PART 1 INTERNSHIP REPORT

I have done my internship in COLUMBIA ASIA Hospital situated in Palam Vihar ; Gurgaun. It is 100 bedded multi speciliaty hospital with wide range of services. This hospital start functioning on JULY 2008. Columbia Asia hospital is a chain of hospitals providing health services to people in different states. Other hospitals are located in Hebbal, Yashwant pur, atila,, Salt lake Calcutta and in Gurgaun. They are also planning to open a hospital in Ghaziabad.

Hospital in Gurgaun expands in 2.50 acres of land situated in middle of Palan vihar, in Block-F, near Gol chakker, Ansal plaza.

COLUMBIA ASIA

RANGE OF SERVICES

- Anesthesiology
- Dermatology
- ENT
- Gastroenterology
- General Surgery
- Internal Medicine
- Maxillo-Facial Surgery
- Medical Oncology
- Minimally Invasive (Laproscopy) Surgery
- Nephrology
- Neurology
- Neurosurgery
- Non-Invasive Cardiology
- Obstetrics & Gynaecology
- Ophthalmology
- Orthopaedic Surgery
- Pediatrics
- Pediatric Surgery
- Psychiatry
- Renal Transplant
- Surgical Oncology
- Urology
- Vascular Surgery

FEATURES & FACILITIES

- Dedicated Labour & Delivery Suites
- Dialysis Unit
- Endoscopy Suite
- Intensive Care Unit
- Café Columbia
- Nursery & Special Care Baby unit
- Nutrition & Dietetics
- Physiotherapy
- Preventive Health Screening

OUR 24 / 7 SERVICES

Emergency | Ambulance | Pharmacy | Laboratory | Radiology

I work as trainee there and act as a part of Quality team working on NABH acredation for the hospital. Quality assurance and its implementation is associated with functioning of whole hospital in order to provide Efective, Affordable and In time care to the patient. My project there was “Discharge Procedure – A Study for its Improvement”. During the study and for data collection I visited all he wards/wings of the hospital ie Medical wing, Surgical wing, Women wing, Pediatrics wing and Nursery.

Beside these wards I also visited

- Hospital Operaions
- Customer care
- Human resource
- Facilities
- House keeping
- Emergency room
- ICU
- Medical and General Stores
- Radiology department
- OPD
- Biomedical engineering
- Marketing
- CSSD
- Dietrics
- Pharmacy
- Medical records

✓ During my training I came to know about the functioning of various departments and their interrelationship while working as a team. I was exposed to detailed functioning of the various departments. My main exposure was to the operations part of the hospital.

✓ During my training I work as a part of Quality team of the hospital and play an active role for NABH accredation.

✓ For NABH accredation we prepare individual department Policies file and Operational mannuals which cantain guidelines that had to be followed by the individual departments for its functioning.

- ✓ A copy of each of these policies and operation mannual is there in each departmennt and a soft copy of these is send to Quality Council of India(QCI)/ NABH office.

- ✓ On the basis these files, Audits are conducted in each department to check wheather norms and conditions mentioned on these files were being fallowed. The information obtained from these aduits were complied inti data and then studied to check wheather the deparment working is upto NABH standards or not. If found short then the department is informed about the shortcomings and instructed to check it, correct it and to maintain it in future. Than a surprise aduit is done after some time ot check the results of previous audit.

- ✓ There were various quality indicators for each dept. which has to updated reguraly to maintain the standards.

- ✓ I have done Radiation safety aduit of radiology department, in which I prepared a questionare on the basis of Radiation safety mannual. These questions were asked by each member of radialogy dept. and scoring was done to check the radiation safety awareness among the members and also to check their knowledge regarding radiation safety norms.

- ✓ After this aduit I also do Team awareness aduit of various employees regarding their awareness about the hospital and its common functions

- ✓ I also take part as an evaluator in CODE RED mock drill(for fire fighting).
- ✓ I took desertation topic as “Dischrrge procedure – A study for its improvement” where i thoroughly studied the process of discharge, various steps and departments that are involved in the process, how the process begins and what factors are there which can lead to prolong discharge time.

- ✓ I also came to know about the method of comunication with TPA? what are the formalities for TPA patient cases?, what are the documents that are required to take claim from TPA? and if denial came than what cn be the causes and how they can be solved?

- ✓ I also came to know about Discharge summary, what is its importance and what are different components of discharge summary?

- ✓ Also get aware of what is the role of nurse in discharge process? How nurses communicate with each other during change of shifts?

- ✓ I also get a touched with the software CARE21 that is used in the hospital to record, retrive and change patient treatment plan. This software connects various departments of the hospital.

  With the help of this software you can:-

1. See the diagnosis and medications that are given to the patient
2. Patient initials like BP, Respiratory rate, Urinaton frequency, blood sugar levels etc
3. Also can check various tests that are done to patient and their reports also
4. Also check whch doctor had visited the patient and what are his/her findings
5. The total bill of pt., outstanding amount, pt is TPA or cash

- ✓ I also attend meetings and came to know about the chalenges that can come during the operation of a hospital and how the problem is discussed and later resolved asa team by the various members of the hospital.

CHAPTER – 1 INTRODUCTION

The discharge process varies from hospital to hospital, but most hospital systems should plan for and educate the patient and family much more thoroughly than they currently do. Hospital social workers and discharge nurses usually focus on the immediate discharge needs rather than on long-term goals and plans. One proven way to ensure that a more comprehensive, individualized plan for continuing care is developed is to establish-as the "*Acute Care for patient model Using an interdisciplinary team approach"*[1]**.** If the discharge process starts when the doctor confirmed that patient is well enough to leave the hospital. Early discharge planning involves a multidisciplinary team. Once the decision is made to discharge the patient, the doctor should talk with the patient and family members about medications (and provide prescription orders if needed), general care instructions related to the diagnosis, and when to follow up with an office visit. If nursing home care is needed, specific information about the medications that the patient will take-including the name, dosage, and schedule of drug to be administered should be provided to the nursing home upon transfer.

Hospital discharge is the process of preparing and facilitating a patient so that they can leave hospital. In principal all people being discharged a discharge plan with proper needs ie health care needs and social service needs is to be required. 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. Discharging patients from hospital is a key aspect of the nurse's role in the acute care settings and despite numerous studies undertaken in this area, it remains problematic. Issues in the initial implementation of the discharge process such as poor assessment and poor documentation often result in rushed discharge and a negative hospital experience for patient [2].

In the next section, the responsibilities of public hospital in relation to discharge process are mentioned.

“Public hospitals should:

• develop comprehensive discharge policies and procedures that clearly identify staff roles and responsibilities, particularly those responsible for the coordination of discharges

• promote the use of criteria-led discharges to reduce discharge bottlenecks caused by senior medical staff being unavailable, and reduce duplicated effort across individual hospitals

• increase the rate of weekend discharge for those patients able to return to their homes without the need for community support .

