DISCHARGE TIME TRACKING OF INPATIENTS IN MAX HEALTHCARE

Dissertation Submitted to

The IIHMR University, Jaipur

For the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

In

Hospital and Health Management

By

SAUMYA SHARMA

Under the Supervision and Guidance of

DR SANDESH KUMAR SHARMA

ASSOCIATE PROFESSOR, IIHMR UNIVERSITY, JAIPUR

2021

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled Discharge Time Tracking of Inpatients in Max Healthcare is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)
Name of Student
-Date

MAX Healthcare

13th May, 2021

Ms. Saumya Sharma
New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Saumya Sharma** has completed her training from **Max Super Specialty Hospital, Shalimar Bagh** from **17th Feb' 2021 to 16th April' 2021** in department of **"Medical Administration"**.

During her period of attachment with us, we found her to be sincere and hardworking person.

We wish her very best in all future.

Yours sincerely,

Anuj Vijh
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CERTIFICATE

This is to certify that dissertation titled Discharge time tracking of Inpatients in Max Healthcare is a record of the research work undertaken by Saumya Sharma in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur

Date

School Dean
IIHMR University,Jaipur

Date

ACKNOWLEDGEMENT

The Dissertation Opportunity I had with Max Hospital, Shalimar Bagh New Delhi was a good opportunity to learn and for professional development. I consider myself grateful to have got this opportunity and the chance to meet such wonderful and professional people who supported me through this time.

Before all, thanks to God & Parents for the blessings and sustenance without which it would have been difficult to complete the project in required time.

Words can never be enough to express my sincere thanks to Medical Administration and operations department and especially Dr Archana Bajaj**,** Medical Superintendent for her continuous guidance and support.

I convey my gratitude to Mr. Abhimanyu Gusian who gave me the opportunity to be a part of Medical Quality Department. I express my greatest thanks to Dr Harpreet Kaur for their support and guidance to make this project possible.

I also express my thanks to my colleagues, for her support. I would also thank Dr. Shivani Arora without whom this project would have been a distant reality. Most of all, I pay my sincere offering to the almighty without whose support I would not be able to add a new dimension to my life.

In the end, I am thankful from the core of my heart to Max Hospital for their support in providing the required information. I am grateful for their patience and kindness.

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ABBREVIATIONS

RMO – Resident Medical Officer

IPD – Inpatient Department

GDA – General Duty Attendant

CGHS - Central Government Health Scheme

TPA – Third Party Administrators

MT- Medical Transcriptionist

ABSTRACT

Title- Discharge Time Tracking of Inpatients in Max Hospital, Shalimar bagh

Keywords- discharge

Background - To study the process of discharge and to calculate the average time taken in process of discharge .The study was conducted at Max hospital Shalimar Bagh, New Delhi

Objectives- To study the process Involved in patient discharge at Max Hospital Shalimar Bagh

Research Question- Is time taken for discharge process is compliant with the adhered time for discharge process?

Methods-The study is a descriptive cross sectional and was conducted on inpatients with a sample of 130 samples. The data was collected via primary method by observation & patient tracking whereas the sample technique used was Non- probability convenience method.

Result-The average Discharge time for patients recorded to be 4 Hours and 37 minutes against the ideal time which was 1 hour in case of 90% of cash & CGHS patients. The main reasons for delay were identified & for improving discharge process recommendations were given.

Conclusion- Discharge process is an important phase for operational and efficient flow of any hospital. It improves the levels of patient satisfaction. It streamlines the discharge process flow and is very essential as it prevents additional costing and saves time as well

CHAPTER-1

INTRODUCTION

INTRODUCTION

People needs healthcare services from the day they are born, and demand for such services varies throughout their lives, resulting in a volume of demand that is nearly equal to the human population. The human body's complexity, as well as the various ailments it may experience, adds to the complexity of what is required of healthcare workers.

A health system is a collection of facilities and organizations that collaborate to provide services related to people's health and well-being. The healthcare system's structure and functioning are greatly influenced by the country or region it serves.

