A Study on Discharge Process of In-Patient Department At a City Based Hospital Sheshadripuram

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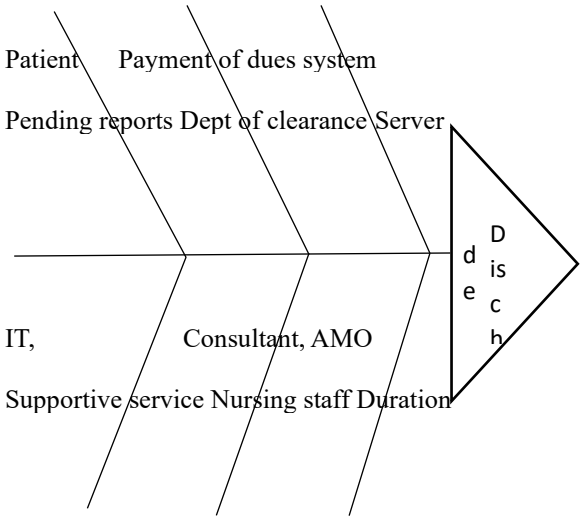
I CAUSES OF DELAY OF DISCHAERGE



Fishbone Diagram Analysis

ISSUES IN THE HOSPITAL:

- As the entire process is a multi-step procedure.
- No specific time of consultants taking rounds.
- Billing process.
- Discharge summary has to be seen by consultant.
- Typist and ward secretary duties impacts discharge process in big way.

II OBJECTIVES.

- To study about the type of discharge.
- To know about payment method of discharge patient.
- To study patient satisfaction rate.

III METHODOLOGY

- NATURE OF DATA:

In accordance with the above objective primary data were collected from the Hospital during Internship Training.

- Primary Data:Primary data were collected by -

1. Observation and interaction with the floor co-ordinator.
2. Day to day interaction with Hospital staff on Nursing station in ward.

- Secondary Data: Secondary data were collected from the hospital and others journals and books related to the topic referred.

3. Organization's Discharge manual.
4. In Patient's guide.

IV REVIEW OF LITERATURE

- According to Lixia Ou, Lis Young, a study was conducted to identify the reasons and determinants of discharge delay in acute patients, the increasing demand for acute care hospital beds and a pushfor cost cutting requires efficient discharge planning. Delayed discharge has become a major issuebecause it leads to unanticipated length of stay and bed block. Both the quality and cost-effectivenessof care may be compromised as a result. In Australian context, delayed discharge is a major reasonfor the unavailability of beds in major acute care hospitals.
- According to the study of Andrew P Costa, Jeffry W Poss, it was identified the acute hospital

discharge delays were the pressing concern for many health care administrators. In Canada,
a delayed is defined by the alternate level of care [ALC] construct and has been the target

of many provincial health care strategies. Little is known on the patient characteristics that
influence acute ALC length of stay. This stay exam in which characteristic drive acute
ALC length of stay those awaiting nursing home admission.

- According to Michael Emes, Smith, Suzanne, in the period from January 2013 to July 2014, three process change initiatives were undertaken at a major UK hospital to improve the patient discharge process. These initiatives were inspired by the findings of a study of discharge process using soft systems methodology. The first initiative simplified time-consuming paperwork and the second introduced more regular reviews of patient progress through daily multi-disciplinary'' situation reports.
- The discharge process is an inevitable and crucial part of patient's stay in hospital. Mc. Keehan, 1981 defined discharge process. There is a large volume of literature, published since the 1980s, which discusses regarding the process abroad. The first large body of discharge research in the year 1990s and early 2000s identified that the discharge process is highly complex, fragile and prone to breakdown. Six Sigma methodologies can help improve the discharge process to large extent especially in highly occupied hospitals (Vanda Ametlli, 2010). Lot of research in between 1980 to 2012 on discharge process abroad concluded major and minor issues on improving the process and using it for the economic benefit of hospitals.
- There is a lack of research papers on discharge process in India. Helping resident physicians can improve many aspects of discharge process (Kathleen et al, 2011). The work abroad does also lack in comparing the discharge time in cash and TPA patients. NABH booklet (2011) of standards for hospitals mentions about the need of standardization of discharge process in each set hospitals in Chapter 1, under standard AAC13 & AAC14. JCI and other national Accreditations also mentions of the processes and cruciality of discharge Patients process. It is surprising that many books on hospital administration in India don't describe this crucial area.

