Analysis, Mapping and Improvement of Patient Discharge Process

By

Namita Mishra

Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2014-2016

The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Sanganer Airport
Jaipur-302029, Rajasthan
Ph: 0141 3924700, Fax: 3924738
Website: www.iihmr.edu.in

INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Namita Mishra** student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Narayana Multispecialty Hospital, Jaipur from January 28th 2016 to May 3rd 2016.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.
The Internship is in fulfillment of the course requirements.
I wish her all success in all future endeavors.

Dr. Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

Dr. Dhirendra Kumar,
Professor
The IIHMR University, Jaipur

1, Prabhu Dayal Marg, Near Sanganer Airport, Jaipur-302029, Rajasthan, India.
Ph.: 0141-3924700, 2791431- 32, Fax:0141-3924738,E-mail: iihmr@iihmr.edu.in,Web: www.iihmr.edu.in

P. D. HINDUJA NATIONAL HOSPITAL
& MEDICAL RESEARCH CENTRE
(Established and managed by the National Health & Education Society)

VEER SAVARKAR MARG, MAHIM, MUMBAI - 400 016, INDIA
PHONE : 2445 1515, 2445 2222, 2444 9199 FAX : 2444 9151

May 5, 2016

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Ms. Deepika Shukla a student of MBA in Hospital and Health Management from Indian Institute of Health Management Research (IIHMR), Jaipur, did her internship in our Hospital from 15th February 2016 to 8th May 2016. During this period her assignment was as follows:

- Study on patient satisfaction at P D Hinduja Hospital.

I wish her all the success in future endeavors.

Joy Chakraborty
Chief Operating Officer

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled A study on patient satisfaction at P.D Hinduja Hospital ,Medical and Research Centre, Mumbai and submitted by Ms. Deepika Shukla Enrolment No 0139 under the supervision of Dr. Neetu Purohit for award of MBA in Hospital Management of the University carried out during the period from 2014 to 2016 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Deepika Shukla

Signature

ACKNOWLEDGEMENT

The internship opportunity I had with Narayana Multispecialty Hospital, Jaipur was a great experience for learning and professional development.

I feel deeply privileged in expressing my deep sense of gratitude to **Dr.Devi Shetty** (CMD Narayana Group**), Mr.Arunesh Punetha** (Facility Director), **Dr. Mala Airun** (Clinical Director), **Dr Manikant Jain** (Medical Superintendant), **Ms VishnuPriya Sharma** (Deputy General Manager-Human Resources) Narayana Multispecialty Hospital, Jaipur for their expert guidance and encouragement which helped me a lot in the process of completing this dissertation. Without their support, exploring such a vast organization could not have been possible.

I am also very thankful to my guide respected **Dr Dhirendra Kumar sir (**Professor, IIHMR University) who always guided and encouraged me throughout my training period and without his kind support my project would not have been completed successfully.

Sincerely,

Dr. Namita Mishra

TABLE OF CONTENTS:

INTRODUCTION TO DISCHARGE PROCESS

DEFINITION

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

"The discharge planning process in a hospital will ensure that patients do not have to remain in hospital for any longer than necessary"

Result of delay in discharges-

Hospital bed demand sometimes exceeds capacity, leading to delays in patient admissions, transfers and cancellations of surgical procedures. Effective strategies must be in place for an efficient use of existing beds.

AIMS & OBJECTIVES OF STUDY

AIM:

To identify the delay in the processes and find out the main causes which gives rise to the different problems.

OBJECTIVES:

- To estimate the average discharge time.
- To understand the process of discharge.
- To find out the factors responsible for delay in the discharge process.
- To suggest mechanism to reduce the time in the discharge process.

REVIEW OF LITERATURE

Discharge Planning

Discharge planning refers to the decision making process required to release a patient from one care facility to the next. Every inpatient discharge involves four critical decisions: 1) the timing of discharge, 2) the discharge process, 3) the location of patient disposition, and 4) the post-discharge follow-up. The planning of patient discharges is complex, and is typically influenced by patient-, provider-, and system-related factors. These decisions concerning patient discharges tend to be highly variable and, when suboptimal, they could result in increased readmissions and emergency department (ED) crowding. For instance, poor discharge planning accounted for 82-delay-related hospital days annually and $170,000 in annual costs, where 22% of reported delays were related to discharge planning (Srivastava et al., 2009). Ineffective care transition into disposition locations is often associated with this poor discharge planning (IHI, 2011). One in 5 Medicaid patients are readmitted within 30 days of the discharge, accounting for a spending of over 17.4 billion annually (Jencks et al., 2009). ED crowding occurs when the demand for emergency services exceeds the number of resources available both in the ED and inpatient units (Hoot and Aronsky, 2008). ED crowding contributes to long wait times for patients, ambulance diversion, and ED boarding, which refers to patients continuing to utilize an ED bed while waiting on an available bed in an inpatient unit (Schull et al., 2003). According to a national survey, 91% of sampled ED staff responded that crowding was an issue (Institute of Medicine, 2007).