“An” “inpatient” is a patient who is taken into a hospital with the motive of obtaining IP hospital care. Even if it is later discovered that discharge or transfer to another hospital is conceivable, A person shall be deemed to be inpatient if he or she is formally admitted to stay at least overnight and occupy a bed. Any inpatient's complete hospital experience can be separated into three separate phases: admission, treatment, and discharge, in the simplest manner feasible. These phases tend to overlap, despite the fact that they occur in that order (1).

Discharge from the hospital occurs when a patient left the hospital and either go back tohome or is sent to other unit, such as a rehabilitation center or a nursing home.
The discharge includes the medical instructions.

Discharge from the hospital process, not a one-time occurrence. It entails the creation and execution of a plan to enable the transition of a patient from a hospital to a more proper

facility. Family, caregivers, hospitals, primary care professionals, community agencies, and social services are all part of the system that must operate together. Activity and performance standards should be properly monitored and there must be open environment to create solutions.

This will guarantee that the patient's experience reflects the whole-systems approach to admissions and discharges. Every hospital should have its own discharge planning operational policies. Staff should be involved in the formulation and revision of these policies on a regular basis. Discharge management, like admissions, has an impact on hospital efficiency, quality, and safety.

Many countries have issued a set of standards for better application in planning of hospital discharge process, recognizing relevance of an effective planning of discharge system in both acute and sub-acute care practice and policy. Beginning in 2004, the National Health Services (NHS) Plan in the United Kingdom (UK) contained a goal of ensuring that every NHS patient had a discharge plan.

Starting with hospital admission, every NHS patient should have a discharge plan.

According to the Department of Health's guideline for England, discharge planning from a hospital is a process, not a one-time event, that should begin as soon as possible. Since 1998, Australia has made effective discharge a top goal. The Victorian government has established a "Effective Discharge Strategy," a five-year plan for all Victorian public hospitals from 1998/99 to 2002/03.In the US, discharge planning is a legally mandated function for hospitals(2).

RATIONALE OF THE STUDY

The motive of the study is to identify the updated planning discharge plan of healthcare staff working at Max Hospital, Shalimar Bagh, to identify the barriers to conducting the existing system's discharge planning, and on suggesting points for making an powerful and efficient discharge of patient planning process. The findings will be used to help Max

Hospital design a discharge planning policy. In addition, current findings will give more data for future research in this vital topic.

CHAPTER 2

LITERATURE REVIEW

REVIEW OF LITERATURE

TIMELY DISCHARGE

When a patient is stable clinically and ready for release, they are released home or transferred to a proper level of treatment(3).

