process. The hospital staff should also be increased so that responsible persons are always available.

104. Good discharge management is vital to ensure:

a) Patient satisfaction.

b) Bed availability for emergency and elective admissions.

c) Quality of patient care remains high.

LIMITATIONS

105. The population studied consisted of a sample of only 100 patients hence some of the pattern identified may have been under or overestimated.

106. Due to long hours of discharge in some cases, some of the information was provided by the responsible person attending the patient instead of direct observation.

107. Due to lack of time and resources, the process of documentation for TPA patients was not studied in detail as in the case of cash or credit patients.

108. The discharge procedure laid down by the hospital was followed and no different tool was applied.

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Appendix A
(Refers to Para 18 of
Recommendations)

SOP for Responsibilities of Functionaries for Discharge Process

Responsibilities of various functionaries in the chain of discharge process are enumerated below for strict compliance and for better inter-departmental communication and coordination:-

1. **Consultant**

   a) Plan for discharge of patients after 48 hours of admission as per treatment protocols.

   b) Educate patient and/or attendant on patient condition, recovery process and medication.

   c) Keep RMO and Nursing staff informed in writing.

   d) Order discharge of patients preferably in evening rounds (discharge in the morning only).

   e) Advise/warn patient or attendant for discharge a day before discharge.

   f) Complete discharge order at earliest – Prescription, review instructions etc.

2. **RMO**

   a) Educate patients on the processes for Diagnostics, billing, discharge, catering.

   b) Prepare draft discharge summary previous evening, if possible or immediately after DO signed by Consultant.

   c) Hand-over discharge summary to Nursing staff or transcriptionist and/ or get transcription completed at the earliest.

   d) Amend transcription earliest, if needed for modification.

   e) Sign discharge summary on completion.

   f) Educate patient/attendant on medication/advice.

   g) Advice Nursing staff in the process.

3. **Floor Manager**

a) Maintain liaison with nursing staff for discharges during the day.

b) Monitor progress of documentation for discharge.

c) Inform IPD billing of discharges.

d) Inform HK staff about rooms/beds being vacated.

e) Keep record of timings during the process.

f) Expedite the process at each level.

g) Obtain feedback from patient/attendant as per performa and inform concerned functionary about observations/points of the customer.

h) Get vacated room/bed prepared after discharge.

i) Educate patients/attendant on the procedures being followed in the hospital.

4. **Floor Head Nurse**

a) Act as Nurse IC for discharge of patient on the floor.

b) Liaise with RMO for completion of discharge summary at the earliest.

c) Obtain transcripted file & ensure signatures of RMO/Consultants.

d) Return balance medicines to Pharmacy for finalization of pharmacy billing and obtain pharmacy bill.

e) Keep availability of GDA/HK staff for move of files.

f) Inform Floor mgr and HK mgr about the progress/delays.

g) Complete nursing assessments and daily progress notes.

h) Ensure completion of patients' file before sending to IPD billing.

i) Educate patients/attendant, if required.

j) Complete all documentation during night shifts- collection & filing of Lab/Radiology reports, photocopying.

k) Move each file immediately on completion- NO bunching.

5. **Transcriptionist**

a) Check records of daily admissions.

b) Check details of discharges from the Nursing staff of floors in the morning.

c) Transcript/complete each discharge summary within 10-20 minutes of receipt from RMO/Nursing station.

d) Clarify doubts from RMO at the earliest, in case of doubt.

e) Inform concerned Floor Nurse IC to collect completed files.

f) Keep updated record of all files/documents movements – in and out.

g) Be pro-active in completion and dispatch of files.

6. **Pharmacy**

a) Keep record of each transaction for each patient.

b) Daily update of transactions.

c) Medicines/expendables to be issued on receipt of indents from Nursing stations only.

d) Keep one counter free for IPD patients and return of medicines.

e) Prepare final bill pertaining to pharmacy for discharged patients within 10 minutes.

f) Ensure file returned to nursing staff/GDA immediately without delay – inform concerned staff if GDA not available.

7. **Housekeeping Staff**

a) Ensure GDA/HK available at the floor as per laid down norms/requirement.

b) GDA responsible for move of files / documents to be in constant touch with nursing staff.

c) Collect all files/reports immediately and handover to next in chain and confirm.

d) Keep beds and rooms in presentable condition at all times.

e) Take stock of room/bed prior to vacation of bed by discharged patient.

f) Explain inventory & equipment to patient/attendant at the time of admission.