The Department of Human Resource should facilitate the development of discharge criteria to enable a consistent approach and reduce duplicated effort).” [3]

When a hospital finishes treating a patient’s injury or illness, it will discharge them to asserting that is more appropriate for their continuing care and needs. Most patients do not require continued care after they leave hospital and for them the appropriate care will be at their home. For those patients who need additional support and care, ‘highlight the importance of planning discharge to meet both long term and short term needs of the patient; however, further studies suggest that patients are often being discharged with unmet needs’[4]. Discharge from an acute inpatient setting is an important hospital process. Hospitals need to ensure that they discharge patients, in a timely manner, so that optimum beds are available for admissions. If managed well, timely discharges can significantly improve patient access and flow.

Timely discharge is where the hospital discharges patients when they are medically fit, can reduce the occurrence of patients ready for discharge continuing to occupy beds and preventing re-allocation of beds to other patients.. Timely discharge is also important for patient care, as it minimizes the risks associated with prolonged hospitalization, such as hospital-acquired infections and reducing ability to function independently.

“To assess how well hospitals discharged patients from the acute inpatient setting, we examined whether hospitals:

• planned discharge to optimize patient flow

• discharged patients in a timely manner

• provided timely access to diagnostic and other specialist and allied health services.”[3]

Many patients are discharged from hospital with test results and reports pending, and physicians are often unaware of potentially test results returning after discharge. Further work is needed to design better follow up systems for tests result returning after hospital discharge.[4]

The issues of discharge planning surrounding the interdisciplinary relationships and in effective process implementations are evidential in the literature [5, 6, 7]

1.1 DISCHARGE PLANNING

Managing discharge is a complex process. To be effective it requires a planned and coordinated approach involving the early identification of patients with treatment needs and addressing them to ensure a successful treatment and discharge from the hospital. It requires a multi-disciplinary approach, with hospital staff and the patient being involved in planning the discharge. To maximize its effectiveness, hospital staff should follow well defined policies and procedures to support the process and guide actions

Discharge policies and procedures underpin discharge processes. They inform staff about organisational requirements and individual roles and responsibilities and promote a consistent approach to discharge planning, enhancing the efficiency and effectiveness of patient discharge. All hospitals would have current, documented discharge policies and procedures to support and guide patient discharge practices.

1.2 DISCHARGE PLANNING PROCESSES

A hospital's processes can have a significant influence on the effectiveness of patient discharge. Processes, like daily ward rounds to assess the patient's suitability for discharge, can increase patient length-of-stay and delay discharge if not performed well, or in a timely manner. Key processes to reduce delays and improve patient flow include early planning for discharge, screening for patients at risk of discharge delay and mechanisms to identify patients for discharge.

1.3 EARLY DISCHARGE PLANNING

Planning for discharge should start as soon as possible, when the doctor informs the patient/his relative and nurse. Early planning provides hospital staff with the best opportunity to inform the patient and their family of when they are likely to be discharged and assists the hospital to better predict its admissions and discharges. For elective surgery patients, discharge planning should start when they undergo their pre-admission assessment.

For unplanned admissions from the emergency department, discharge planning should start on the first day of the inpatient stay.

" **Common elements of early discharge planning include:**

• determining the likely discharge destination for the patient, for example, home, to rehabilitation or to aged care

• estimating the date of discharge within 48 hours of admission

• identifying the required actions to facilitate the discharge, for example, referral to home help services, coordination of family meetings, referral to aged care assessment services."[3]

1.4 IDENTIFYING PATIENTS FOR DISCHARGE

Timely identification of patients who are medically fit for discharge is an important part of patient discharge process. Delays can result in unnecessary use of beds, diminish the patient's quality of care and increase health care costs. Hospitals should have processes that enabled them to identify patients timely who best suited for discharge. All hospitals should had processes to identify patients for discharge, including ward rounds, discharge meetings and monitoring of long-stay patients.

1.5 WARD ROUNDS

Ward rounds is one way for staff to review a patient's progress in getting well and are usually the time when doctors decide that a patient is medically fit for discharge. For timely patient's discharge, ward rounds need to occur as early as possible in the day. Late decisions will likely result in patients delayed discharge.

The effectiveness of ward rounds as a means to identify patients for discharge was significantly reduced at the hospitals that relied on the services of Visiting consultants. Unlike full-time medical staff directly employed by the hospital, Visiting consultants are private practitioners who work in for a fixed specific time period. These hospitals reported that they experienced delays in identifying and discharging patients because junior doctors cannot took discharge decisions on ward rounds without Visiting consultants confirmation, and the Visiting consultants were not available each day.

Wards round varies accordingly with hospital to hospital and mainly depends on doctor availability. Generally there could be three ward rounds by doctor i.e. Morning, Evening/after lunch and Night round

1.6 DISCHARGE MEETINGS

Each hospital conducted meetings to identify patients that are suitable for discharge, although the nature and frequency of these meetings varied considerably. All hospitals used daily ward meetings to identify dischargeable patients with hospital staff including nursing, medical, allied health and care coordinators. A hospital usually depends upon Doctors for probable patient discharge list. "Hospital staff discussed patient discharge at a range of forums. Some of the hospitals used patient flow and bed management meetings, although in these cases, discharge was often not the main focus but part of broader hospital access discussions. Other hospitals used daily discharge-specific forums to focus on discharge and impediments to discharge. For example, at one hospital, in addition to the daily ward meetings, medical staff also participated in daily meetings to discuss dischargeable patients and identify barriers to discharge. This meeting was led by a senior manager and the timing of the meeting was built

into the schedules of medical staff to ensure they participated, overcoming participation issues that some other hospitals experienced."[3]

1.7 DISCHARGE PERFORMANCE

Timely discharge from a hospital important not only for improved patient outcomes, but also for improved patient flow through the hospital system. Movement through the system will be slow if patients is not timely discharge as a prolong stay in the hospital will not able to provide tha treatment to neat patient that is waiting for the admission and limiting the ability of hospitals to offer appropriate care to people who need it. Availability of beds should be in associated with the type and time of treatment for eg. Early morning surgeries need bed in the morning not in between; patients with organ transplant need more time to stay in the hospital till he recovers etc. Each hospitals should follow this need, with timely discharge planning policies by which hospitals should discharge inpatients.

Due to increase in health care needs hospital are absorbing tremendous amount of resources. Health care industry has a turnover of Rs. 1, 00,000 crore per annum and growing annually at a rate of about 13 [8]). The demand for effective health care is increasing in present competitive environment and for quality health care discharge are important parameters in patient satisfaction.