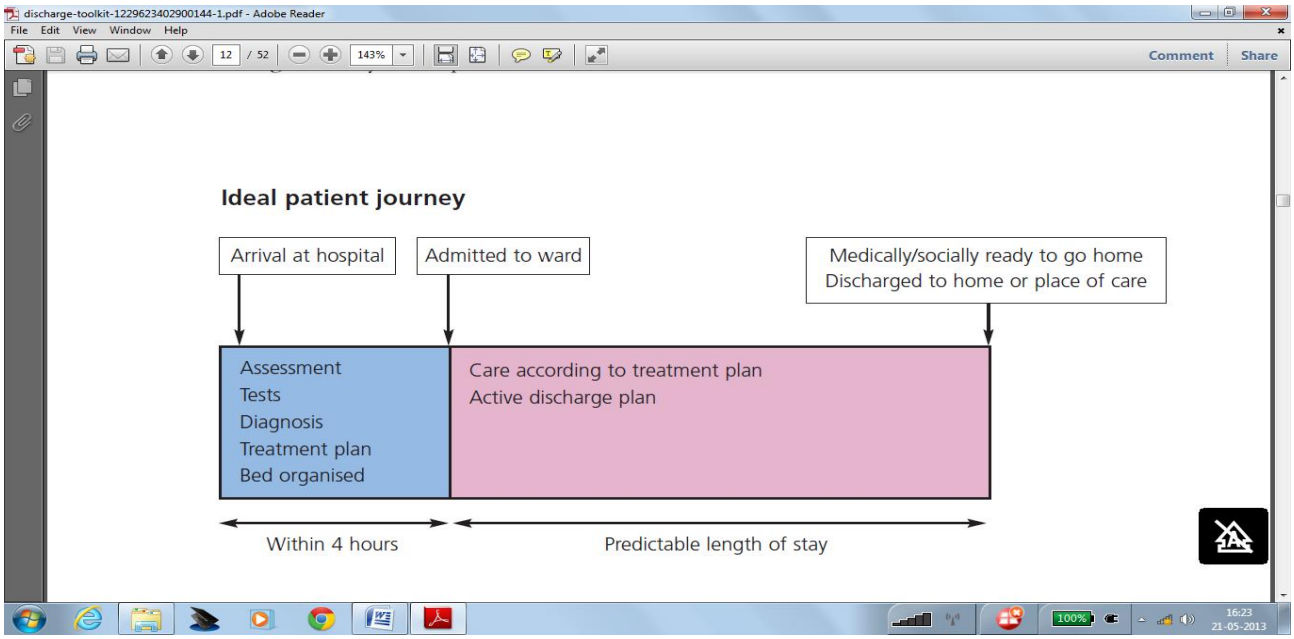

Figure 1. Figure showing ideal patient journey in a hospital

DEFINITION OF CILINICAL STABILITY

Clinical stability and medical stability are the same. When blood tests and investigations are considered to be within the regular range, patients can be defined as clinically or medically stable. 'Fit for discharge(3).

CRITERIA FOR PATIENT TO BE "FIT FOR DISCHARGE"

The patient is deemed "fit for release," if physiological, social, functional, and psychological factors, as well as a multidisciplinary evaluation are considered. The patient is secure to be released or transferred to home or other premises from the hospital. If a patient is deemed to be fit for discharge, he or she no longer requires the services of a secondary care provider or a specialist and where:

- A patient's condition review, including medication adjustments, can be shared with the doctor.
- Ongoing general, nursing, and rehabilitation requirements can be handled at house or through primitive, community, secondary, and social care services.
- Further investigations and tests can be performed in an ambulatory care setting or outpatient(3)

KEY PLAYERS IN THE DISCHARGE PROCESS

Discharge process's key members are:(3)

The Patient: The patient is the most essential entity in the patient process of discharge planning . During the discharge process, the care squad will usually respect the patient's choices. Studies recently, have shown that home recovery is comparable to, and in some cases superior to, recovery in a facility. When it comes to discharge, however, everyone has their own preferences. As a result, Open communication channels during hospitalization are critical as soon as possible. Clear communication enables patients to express their personal wishes and concerns while allowing their families and their referrals to participate.

The Members of Patient Family: People of family and carers are essential components of the patient discharge planning process, because they will be in charge of the care of patient at home or in a “post-hospitalization facility”. They can offer important feedback to the discharge team that the patient may not have considered fully. It is frequently the responsibility of the patient's family to make the best decisions for the patient's recovery and well-being.

The Discharge Planner: The discharge planner, who is usually a discharge coordinator, specially designated for managing discharges, arranges for a patient's release from the hospital. The discharge planner has many hats to wear. She must consider the hospital's cost effectiveness as well as the wishes of the family and the patient's well-being.

The Nursing Team: Patient caregivers are an invaluable source of resources during the process of discharge planning. They can comment for example on the mental state, endurance, ability and readiness of a patient to follow directions. Their experiences and knowledge of the patient's hospital visit are also the basis for valuable advice to the family.

The Physician: The doctor approves the final discharge scheme and there is a responsibility for mentioning medicines that directly affect the comfort and mood of the patient. The physician's primary purpose is the mental and physical wellbeing of the patient.

The Social Worker: They responsible for 3 things: (1) assessing the psychosocial state of patient that may influence discharge plans, (2) connecting families with relevant community resources, and (3) provide patients and their families with emotional support and guidance. MSH can be an invaluable resource especially, if the patient spends considerable time in hospitals or is in danger of mental problems during the transition home.

The Various Skilled Therapists ("OT/PT/ST"): "Occupational", "physical" and "speech" therapists may help to plan the disposal by communicating to the discharge planner the patient's skills and deficits. These qualified therapists are also essential in the treatment process after hospitalization.