In 2006, the NOF Consensus Standards Maintenance committee was charged with the task of updating the Safe Practices for Better Healthcare developed in 2003. The committee recognized the critical importance of the transition point of discharge and decided to expand a preexisting practice from focus on promoting accurate communication about treatment and procedures to a broader comprehensive approach to hospital discharge that would be evidence based and patient centered and target existing systems failures.

A thorough evidence-based review of the domain was undertaken by the committee, followed by consultation of a number of subject matter experts. The Safe Practice regarding discharge systems ultimately paralleled the components of the RED that are detailed above.

A harmonization approach was undertaken by the committee to synchronize the practices across the pertinent requirements or initiatives of the Joint Commission for Accreditation of Healthcare Organizations, the Centers for Medicare and Medicaid Services, the Agency for Health- care Research and Quality, the Leapfrog Group, and the Institute for Healthcare Improvement. This harmonization effort coined "the 4 C's" across each of these organizations. was composed of a crosswalk of requirements, cross language or synchronized descriptions where possible, cross credit opportunities, and cross communication of common performance targets. This set of processes was undertaken to establish the new discharge practice that was ultimately developed, providing a clear road map for hospitals to follow that will satisfy a commonset requirement of major purchasing, accrediting, and quality organizations.

In summer of 2006, the practice was provided to the national health care community for review and input for revisions. Substantial input from providers and purchasers was obtained, and the practice was slightly revised. In October of 2006, the national members of the NOF voted to endorse the practice, and the NQF-endorsed practice became a national standard.

The stated objective of the practice is "to ensure that effective transfer of clinical information to the patient and ambulatory clinical providers occurs at the time of discharge from the healthcare organization.

V RESULTS AND OBSERVATIONS (ANALYSIS)

- All patients leaving the organization are provided with Discharge summary including patients leaving against medical advice. Discharge procedures shall be followed to ensure patients are discharged effectively and efficiently, allowing for optional utilization of available resources. The Discharge shall be planned at the time of admission.
- An authorized hospital discharge shall only be made by an authorized, written order where in consultant advice discharge on satisfaction with the patient's condition. Discharge information shall be given to the register/resident/staff/nurse/ward secretary. Discharge summary shall be prepared by the resident and approved by the consultant. However, a patient shall also have the right to obtain discharge against medical advice.
- The physician shall be required to document discharge instructions in the patient's medical record at the time of anticipated discharge. The final Discharge summary should be signed by the consultant and the resident, before handing it over to the patient. In any situation the discharge summary will not be dispatch without the treating consultant signature.
- In case of patients being in hurry, prescription written by the consultant/register/resident shall be made available immediately and the discharge summary signed by the consultant shall be sent to the patient by post. A copy of the discharge summary shall also be filed in the patient's medical record.
- The Discharge summary shall include – the reason for admission, significant findings, diagnosis and patient's condition at discharge.
- It shall also include the investigation results, important laboratory results, the medications given and the procedure performed.
- It shall include the follow up advice, medication and other instruction and how to obtain urgent care in an understandable manner.
- In case of death the same shall include the cause of death.

VI DATA ANALYSIS AND INTERPRETATION

Table: 1. Total No of patients who got discharged in the month ofJanuary, February and March.