. The purpose of our study is to watch and study each step of discharge process minutely and then suggest and imply certain changes in the old discharge procedure. Benefits of this will be more effective and efficient discharge procedure having improved out put to patient and hospital in terms of finance and time. All patients should have access to their discharge information in their language they understand. A timely discharge experience leaves the patient with positive impact and develops a strong affinity for returning to the facility but a negative experience can mask the good impressions and positive considerations of hospital.

1.8 PROBLEM STATEMENT

The problem faced in the hospitals is how to reduce time taken in discharge process so as to increase patient satisfaction s patients admitted are very much demanding for earliest discharge out of the hospital. In this hospital there are two types of inpatients admitted into the hospital :-

1) Cash patients.

2) TPA patients

On the basis of discharge intimation of Doctor. they are further classified into

A. **<u>Planned discharge</u>** -when dr. has intimated a day before (in evening round) that this pt. has to be discharged next day.

B. **<u>Unplanned discharge</u>** – when dr. decide for the discharge in the morning round that this pt. has to be discharge today itself.

1.9 PROBLEM FORMULATION:

- The problem due to delay inn discharges led to increase in pt. stay which can result in decrease in customer satisfaction, also increase in discharge time make pt uncomfortable and irritated also.
- No systematic way of transferring of information from dr. to nurse.
- Inpatient stay timing is also considered as a quality indicator, so increase stay timing in hospital points towards fall in quality service
- Due increase in pt stay, the availability of that bed to the other pt is not there and he has to wait and could leave the hospital ie don't take admission in hospital
- Time take for planned discharge is almost same as that of unplanned discharge which should not be there.
- Cash patients should be discharged be discharged before 2:00 pm as process steps and time in cash pt is very much less when compared to TPA case.

- Inadequate attention to discharge planning
- Poor communication and lack of coordination between hospital's department.
- Overload to the employs like in finance pooling of files immediately increase the work load on the finance staff.

1.10 LITERATURE REVIEW

AUTHOR/TITLE	DESCRIPTION	RESULTS	COMMENTS
Moore, C. (1998). Discharge from an acute psychiatric ward. Moore, C. (1998).	This descriptive study aims to find out whether "discharge is planned to support improvement of symptoms and prevent future readmissions". However, little information is given about how the study was carried out. The Brief Psychiatric Rating Scale (BPRS) was administered weekly for 215 patients from 9 acute psychiatric wards.	Major conclusions: Scores from the BPRS showed an improvement in patient symptom during admission. The authors report that discharge is often unplanned, community services are not involved and carers and families are not informed about discharge plans. Beds are often occupied by patients for social reasons.	The BPRS measures severity of patient's symptoms and is not related to any measurement of discharge planning. However the article makes many conclusions about the discharge planning process and there is limited discussion of how the measurements from the BPRS are linked to these conclusions.
		Discharge planning	It is stated that the

Cohen, N., Gantt, A.B., Sainz, A. (1997). Influences on fit between psychiatric patient's psychosocial needs and their hospital discharge plan.	Purports to examine the factors that influence the inpatient teams ability to secure a "good enough" fit between the patient's needs and an optimal discharge plan. 494 consecutive admissions had the Mount Sinai Discharge Planning Inventory completed weekly during admission	was able to have greater impact in the areas of strengthening daily activities and establishing relevant treatment options. Assisting patients to find a more suitable living arrangement was an area that discharge planners had greater difficulty with. The authors advocate the Discharge Planning Inventory as a tool to track progress and evaluate discharge planning	optimal first choice discharge plan was "identified by a consensus among professional clinician's based upon patient's needs" (p. 520). This implies that there was little input from patients in identifying their own needs for discharge. Similarly the Discharge Planning Inventory was completed by a Social worker with seemingly little input from patients. Reference given for inventory however, little information is given in the article about the format of the inventory and how the data was recorded.
Batey, S.R. & Ledbetter, J.E.	An article describing the	The authors propose that this model	This is an interesting outline of group

(1981). Consumer education in discharge planning for continuity of care.	Resource Group Model. The consumer education model is used in a small group setting to provide information about medications, community resources and vocational rehabilitation services.	encourages involvement of consumers in discharge planning, facilitation of interpersonal skills, and integration of services.	work in an inpatient setting but is limited in the discussion and analysis of outcomes.
Buckwalter, K. C., (1982). Teaching patients self care: A critical aspect of discharge planning.	An article which describes the methods used by the authors in predischarge planning programs to assist patients "take charge of their illness and become partners in the treatment process" (p.15) and reduce likelihood of readmission.	The main components that should be included in discharge planning according to the authors are: Assisting patients to understand what their diagnosis means. Working with the patients family Giving the patient simple and accurate literature to read about their illness. Assigning homework that requires the patient and family to read instructional	This article reflects the opinion of two clinicians from one discipline and so may be a limited representation of the issues related to discharge planning. This article is written from the perspective of the clinician and does not discuss at length the process of having the patient assess their own needs for discharge

		material between appointments. Assisting patients in looking at their stressors and exploring stress management techniques.	

1.11 OBJECTIVES

General objective are:-

1. To do discharge mapping in Columbia Asia hospital, Gurgaun.
2. Application of business process reengineering into discharge process resulting in efficient discharge procedure for patient as well as for hospital
3. To determine the need of additional inputs and changes required then, develop a new network diagram, imply it and than evaluate the impact of proposal that is undertaken in the project

SPECIFIC OBJECTIVES :-

a. Implication of reengineering discharge process

b. Assess the impact of knowledge and attitude

c. Measure the outcome

d. Maintain the improved outcome

CHAPTER- 2 RESEARCH METHODOLOGY

2.1 RESEARCH PROBLEM (HISTORY)

- Total discharge in January 2010 – 260
- Before 2 pm, total discharge were 40%, ideally it should be at least 70 – 80%
- Discharge after 5 pm(including rejections) were 14% which should be 5 – 7 %

Main focus of the study are :-

- Planned discharge VS unplanned discharge in Columbia Asia hospital.
- Inadequate attention to discharge planning and/or divided attention result in inefficient discharge of patient.
- To study and identify the steps that are involved in the discharge process and reengineering the process by implementing changes to improve discharge process and reduce the time taking in discharge process
- To maintain the improved results by fallowing the improved process.

2.2 RESEARCH DESIGN

- Concurrent study to find out the time taken for individual patient. Simple random sampling is done for selection of cases regardless of name, age, sex, diagnosis etc.
- Data is collected from all the wards of the hospital in form of time taken for completion of various sub process that are included in the process of discharge procedure as a whole.
- Then this recorded time frame is analyzed and processes which take maximum time in completion are identified. Than all possibilities that can result in deduction of time is identified and implied – Phase 1 data collection..

- Once after reengineering of the preexisting model, than again time frame is studied and difference in time is complied to access the improvement – Phase 2 data collection.