DISCHARGE PLANNING

The process of discharge planning begins with an early assessment of the patient's projected care needs. Physicians, nurses, case managers, dieticians, educators, therapists, and social workers are all involved in effective discharge planning.

Because hospitalization is frequently a shorter event, discharge planning start soon after admission. "Physicians, nurses, and managers involved in a patient's care form part of an assessment team that considers the patient's pre-admission level of functioning as well as whether or not the patient will be able to return home after the present hospital stay". Information that may have an impact on the patient's discharge plan should be recorded in the patient's medical record so that it can be considered when discharge is scheduled. .During their stay in the hospital, the patient's treatment was overseen by physicians other than their main care physician. "Clear communication between the hospital physician(s) and the primary care physician is essential for successful discharge planning". This can be done either over the phone or in writing. The following is a list of the information to be conveyed:

- Results of test and surgeries performed.
- Case Summary.
- Pending Test list.
- List of tests to be performed after discharge for e.g. x-ray.
- Medication List with dosage and frequency.
- Discharge patient instructions that needs to be followed.
- Follow up appointment details.
- Discharge instructions on activity level, diet etc. to attendant.

The patient will receive instructions on discharge before leaving the hospital:

- In Hospital a summary of care is provided to the patient.
- Medication chart that patient needs.
- Information regarding newly prescribed medications and its instructions.
- A new prescribed medications prescription
- Follow-up appointment with doctor.
- Order for attendant for patient's homecare.
- Infection signs and symptoms or condition worsening, such as pain, vomiting, fever, bleeding, breathing difficulty.

1. Caregiver Perceptions of the Reasons for Delayed Hospital Discharge(4)

Tracey M. Minichiello, Andrew D. Auerbach, Robert M. Wachter

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

The result of the study suggested that nurses can be one of the reason delays in discharge than house staff and physicians. Also, Caregivers from the same institution had different discharge barriers and thought that activities related to discharge had taken place at various times.

The conclusion was, to address discharges in hospitals &gaps in communication .

2. Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professionals (5)**.**

The study was conducted to examine the grasp quality from perspective on healthcare providers of current hospital discharges and for barrier identification for successful planning of discharge in Hong Kong.

Several medical workers currently in charge of organizing the process of discharge planning were interviewed in public hospitals. All present practice on discharge of hospitals, challenges to effective discharge of the hospital and suggested structures and processes for successfully planning the discharge were discussed.

Participants noted that in Hong Kong's public health system, there were no uniform hospital-wide discharge planning or policy-driven approach. Lack of a consistent policy-driven discharge planning program, as well as a lack of coordination and communication between providers of various healthcare services and patients in care settings, were recognized as potential impediments. “To improve the quality of hospital discharge, a multidisciplinary strategy with clearly defined duties among healthcare staff was proposed”. The communication skills of health professionals as well as their understanding of patient psychosocial requirements were also improved.

3. Factors contributing to the process of intensive care patient discharge: An ethnographic study informed by activity theory.(6)**.**

The purpose of the article was to find reasons that affects ICU patient discharge.

This research took place at the Australian Metropolitan Tertiary Hospital at a 14-bedding intensive health unit level 3. The study included medical and nursing staff from intensive and acute care units and another staff involved in the process of discharge for critical care patients.” A total of 28 releases were reported and 56 one-on-one interviews were conducted.

Direct observations, semi-structured interviews, and collection of existing documents are the data collection techniques which were used”.

“Three patient activity systems were identified: Intensive Patient Discharge Activity, Acute Patient Acceptance Unit, and Hospital Bed Control Activity. Conflicting aims, communication breakdowns, and teamwork issues were observed as a result of the interactions between diverse activity systems”.

4. Framework and components for effective discharge planning system: a Delphi methodology. (7)

“The purpose was a 3-staged process to develop, pre-test and pilot a framework for an effective discharge planning system in Hong Kong”.

The Delphi technology has been used to rating and discuss the structure and components of effective discharge planning for a group of experienced health professionals. The framework included 36 assertions in five categories: first screening, discharge planning, dissection coordination, execution of the discharge and follow-up after the discharge. Each statement was scored on three aspects in a five-point Likert scale, namely: clarity, validity and applicability.