Months	No. of patient
January	89
February	98
March	234

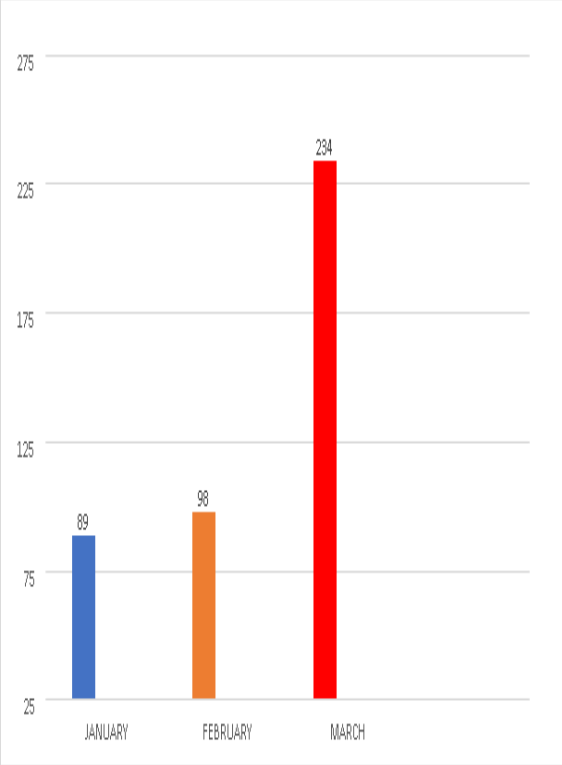


FIG - 23

Data & Interpretation:Total Discharge patients in January = 89

Total Discharge patients in February = 98

Total Discharge patients in March = 234

- In the month of March higher patients got discharged.

Table 2. Bed Occupancy Ratio

Months	Percentage (%)
January	80.65%
February	66.67%
March	93.33%

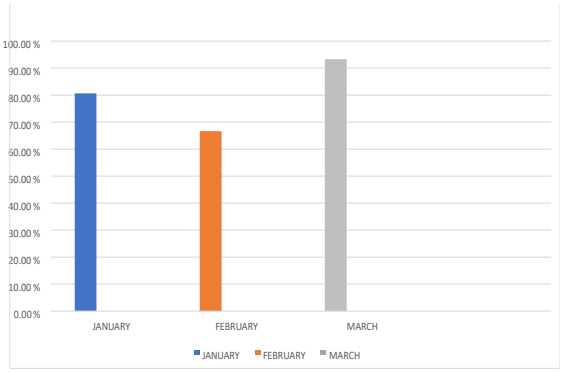


FIG - 24

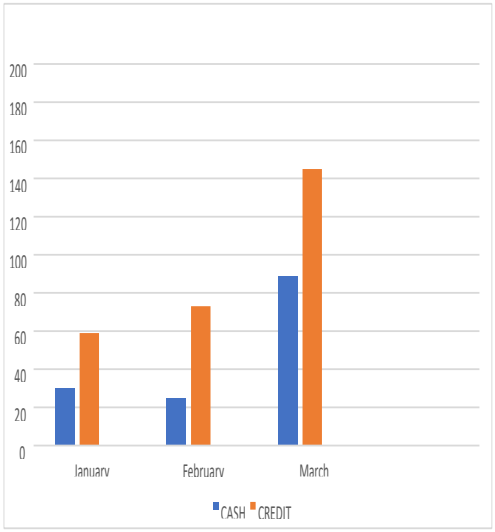
Data & Interpretation:Bed occupancy ratio: January = 80.65%

February = 66.67%

March = 93.33%

Table: 3 Types of payment of Discharge patient

Payment Method		
Months	Cash	Credit
January	30	59
February	25	73
March	89	145



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Data & Interpretation:January:Total cash Patients = 30, Credit Patients = 59

February: Total Cash Patients = 25, Credit Patients = 73

March: Total Cash Patients = 89, Credit Patients = 145

TABLE: 4 ALOS (AVERAGE LENGTH OF STAY)