Failure Mode and Effects Analysis (FEMA) is a systemic, proactive method for evaluating a process to identify where and how it might fail to assess the relative impact of different failures, in order to identify the parts of the process that are most need of change.

FMEA includes review of the following:

- Steps in the process
- Failure modes (what could go wrong?)
- Failure causes (why would the failure happen?)
- Failure effects (What would be the consequences of each failure?)

This emphasis on prevention may reduce risk of harm to both pt and staff.. FMEA is particularly useful in evaluating a new process prior to implementation and in assessing the impact of a proposed change to an existing process.[9]

3.1 Graphs on the basis of data collection

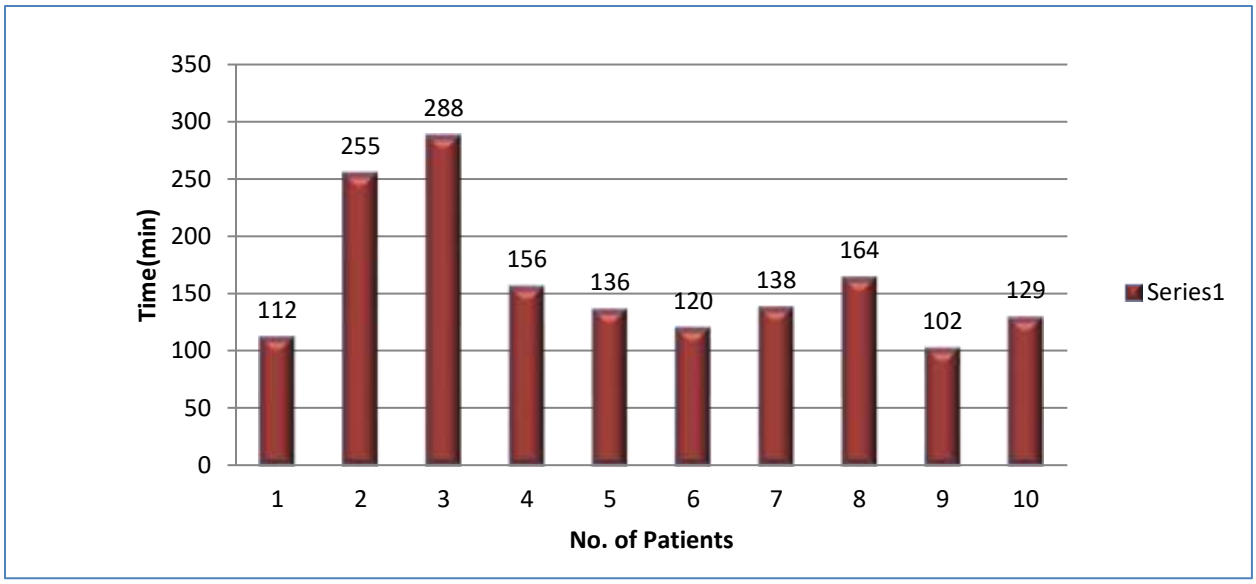


Fig **1 Time taken by CASH (planned) pts. Before Reengineering Discharge procedure.**

- The above graph depicts time taken by patients (in minutes). Total 10 patients are represented the time motion study
- The maximum time taken is 288 minutes and minimum time is 102 minutes.
- The difference between the highest value and lowest value is 186 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average total time taken = 160 minutes**

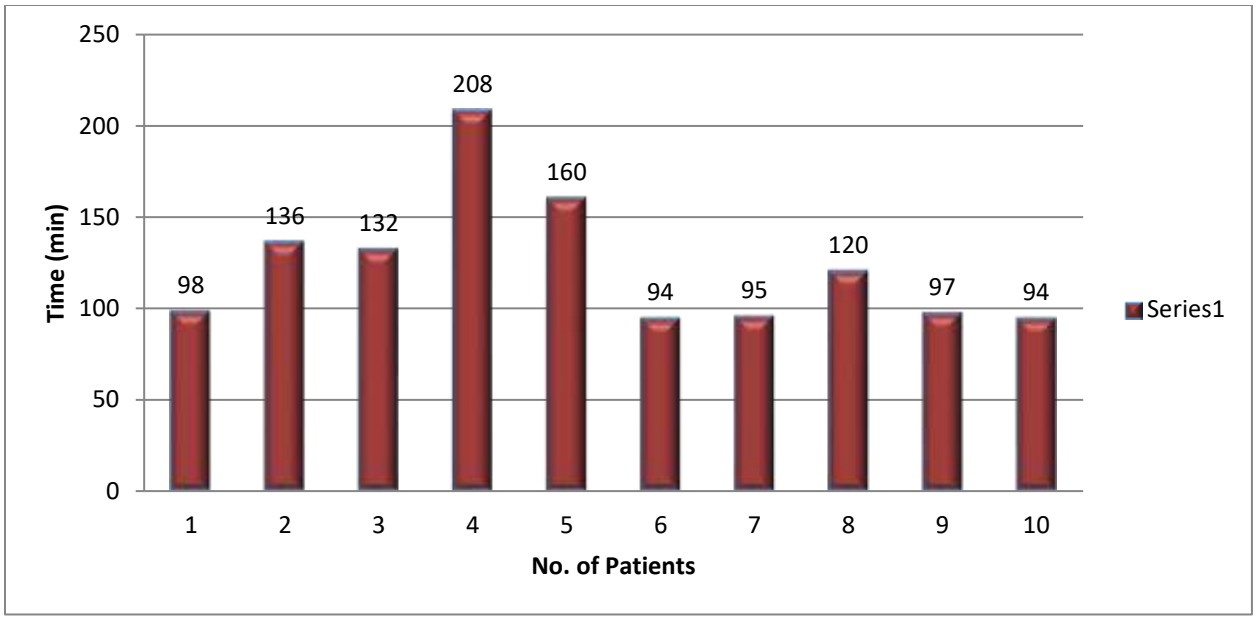


Fig 2 Time taken by CASH (planned) pts. After Reengineering the Discharge procedure

- The above graph depicts time taken by patients (in minutes). Total 10 patients are represented the time motion study
- The maximum time taken is 208 minutes and minimum time is 94 minutes.
- The difference between the highest value and lowest value is 114 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 123.4 minutes**