Within the discharge process, a multi-disciplinary discharge team, often composed of physicians, nurses, social workers, and case managers, work to get this patient off the unit and to their discharge location. This discharge planning ideally spans a patient's entire stay at the inpatient unit, starting from when they enter the unit and continuing throughout their stay at the unit. As a part of the

discharge process, various support services such as laboratory work, physical therapy, and occupational therapy are involved to satisfy each patient's needs. All of these services must be successfully accomplished (and often in a prescribed order) before a patient is discharged from the unit (and the hospital). Almost always, the corresponding room and bed must be cleaned before it is made available to a patient waiting (and many times, boarding) in an upstream unit.

1.3 Day-of-Discharge

While the overall discharge planning is very broad and spans across multiple days of inpatient stay, we focus on the day-of-discharge process for a patient who has been determined medically ready to leave the unit. On this day-of-discharge, the multi-disciplinary discharge team, often composed of physicians, nurses, social workers, and case managers, work to get this patient off the unit and to their discharge location. Although this discharge planning ideally spans a patient's entire stay at the hospital, the day-of-discharge process becomes especially vital in getting the patients off the unit in order for the previously occupied bed to be cleaned an made available to the next patient.

There are many key pieces that must be in order before a patient can be discharged from an inpatient unit (IU). A key piece is that discharge orders must be completed by a physician or physician's assistant giving approval that the patient is ready to be discharged. Also as a part of the discharge process, various support services such as laboratory work, physical therapy, and occupational must be completed, as shown in Figure 2. Another aspect of the discharge process is the social worker's responsibilities in arranging transportation, getting insurance approvals, and finding availability in discharge disposition locations (skilled nursing facility, rehab facility, etc.), if applicable. All of these must be accomplished in order before a patient can leave the hospital and the

METHODOLOGY:

The present study was carried out at Narayana Multispecialty hospital, Jaipur with the objective of finding out the hindrances in the discharge process. Study reveals that there are many hindrances which cumulatively cause delay in discharge processes. Delay was observed and recorded in 55.7% of cases in discharge process (39 delayed discharges out of 70)

- **Study design**: Exploratory Study

  .

- **Study type**: Prospective study

- **Study area**: Narayana Multispecialty Hospital, Jaipur

  .

- **Study Population**: Indoor patients who have admitted for some kind of medical / surgical interventions

- **Nature of study**: Quantitative data collected through discharge tracker.

- **Study tool**: Discharge tracker

- **Period of study:** 11days.

- **Sample size**: 70 discharged patients in the between the month of January to April 2016.

STEPS OF DISCHARGE PROCESS:

Discharge advice given by doctor to nurse/RMO

↓

Discharge intimation given by nurse/RMO

↓

Draft discharge summary given by RMO to consultant

↓

Corrected draft discharge summary given back to RMO

↓

Final discharge summary made by DEO and print taken

↓

Discharge summary signed by consultant/RMO

↓

IP issues/returns done, marked for discharge in system, pharmacy clearance

↓

File sent to billing /TPA

↓

File checked, bill finalized

↓

Patients relative call for billing/TPA

↓

File sent back to nursing of respective ward

↓

Bill settled by pt. /TPA

↓

File handed over to pt. /medication explained/feedback taken

↓

Patient vacates the room.

The standard time of discharge for cash patient is 2-2:5 hrs and for credit patient its 3-4 hrs but in some cases delay in process occur thus to identify the causes of delay in process whole process is divided into sub processes and assumptions have been taken for them

SUB PROCESSES	**ASSUMED TIME**
A. Starting process(discharge order given, discharge summary made, TPA file prepared)	30 minutes
B. Discharge summary correction and signed, billing/TPA file sent, mark for discharge done.	15 minutes
C. Pharmacy clearance done	30-40 minutes
D. Bill prepared	20 minutes
E. File sent to TPA from billing	10 minutes
F. Bill sent to the billing counter	5-10 minutes
G. At billing counter	20 minutes
H. No dues clarification	15 minutes
I. Discharge card prepared	10-15 minutes
J. Final bill given to patient with discharge card.	10-15minutes
TOTAL TIME	2-3 Hrs

RESULTS AND OBSERVATIONS:

Discharge Tracker: hyperlink diacharge tracker.xls

DOA	Discharge declared by the doctor (Time)	Marked for Discharge (Time)	Pharmacy Clearance (Time)	Manual Billing by billing dept (Time)	TPA (Time)	Discharge from system (Time)	TAT Pharmacy	TAT Billing	TAT discharge
1/2/2016	12:00 PM	12:20 PM	1:00 PM	1:15pm	4:00pm	4:15min	15 min	30 min	4 hrs 15 min
26/1/16	10:00 AM	11:45pm	1:15 PM	1:30pm	4:45pm	3:00pm	20 min	15 min	5 hrs
4/3/2016	12:30pm	12:40pm	12:30	1:00pm	4:00pm	4:00 PM	20 min	30 min	3:30 hrs
28/2/16	9:30 AM	10:00 AM	1:00 PM	1:30pm	2:00pm	1:15 PM	35min	30 min	4 hrs 30 min
6/3/2016	10:30am	11:00 AM	12:00 AM	12:30p	1:30pm	1:00 PM	30min	30min	2hrs 30 min