Months	Average Length of Stay
January	2.87
February	3.38
March	7.55

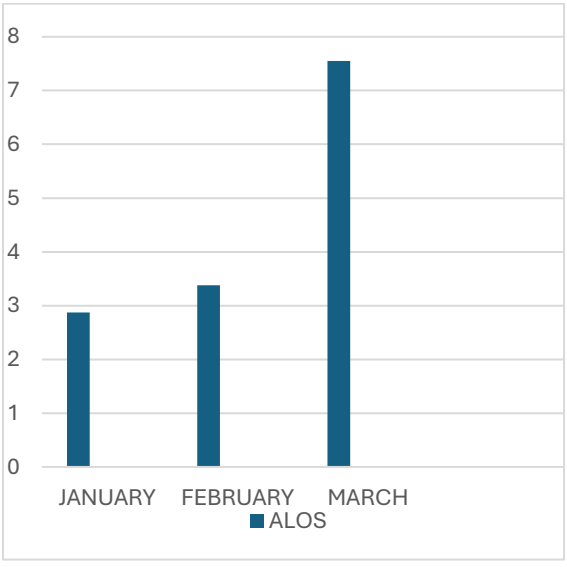

FIG - 26

Data & Interpretation:Average Length Of Stay in Months of:

January = 2.87

February = 3.38

March = 7.55

TABLE: 5 PATIENTS SATISFACTION RATE

MONTH	RATE		
	Satisfied	Partially satisfied	Unsatisfied
JANUARY	85%	65%	23%
FEBRUARY	80%	62%	15%
MARCH	92%	59%	18%

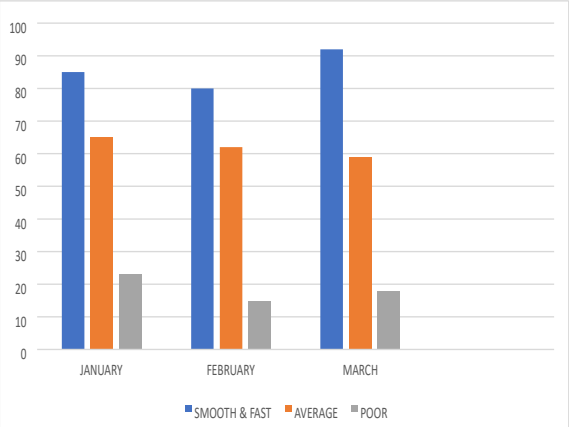

FIG - 27

Data & Interpretation: Patient satisfaction rate:

In month of January satisfied = 85%

In month of February Partially satisfied = 80%

In the month of March unsatisfied = 92%

Table:6 Discharge Experience Rate

Discharge Experience Rate						
Discharge experience	Excellent	Very Good	Good	Poor	Total	Rate
January	400	51	5	2	458	4.8
February	412	42	9	1	464	4.7

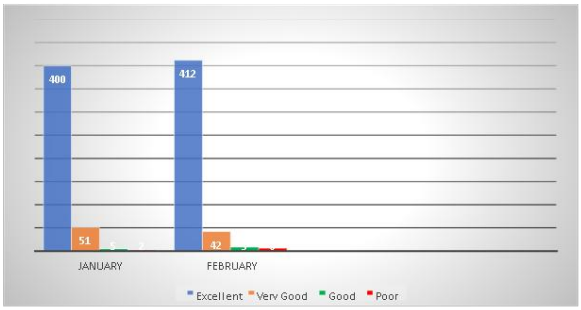

FIG - 28

Data & Interpretation:Discharge experience rate:

- Excellent experience in January = 400
- Excellent experience in February = 412

Table: 7 Aspects of the Discharge Services can be Improved

Aspects of the discharge service can be improved	Waiting time	Ease of the process	Total
January	5	3	8
February	1	1	2