This article provides a framework for policymakers and hospital administrators to employ in building a rational and systematic discharge planning approach.

“Adopting a Delphi approach further emphasizes the method's value as a pre-test (before the clinical run) of the components and requirements of a discharge planning system while taking the local context and system” restrictions into account, resulting in greater applicability and practicability.

KEY PRINCIPLES

“The key principles for effective discharge and transfer of care are that:

• A 'whole system approach' to evaluation processes, commissioning, and service delivery aids in reducing unnecessary admissions and facilitating effective discharge.

• Individuals and their caregiver(s) must be involved and actively participate as equal partners in the delivery of care and the planning of a successful discharge.

• Discharge is not a one-time event, but a procedure. It should be planned for all primary, hospital and social care systems as rapidly as possible, to ensure that individuals and carers understand and can take part in care planning decisions when necessary."

• A named person responsible for coordinating all stages of the patient journey should supervise the discharge planning procedure. This means that the pre-admission case coordinator in the community is contacted as soon as possible, and these obligations are transferred upon release.

• "Employees should work within the framework of an integrated multidisciplinary and multi-agency team to manage all aspects of the discharge process".

• Transitional and intermediate care services are effectively used to make proper use of existing acute hospital abilities and to achieve the desired results of patients.

• People understand and receive advice and information on the continuum of health and social care services to enable people to make informed decisions regarding future care as they are responsible for assessing, providing, maintaining health care and social care to understand their rights and their rights and receive advice and information about the continuum of health and social services.

OBJECTIVES

Broad Objective:

To study the process involved in patient discharge at Max Hospital, Shalimar Bagh

Specific Objectives:

- To observe the process involved in patient discharge process at Max Hospital.
- To study the workflow and responsibilities of various departments involved in discharge process.
- To estimate average time taken in discharge of patients from the hospital.
- To find out the gaps causing delay in discharge process.

CHAPTER 3

METHODOLOGY

METHODOLOGY

The researcher employed quantitative approach to data gathering. The data collection source for the study is primary data source. The primary data will be collected through the use of observation and Discharge patient tracking that include, Patient information, timings of various events occurring in the process of discharge.

Study design: - Descriptive cross-sectional study (Time motion study)

Study area: - Max Hospital Shalimar Bagh, Delhi.

Study population: - Patients admitted in the hospital for treatment from 17 Feb to 16 April 2021

Sample design: - Non probability- convenience method

The first two patients discharged in the morning per day were included in the sample.

Patients admitted in the Inpatient department situated in the fifth floor of the hospital only, were taken into consideration while sampling.

Sample size: - 130

Study duration: The study duration was of 1 month from March 2021 to April 2021.

Data collection tool and technique: - Observation and Discharge Process.

In Max Hospital, Shalimar Bagh discharge process of 130 patients is monitored.

Firstly, 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 each and every event which is followed by the departments and the staffs are documented over a period of 30 days and 130 patients are monitored.
- Time taken between each event is calculated.
- Then, total time taken in the completion of whole discharge process is calculated.
- The average time taken in the completion of each event is calculated and average time taken in the discharge process of all 130 patients is calculated.
- Graphs are plotted accordingly.

Inclusion Criteria: IPD Patients

Exclusion Criteria: Day care Patients, Patients Discharged after 5 PM & Emergency Patients

CHAPTER-4

RESULTS AND DISCUSSIONS

STUDY FINDINGS

DISCHARGE PROCESS FLOW MAX HEALTHCARE, SHALIMAR BAGH

Figure No. 2. Figure showing workflow of discharge Process

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

1. Nursing

2. Pharmacy

3. 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

POPULATION PROFILE

1. Graph showing number of genders of selected sample.

GENDER	NUMBER
MALE	66
FEMALE	64
TOTAL	130

Graph 1: Showing number of gender of selected sample

Maximum patients were male (51%) out of 130 selected sample.