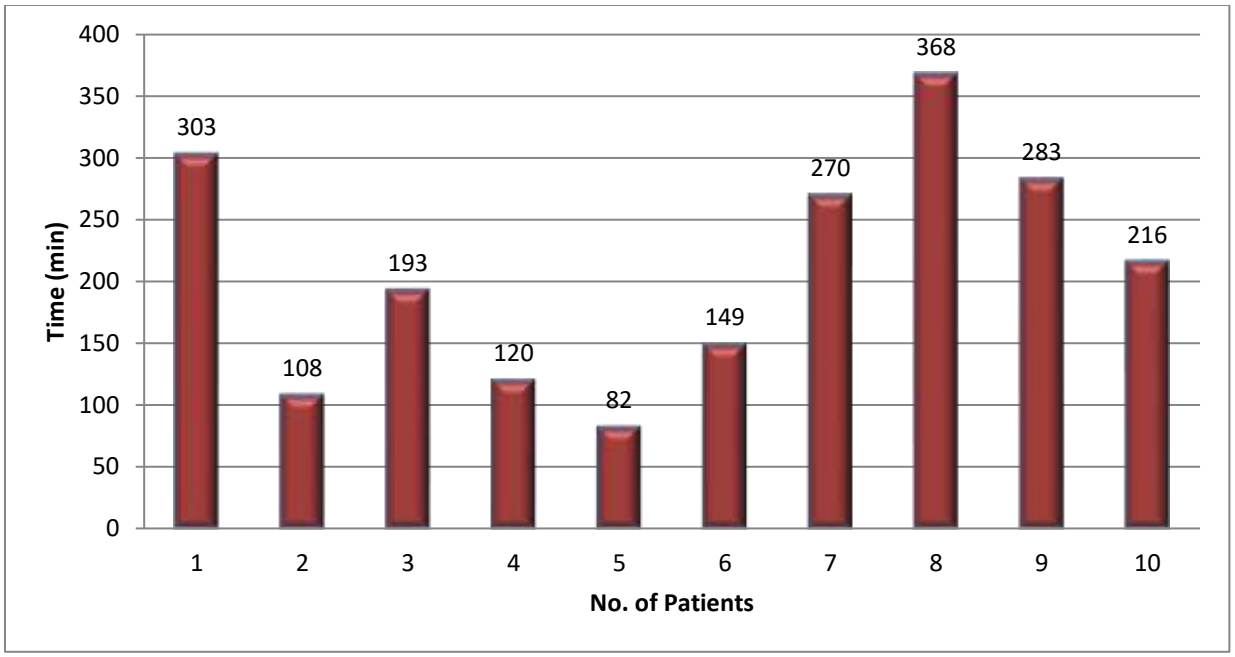


Fig 3 **Time taken by CASH (unplanned) pts. Before Reengineering Discharge procedure.**

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 368 minutes and minimum time is 82 minutes.
- The difference between the highest value and lowest value is 286 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 209.2 minutes**

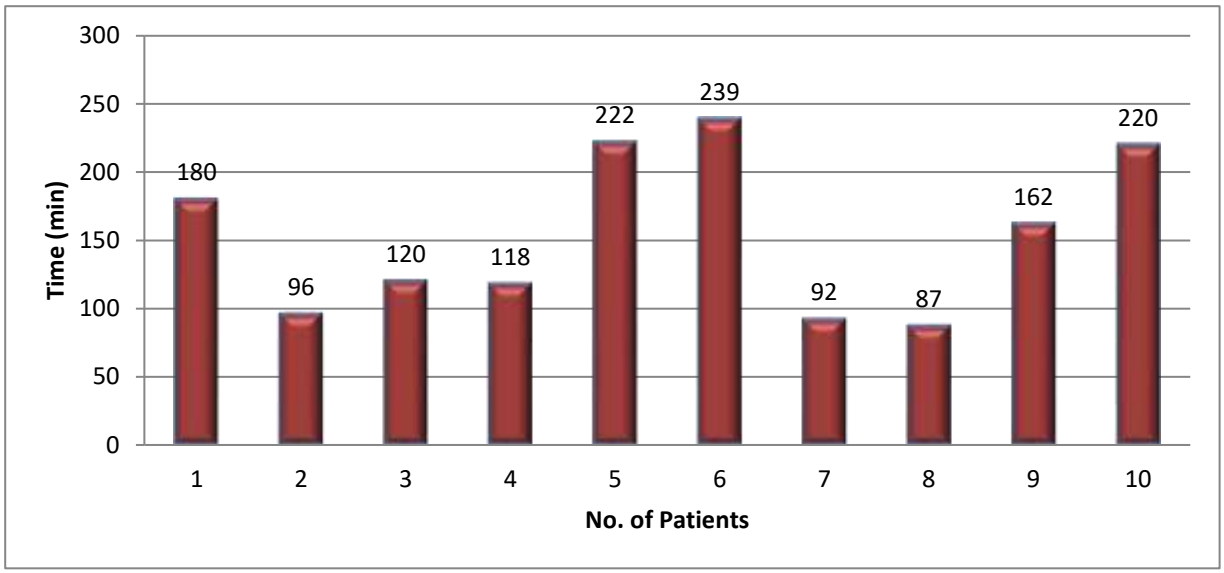


Fig 4 Time taken by CASH (unplanned) pts. After Reengineering the Discharge procedure

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 239 minutes and minimum time is 87 minutes.
- The difference between the highest value and lowest value is 152 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 153.6 minutes**

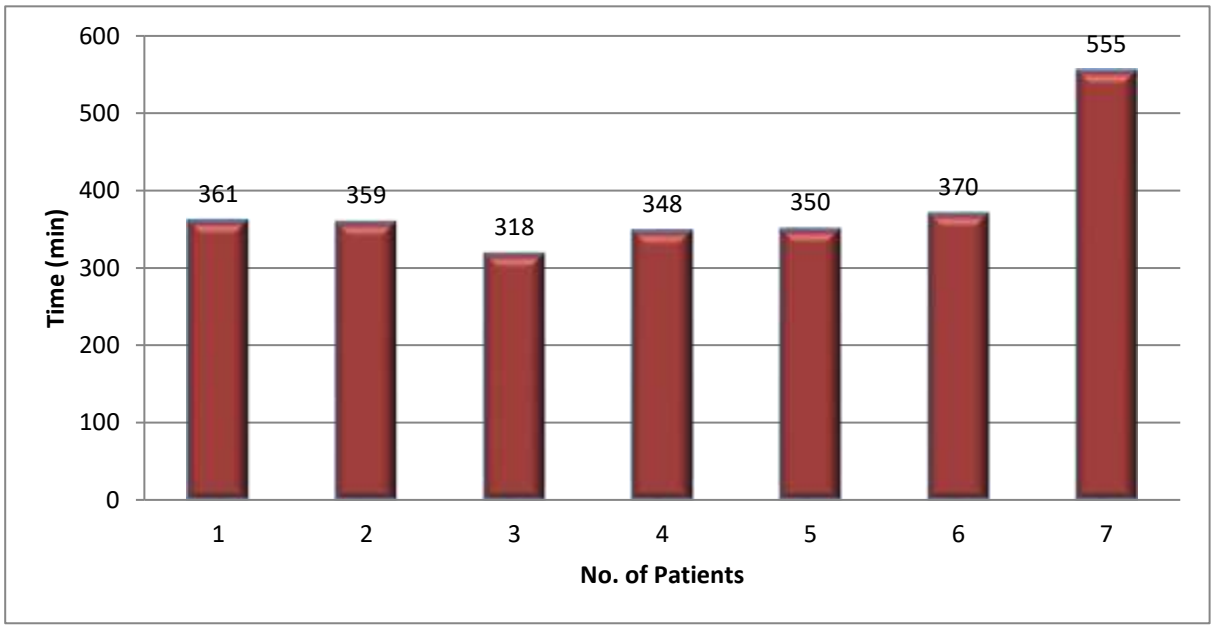


Fig 5 Time taken by TPA (planned) pts. Before Reengineering the Discharge procedure.