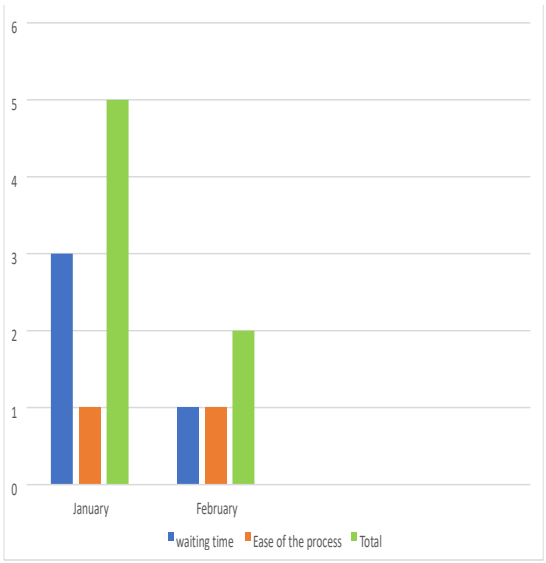

FIG - 29

Data & Interpretation:Discharge services improved in month of:

January = 5

February = 1

VII DISCUSSION AND RECOMMENDATION

Discharge time taken by hospitals is an important indicator of the quality of care and patient satisfaction. Delay in the discharge of patients leads to a bad impact on both patients and the hospital.

- After the analysis of data, It has been found that the Discharge process is delayed by average of 71 minutes compared to the hospital's targeted time. The average TAT for Nursing clearance is 125minutes which exceeds 35minutes than the targeted time. The average TAT for Pharmacy clearance is 9minutes which is under than the targeted time. The average TAT for IP Billing department is 49minutes and 176minutes which exceeds 105minutes than the targeted time. The average TAT for Housekeeping is 121minutes and 31minutes which exceeds 107minutes than the targeted time.
- It was observed that nursing clearance, IP billing, and housekeeping consume the most time, leading to a longer discharge time. Through observation and interaction, it was also found that both doctors and patients are also responsible for the delay in the process.
- It can also see that every department is interlinked with each other. So, management needs to look into this matter and take action regarding the delay in time and also suggest hospital personnel to work as per recommendation given to the management. Other department should also try to work efficiently so that it does not hamper the working of other departments.
- This time can be improved with the help of care teams and managers, and planned discharges are encouraged. It was also advised that few more manpower can be hired to ensure that the process runs well and on time.
- The discharge process needs to be more individualized and person- centered. Both accessibility and continuity need to be improved. Patients described misperceptions regarding information and communication before discharge. The information given needs to be modified and met with the patient's level of understanding.

VIII CONCLUSION

It was found that patient Discharge process in Hospitals id evergreen topic and rigorous research is being carried out and much is needed to make the discharge process ideal for patient satisfaction and to leave them delighted while leaving the hospital. Also reducing the discharge process timings of hospitals lead a lot of benefits to the Hospital and proves to be very fruitful in terms of cost benefit analysis in terms of revenue and for patient satisfaction to sustain in this competitive world.

In accordance with the objective of the study, primary data were collected from the Hospital during 3 months internship training by daily observation and day to day interaction with the hospital ward staff, Secondary data were collected from the hospital's SOP's and policies on discharge and others journals and books related to the topic referred.

IX LIST OF REFERENCE/BIBLIOGRAPHY

- Daily observation and guidance of Hospital administrator.
- Various links from internet such like:
- https://www.slideshare.net/RameezShah5
- https://www.researchgate.net/publication
- https://www.ahrq.gov/sites/default/files
- https://www.scielo.br/j/ape/a/bTrs5Khx8F359YXpMWvSdFm
- https://www.sciencedirect.com/science/article/pii/S1873959812000695
- https://www.scribd.com/

X APPENDIX

- Patient's name
- Unique Hospital Identification Number
- Bed Number
- Doctors Name
- Date& time of Admission and date & time of Discharge
- Reason for admission or chief complaints.
- Significant positive and negative points of history and findings.

- Diagnosis
- Patient condition at the time of discharge.
- Investigation results.
- Procedure performed.
- Medication
- Other treatment given.
- Follow up advice, medication and other instructions.
- When and how to obtain urgent care.
- Cause of death (in case of death summary).