2. Graph showing number of category of selected sample according their mode of payment.

CATEGORY	NUMBER
CASH	50

Graph 2: Showing category of selected sample acc. To their mode of payment

Out of 130 patients taken in the study 51 patients were CGHS credit patients, 50 patients were Cash patients and 29 patients were TPA patients.

3. Graph showing peak hours of discharge of patients.

Time range	**Frequency**
8:00 - 9:00 am	15
9:00 - 10:00 am	20
10:00 - 11:00 am	51
11:00 - 12:00 pm	19
12:00 - 1:00 pm	14
After 1:00 pm	11
Total	130

Graph 3: Showing peak hours of discharge of patients

The number of patients discharged were maximum between the time range of 10:00 am to 11:00 am, whereas less number patients were discharged after 12:00 noon. One of the main reasons for maximum discharges between this time is planned discharges.

4. Graph showing time gap between written discharge communication by the doctor and time of providing intimation to medical transcriptionist for making discharge

Graph 4: Showing time gap between written discharge communication by doctor and time of providing.Intimation to MT for making discharge.

The average time taken for communication for making discharge summary draft by the consultant to medical transcriptionists was 10 minutes. It has been observed that out of 130 patients, communication between consultants and MT took place within 1 hour for 91(70%) patients. Whereas in between 1 to3 hours intimation took place for 27 (21%) patients. The maximum time taken was 8 hours 10 minutes. in case of the sample patients taken.

5. Graph showing time taken to make final discharge summary by the Medical Transcriptionist.

Graph 5: Showing time taken to make final discharge summary by MT

Typing of discharge summary by the Medical Transcriptionist on an average took 59 minutes. In this study, it has been instructed that making discharge summaries has been kept on priority in order to smoothen the discharge process in which discharge summaries were prepared within 1 hour for 58 (45%) patients. The maximum time taken by the typist was 5 hours 25 minutes whereas the minimum time taken was 15 minutes. By the Medical Transcriptionist. Also, the time taken for making discharge summary keeps on varying between 1 hour to 5 hours.

6. Graph showing time taken by the nurse for preparing activity sheet & pharmacy return and handling over the medication to GDA for returning it to pharmacy.

Graph 6: Showing time taken by the nurse for preparing activity sheet & pharmacy return and handling over the medication to GDA for returning it to pharmacy.

The average time taken by Nurse to prepare the activity sheet, pharmacy return and handling the return medicine to GDA was 15 minutes. The maximum time taken was 1 hour 11 minutes and minimum was 4 minutes. It has been observed that medications were returned by GDA within 1 Hour for 91(70%) patients and for 2 (1.5%) patients it took more than 2 hours due to some carelessness of GDA present in the ward.

7. Graph showing time taken by Pharmacy to complete the medication return process.

Graph 7: Showing time taken by pharmacy to complete the medication return process.

The time taken by the Pharmacy to complete the medicine return process took 7 minutes. on an average whereas maximum time was 25 minutes and minimum were 1 min. This time depended on the amount of return medicine from IPD of each patient. Medication return process were also the fast process because of fast activity within pharmacy department. It has been seen that medication process for 92 (71%) patients were completed within 5 to 10 minutes.

8. Graph showing time taken by billing department to prepare the final bill.

Graph 8: Showing time taken by department of billing to prepare final billsheet.

The maximum taken time by billing department to prepare final bill was 6 hours 10 minutes. whereas minimum time taken was 5 minutes. on an average it took 1 hour 5 minutes to prepare the bill. The preparation time of final bill depended on type of patient. For Cash patients it was minimum whereas it took longer time in case of CGHS and TPA patients. It has been observed that usual time for bill prepration is between 1 to 3 hours for 50 (39%) patients. A point to be noted here that, for 14 (11%) patients the bill prepration of bill almost took between 5 to 7 hours.

9. Graph showing time taken by the patient to clear the bill.

Graph 9: Showing time taken by the patient to clear the bill.

Once the final bill was prepared, the patient or his attendant had to clear the bill. On an average it took 1 hour 10 minutes. The maximum time taken was 7 hours 4 minutes. For TPA patient's bill clearance takes longer time. This time also depended on the type of payment. In most of the cases TPA patient took longer time to clear the bill than Cash or Credit patients. Bill clearance for 45 (50%) patients were done in between 1 to 3 hours and a major point to be noted is that for 7 (6%) patients the time took almost 7 hours for bill clearance.