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 555 minutes and minimum time is 318 minutes.
- The difference between the highest value and lowest value is 237 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 380.14 minutes**

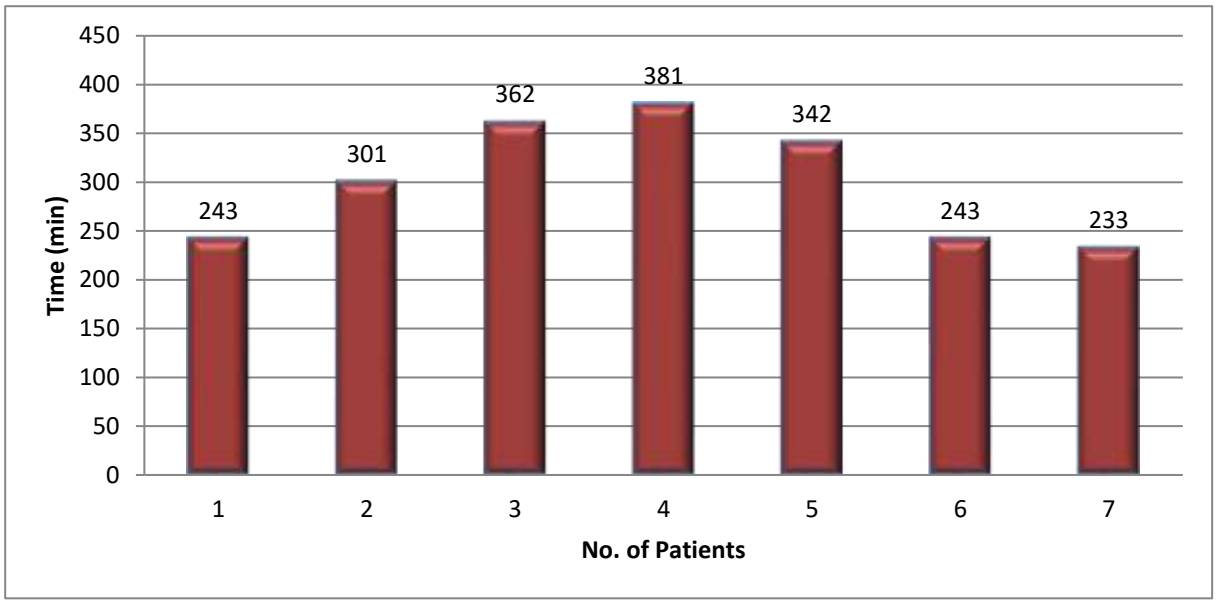


Fig 6 Time taken by TPA (planned) pts. After Reengineering the Discharge procedure

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 381 minutes and minimum time is 233 minutes.
- The difference between the highest value and lowest value is 148 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 300.50 minutes**

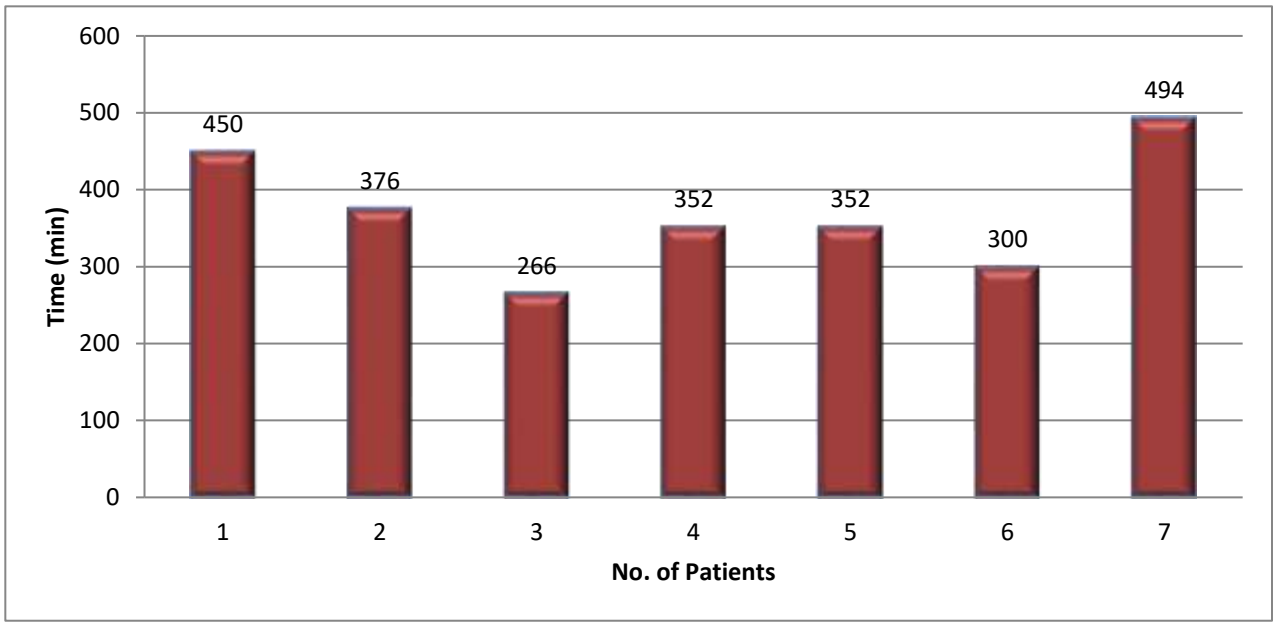


Fig 7 Time taken by TPA (unplanned) pts. Before Reengineering the Discharge procedure

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 494 minutes and minimum time is 266 minutes.
- The difference between the highest value and lowest value is 228 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 370 minutes**