10. Graph showing time gap between clearance of the bill and patient vacating the room.

Graph 10: Showing time gap between clearance of the bill and patient vacating the room.

The time taken by the patient after clearance of the bill was maximum of 4 hours 10 minutes and minimum of 20 minutes. The average time taken was 25 minutes. Once bill is cleared, the process of vacating room is completed mostly within 1 hour for 55 (43%) patients but in some cases, more than 4 hours were consumed for 4 (3%) patients.

11. Graph showing Average time taken by the hospital for discharge process of patient.

Graph 11: Showing average time taken by the hospital for discharge process of patient.

The total time taken in the discharges of sample patients taken was on an average 4 hours 30 minutes. The maximum time was 9 hours 10 minutes and minimum was 1 hour 40 minutes. From the above graph it has been observed that in case of 58 (45%) patients the discharge process is completed in between 4 to 6 hours. Also it has been seen that it took more than 9 hours for 6 (7%) patients which needs to be reduced.

12. Table and graph showing maximum, minimum and average time taken in various events in discharge process.

TIME (HH:MM)	A	B	C	D	E	F	G	H
MAX	08:10	05:25	01:11	00:25	06:10	07:04	04:10	09:10
MIN	00:02	00:15	00:04	00:01	00:05	00:07	00:05	01:40
AVERAGE	00:10	00:59	00:15	00:07	01:05	01:10	00:25	04:30

A	Time gap between written discharge communication by the doctor and time of providing intimation to MT for making discharge
B	Time taken to make final discharge summary by the MT
C	Time taken by the nurse for preparing activity sheet & pharmacy return and handling over the medication to GDA for returning it to pharmacy.
D	Time taken by Pharmacy to complete the medication return process.
E	Time taken by Billing department to prepare the final bill.
F	Time taken by the patient to clear the bill.
G	Time gap between clearance of the bill and patient vacating the room
H	Total time taken by the hospital for discharge process of patient.

From the above graph it is clear that the events taking longer time in discharge process are- preparation of bill, clearance of the bill and typing of discharge summary.

Graph 12: Showing maximum, minimum and average time taken in various events in discharge process.

13. Table and graph showing average discharge time of Cash, CGHS and TPA patients.

PATIENT CATEGORY	AVERAGE DISCHARGE TIME
CASH	03:37:00
CGHS	04:56:00
TPA	06:31:00

Graph 13: Showing average time of Cash, CGHS and TPA Patients.

It was observed that average time for discharge of TPA patients was much more (6 hours. 30 minutes.) than that of CGHS (4 hours. 56 minutes.) and CASH (3 hours. 37 minutes.) patients.

DISCUSSION

1. In Max Hospital the average time taken in the patient discharge is 4 hours 30 minutes. According to the hospital's set target it should be completed within 1 hour in case of 90% of Cash & CGHS patients.
2. In Max Hospital the average time taken for discharge of cash patients is less than that of CGHS & TPA patients. In case of TPA patients it takes time to get the clearance from the company. This is the main reason which takes around 6 - 7 hours to discharge a TPA patient.
3. Some of the other causes for delayed discharge of TPA patients include:
    a. Finance clearance delay in hospital.
    b. Incomplete medical records filled by the treating doctors,
    c. Delay in signing discharge summary by the treating doctor,
    d. Not mentioning remarks in the discharge summary,
    e. Delay in enhancement approval and final bill is more than the approved amount.

f. TPA on 'final authorisation approval' leads 'Delayed response' from the - TPAs typically take two to three hours to finalize a claim, whereas the hospital takes approximately two hours to complete the administrative formalities, which include the discharge summary, collection of reports, billing, and other relevant documentations.