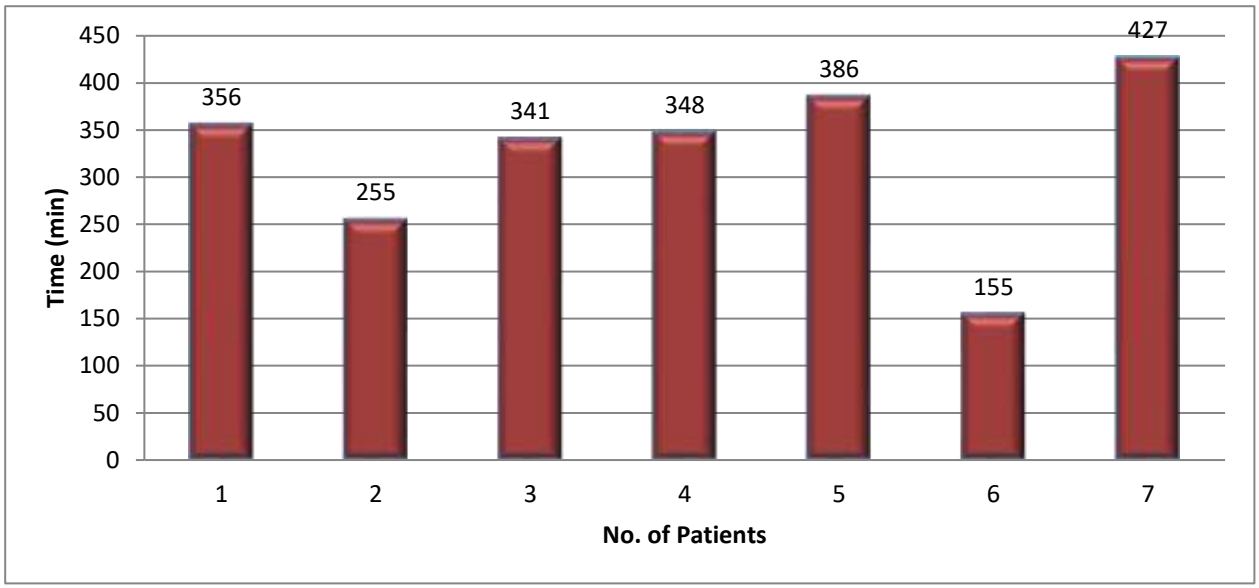


Fig 8 Time taken by TPA (unplanned) pts. After Reengineering the Discharge procedure

Average time = 324 min

- The above graph depicts time taken by patients (in minutes). Total 7 patients are represented the time motion study
- The maximum time taken is 427 minutes and minimum time is 155 minutes.
- The difference between the highest value and lowest value is 272 minutes, so if discharge process is carried in systematic, we can make discharge happen in less time.
- **Average time taken = 324 minutes**

3.2 FINDINGS

Average time improvement(approx)

- **CASH Patient**

Planned cases ➔ 160 – 123.4 = 36.6 minutes

Unplanned ➔ 209 – 153 = 56 minutes

- **TPA Patients**

Planned cases ➔ 380.14 – 300.50 = 79 minutes

Unplanned ➔ 370 - 324 = 46 minutes

By analyzing the data it can be figure out easily that there is a reduction in total time take in discharge process after applying the changes in the process. Approximately there is a difference of 30 minutes in discharges of all type of patients

3.3 AREAS OF CONCERN

1. Information gap between doctor and nurse on probable discharge.
    - Reasons :-

    a) Doctor went on patient round alone

    b) Nurse who accompany doc. On round did not pass information about discharge to others

    c) Doc. documented about discharge in progress note but nurse didn't read it

2. No proactive action is taken on tentative discharge list.

3. If process is stuck at any step, no body consciously follow on the same unless pointed. Discharge process is not coordinated by anybody as a whole, each dept works in isolation.

4. Discharge meeting happens between 5 – 5:30 pm, while evening rounds of doc. Continue till 8 pm.

5. **Areas where more than required time was taken as follows-**

a) Discharge summary preparation:-

- ✓ Not prepared on day 1
- ✓ On day 2 due to more workload in morning it takes time to prepare discharge summary
- ✓ Redoing of wrong DS
- ✓ Updating of date on DS

b) Signing of discharge summary :-

- ✓ Unavailability of doctor or MO
- ✓ Print of DS is taken but no follow up to get it signed

c) Transfer of file/DS/Discharge slip from ward to finance department.(average 8-10).

d) Priority in processing cash patient over TPA patient.

e) Average time taken for clearance from dept. is about 30 minutes.

f) In 2 out of 14 cases patient(cash) cleared the bill but was not able to go home because discharge summary was not ready.

g) One patient got discharged within 50 minutes because attendants were following it up.

h) Change of patient type from cash to TPA on the day of discharge.

i) Sometimes two or more discharge files are pooled together and than only send to finance.

3.4 FMEA analysis results

S No.	Potential failure mode	Resultant Problem	Possible Action Steps
1	Patient not assigned to same inpatient team for each admission	Discontinuity	• Work with Admitting/Residency Office: • Readmit to same physician team • Readmit to same nursing team/unit • Talk with Administration regarding ways to work with problem patients, i.e. in ER, problem patients are readmitted to the same nursing unit
2	Incomplete information on transfer between services	Poor communication and poor fallow up care	• Co-authors on discharge summary • Standardize transfer summary
3	Too many people involved in discharge decision	Prolonged hospitalization	• Develop process to streamline voices instead of eliminating them • Electronic check-out form to coordinate discharge readiness decision • Need correct information and patient knowledge

4	Too many people involved in discharge notification: Chaotic, repetitive process with various gaps Excludes any input from patient regarding their perceived readiness for discharge	Everyone involved in patient care is not always informed of discharge decision; no patient perceived readiness for discharge care which can lead to inappropriate placement; delays in discharge process	• Create centralized electronic service for communication • Develop appropriate, clear assignment/delineation of responsibilities • On centralized electronic form, clarify who's responsible with checklist as each team member completes components they are responsible for • Discharge coordinators can serve as liaison between patient and various providers of pt. care
5	When making PCP follow-up appointment, no one checks with patient to see if time is convenient/possible	No appointment New system is having patient schedule their own appointment if they're able	• Patients not capable, need quick appointment, etc • Coordination between unit clerk and patient regarding availability/ability to make appointment • All appointments to be made other than by patient, are made by unit clerk • Dedicated schedulers to make follow-up appointments efficiently • Give coupon, go to "schedulers", and make all appointments before leaving

			• With access to computing systems to ACC and other outpatient clinics to make appointments directly • Laptops available to make appointment process more efficient • Have office on inpatient floor to schedule appointments
6	Lack of appropriate training regarding components of discharge paperwork and responsibility of each component/step in the process	Discharge summary not complete or not correct	• Shift responsibility for discharge summary/paperwork from interns to residents • Include appropriate training for interns and residents clarifying whose role each component is • Automating the process and discharge summary will help with this shift of responsibility since lots of work will automatically be completed by transferring information/data from one area of system to the discharge summary
7	Patients leave hospital without prescriptions (meds)	No medications; wrong medications given to patient at discharge; wrong medications taken by patient upon discharge; delay in discharge process	Med Teach – provide training on how to use this
			Prescriptions computer linked to outpatient pharmacy (VA does this now)
	Discharge medications – if changes are made during hospitalization, are		Develop contact at pharmacy, both inpatient and outpatient
			Have prescriptions filled and delivered to

	these changes incorporated into discharge instructions by nur nursing team? – confusion between admission and discharge medication (reconciliation) duplications/gaps Nursing team not notified regarding changes in medications/prescriptions at discharge		nursing team Conduct patient education with actual medications, pillbox filled Have designated window at pharmacy for hospital discharges Have pharmacy involved in patient education Add "changes from admission" section on discharge summary with details regarding admit and discharge medications and notes regarding all changes made during hospitalization
8	Too many people involved in patient education but not assigned or defined to a particular role and therefore no one accountable for the outcome	Patient gets mixed messages while discharge education is either missing or incomplete	Make someone responsible for patient education
9	There is not time for patient education	Patient education either either missing or incomplete	More in-service training regarding patient education
10	No clear mandate/system	Poor patient discharge	Allow time for this!

	for discharge education	education, lack of patient understanding of disease, treatment, and follow-up care	
	No system to identify degree of need for discharge education so education can be tailored		Assign some type of responsibility for which patients:
			□ need/require patient education
			□ what type of patient education would be best suited
			□ assess patient's literacy level and tailor education to that level, electronic checklist can help with this
	Patient education and literacy not adjusted according to patient's level of literacy/health literacy		□ develop "education sheet" as part of electronic hospitalization – documents
	Patient education about disease is not part of discharge		Develop Discharge Plan for each patient which includes:
			Information regarding inpatient hospitalization
11	No discharge plan given to patient	Lack of understanding of what to do next • Missed appointment, lab not followed up • Patients don't understand medications	All changes in medications with clear details regarding what and how to take upon discharge clear follow-up instructions for patients written at a level that patient can read and understand regarding appointments, nutrition, exercise, lifestyle changes,
	Literacy level of patient medication sheets too high		

	Patient not told about pending lab/tests		when to follow-up
12	When does the discharge process start? In order to have timely discharge, often rushed at end when have timely discharge, often rushed at end when much detail needed	Rushed discharge causes errors	Involve Emergency Department in discharge process: Begin on-line data collection and discharge planning form in ED and have linked to
			Begin on-line data collection and discharge planning form in ED and have linked to inpatient record and/or discharge summary paperwork
			Include section on discharge plan with details of significant psychosocial issues that have led to admission
13	No in-service on how to do discharge	Incomplete discharge	Quarterly reviews for interns and attending, nursing personnel, and other providers as needed
14	Patients cannot get medications from pharmacy days/nights/weekends	Patients don't get medications	Organize system to get medication to patients upon discharge
15	Many assumptions about who does what but lack	No checklist or toolbox or patient discharge	Need centralized discharge facilitator

	of accountability		
16	No follow-up with patient post-discharge, "did you get medications, etc?"	No medications/implement 48-72 hour pharmacy telephone cell	Follow-up by member of inpatient staff within 48-72 hours
17	No auditing system for discharge processes	No improvement	person can track outcomes/issues identified
18	Medical mistakes	No process to discuss and fix	Increase ease of error reporting with formal review

CHAPTER – 4 CONCLUSION

Discharge from an acute inpatient setting is one of the most important hospital processes. Hospitals need to discharge patients, in a timely manner. Effective discharge practices can significantly improve patient access and flow, as well as patient outcomes.

Discharge planning is an important part of the discharge process and if done well help assist hospitals in discharging patients in a timely way and with their ongoing care needs addressed. The lack of detailed procedures and clearly stated roles and responsibilities at most hospitals reduces the effectiveness of the discharge process, particularly given the range of people involved in discharge and the need for a coordinated approach. Hospital managers need to make all staff are aware of their particular roles and responsibilities in the discharge process so that discharge delays do not occur due to non-participation. Developing comprehensive policies and procedures that reflect better discharge practice and the hospitals expectations is an important first step.

Early discharge planning at each of the hospitals was notable, enabling staff to prepare patients for timely discharge once their treatment was complete. Ward rounds and discharge meetings provided hospital staff with regular opportunities to identify patients who were ready for discharge. Ward rounds need to occur as early as possible to maximise the time available to arrange a patient's discharge, and meet the hospitals' discharge goal of before 1 PM. This would reduce the likelihood that patients spend additional and unnecessary time in an acute inpatient bed. While the issue of junior doctors' reluctance to discharge patients without first consulting with senior medical staff is common in most hospitals, it was exacerbated at the two hospitals that were reliant on VMOs. While the limited availability of VMOs may be unavoidable, this should not be allowed to create a bottleneck that delays discharge. Hospitals need to establish processes to overcome these bottlenecks, such as criteria-led discharges, where senior medical officers identify key conditions that patients must meet before the hospital can discharge them. Criteria-led discharges are increasingly being used and should be pursued at hospitals where senior medical officers are not always available.

4.1 MANAGING INPATIENT DISCHARGE

"Discharge performance was generally consistent across the hospitals reviewed and also with the statewide average. However, in line with better practice and the hospitals' own discharge policies, hospitals should direct more effort to increasing the percentage of patients being discharged early in the morning. Hospitals also need to improve the

rate of weekend discharge. The current lower rate of weekend discharges has been an issue for most of this decade with only limited improvements made. Hospitals should focus their weekend effort on 'simple' discharges. The low complexity of these patients' discharge warrants greater use of criteria-led discharges. Increasing weekend discharges may require additional staff and this may represent additional costs to the hospital. Hospitals need to properly assess the costs of increased weekend staffing against the benefits of better patient access and flow.:[3]

4.2 SUGGESTIONS

- Nurse should accompany doc during patient round or if not than doc should inform the nurse about discharge or any other change in discharge medications.
- Nurse to update tentative discharge list as soon as she gets information about discharge(tentative discharge folder on Y drive).
- Discharge summary should be prepared on day 1 as per tentative discharge list. Print out of the DS can be taken on the next day after morning round of doc with change in the date.
- IP DESK OF FIRST FLOOR EXCLUSIVELY FOR IN PATIENTS

CHAPTER –5. REFERENCES

1] (Rorden & Taft, 1990)

[2] (Jewell, 1993)

[3] (Book ‘Managing Inpatient Discharge’, chapter 6)

[4] (safe practices for better healthcare – 2006 update : a consensus report)

[5] (Anderson & Helms, 1994)

[6] (Lowenstein & hoff,1994)

[7] (Bull & Roberts,2001)

[8] (ET intelligence report 2006).

[9] www.wikipedia.com