4. The main cause of delay is poor communication between the doctors, nurses, personnel of pharmacy and billing department and patient's attendant.
5. The typing of discharge summary takes longer time. There are less medical transcriptionists appointed in the hospital and the work load is more.
6. In IP pharmacy, the pharmacist generally takes 4 – 5 minutes for clearance.
7. In Pharmacy also sometimes it take long time 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.
8. The billing department workflow is good although they have high workload.
9. 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 especially of TPA and Credit patients.
10. Sometimes patient's attendants are also responsible for delayed discharge. The reason being.
    a. non availability of patient attendant at the time of bill clearance
    b. Delayed payment of bill by patient attendant.

CHAPTER-5

RECOMMENDATIONS

RECOMMENDATIONS

1. Doctors should provide the information to the assigned nurse as well as Floor Manager about the tentative discharges during the evening rounds (1 day prior to discharge)
2. As the peak hours of discharge is between 10:00 am to 11:00 am, the Doctor's morning round should be completed before 9:00 am and first, "to be discharged" patients should be seen by the doctor.
3. Tentative discharge summary should be prepared by MT in the night time proceeding the day of discharge.
4. In case of planned discharges, medications return should be done in the night time 1 day prior to discharge.
5. Morning dose of all medications should be kept separately for giving to the patient.
6. All pending Lab/Radiology reports should be collected during night time and filed in the patient's records.
7. Inter departmental communication and communication between nurses & patient attendant need to improve.

8. Nurses should properly check the medication before sending requisition pharmacy to avoid extra accumulation of drugs.
9. Nurses should not send the pharmacy return of many patients in bulk which increases the pharmacy return time.
10. IP Billing section to keep a track of outstanding balance.
11. Number of GDA should be increased.
12. Checklist for discharge at patient bedside can be implemented e.g., not planned, discharge tomorrow etc.
13. The billing mechanism for all hospital should be standardized so that there is transparency between the hospital and the TPA groups. The risks of a delay are minimized, and the claim procedure is smoother because of this technique.

CONCLUSION

For healthcare professionals, patients, and caregivers, hospital patient discharge process is a complex process. Effective discharge planning has the potential to improve health of patient's while also reducing patient costs.

A plan for facilitating the shifting of an individual from the hospital to another environment must be developed and implemented. The concerned persons and their caregivers should participate at all stages and be fully informed by regular reviews and care plan updates. Planning discharge to hospital is part of an ongoing process that should begin for planned entry before admission and for all other admissions as quickly as possible. This includes developing or adding to any pre-admission assessments .

Effective and timely discharge requires alternative and suitable care options for ensuring the identification and satisfaction of all needs for rehabilitation, recovery and continued health and social care.

The satisfaction rate of patients with the process of discharge in Max Hospital was found to be only 35% in the month of April. The average time taken for discharge of a patient was 4 hours 30 minutes. Which is much higher than the estimated target of the hospital i.e. 1 hour. Various reasons for delayed discharges include longer time taken by the typist to type the discharge summary, improper nursing activity, longer time in clearance of bill in case of TPA patients.

Hospital management should set an aim to decrease the discharge time to 1- 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.

Accurate discharge management is essential to ensure:

- Patient satisfaction;
- For emergency and elective admissions availability of bed
- High quality of patient care.

LIMITATIONS

1. The population studied consisted of a sample of only 130 patients hence some of the pattern identified may have been under or overestimated.

2. Increased cases of COVID-19.

2. 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.

3. Due to lack of time and resources TPA patients were not studied in detail as in the case of cash or credit patients.

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APPENDICES

Steps	Responsibility	Time	Remarks (in case of any delay)
Written discharge communication by the doctor	Nursing		
Time of providing intimation to the resident doctor for making discharge summary	Nursing		
Time of receiving the final print out of discharge summary (signed) by the nurse	Nursing		
Time taken for preparation of activity sheet by the nurse	Nursing		
Time taken for preparation of pharmacy return by the nurse	Nursing		
Time of handing over the Medications to GDA for returning to pharmacy	Nursing		
Time of sending the intimation to Billing section by pharmacy after completing the pharmacy clearance	Pharmacy		
		Time	
Time of completing the final billing	IP Billing		
Time taken for explaining the advice & handing over of folder to patient	IP Billing		
Time of vacating the room by the patient	Nursing		
Time of completing the room Cleaning	Nursing		