8/3/2016	9:15 AM	10:00 AM	10:30am	11:00am	12:30pm	1:15 PM	30 min	30min	2 hrs 30 min
9/3/2016	3:15 PM	3:35 PM	4:00pm	4:30pm	7:35pm	8:15pm	30 min	30min	5 hours
8/3/2016	10:30 AM	11:00am	11:30am	12:00pm	1:30pm	2:00pm	30min	30min	2hrs 30 min
1/3/2016	10:00 AM	11:30am	12:00pm	12:30pm	2:00pm	4:15pm	40min	30min	6hrs 15 min
8/3/2016	10:30 AM	11:00am	11:30 AM	12:00pm	1:00pm	1:15pm	30min	30min	2hrs
11/3/2016	11:00 AM	11:30am	12:00pm	12:30pm	1:30pm	4:45pm	40min	30min	4hrs 45 min
11/3/2016	11:20 AM	12:30pm	1:00pm	1:30pm	3:00pm	3:15pm	15min	30min	2hrs 30 min
13/3/16	11:45am	12:45pm	1:00pm	1:30pm	4:15pm	4:30pm	30min	30min	4hrs 40 min
15/3/16	10:30	11:00am	11:15am	12:oop	1:30pm	1:55pm	35min	45mi	2hrs

				m				n	30 min
15/3/16	11:00	11:30am	11:45am	12:00pm	2:00pm	4:15pm	30min	15min	4hrs 15 min
14/3/16	11:15	11:45am	12:00pm	12:30pm	2:45pm	3:00pm	25min	30min	3hrs
10/3/2016	11:30pm	12:00pm	12:30pm	1:00pm	4:00pm	4:15pm	20min	30min	4hrs 15 min
7/3/2016	11:00 AM	11:30am	12:00pm	12:30pm	2:00pm	2:15pm	30min	30min	2hrs 30 min
5/3/2016	10:30am	11:00am	11:30am	12:00pm	1:30pm	3:30pm	40min	30min	5 hrs
14/3/16	11:30am	12:00pm	12:30pm	1:30pm	3:00pm	4:15pm	45min	60min	4hrs 15 min
15/3/16	12:00pm	12:30pm	1:00pm	1:35pm	3:30pm	4:45pm	30min	35min	4hrs 45min
18/3/16	12:15pm	12:45pm	1:00pm	1:25pm	3:45pm	4:00pm	25min	25min	3hrs

17/3/16	11:00am	11:30am	12:00pm	12:55pm	2:00pm	4:15pm	35min	55min	4hrs 15 min
17/3/16	10:30am	11:00am	11:30am	12:00pm	2:00pm	2:10pm	35min	30min	2hrs 30 min
17/3/16	11:45am	12:15pm	12:30pm	12:55pm	3:00pm	3:15pm	30min	25min	2hrs 30 min
17/3/16	12:40pm	1:00pm	1:30pm	2:00pm	4:00pm	5:40pm	30min	30min	5hrs
16/3/16	10:00am	10:30am	11:00am	11:45pm	1:30pm	1:15pm	25min	45min	3hrs
16/3/16	11:00am	11:30am	12:00pm	12:35pm	2:00pm	4:15pm	30min	35min	4hrs 15 min
21/3/16	11:15am	11:45am	12:00pm	12:45pm	2:00pm	2:15pm	25min	45min	2hrs 30 min
21/3/16	11:40am	12:00pm	12:30pm	1:05pm	3:00pm	3:15pm	30min	35min	3hrs
19/3/16	12:30pm	1:00pm	1:30pm	2:15pm	3:30pm	5:30pm	25min	45min	5 hrs

20/3/16	12:00am	12:30pm	1:00pm	1:40pm	3:00pm	3:15pm	30min	40min	2hrs 30 min
14/3/16	12:15pm	12:45pm	1:00pm	1:40pm	3:45pm	4:00pm	25min	35min	3hrs
17/3/16	11:30am	12:00pm	12:30pm	12:55pm	3:00pm	5:00pm	35min	25min	4hrs 30 min
21/3/16	10:00am	10:30am	11:00am	12:00pm	1:00pm	1:15pm	25min	60min	2hrs 30 min
16/3/16	10:30am	11:00am	11:30am	12:10pm	3:00pm	3:15pm	20min	40min	4hrs 15min
28/3/16	11:00am	12:00pm	12:30pm	1:10pm	4:00pm	4:15pm	35min	35min	4hrs
27/3/16	11:45am	12:45pm	1:00pm	1:25pm	4:45pm	5:00pm	20min	25min	5hrs 15min
24/3/16	12:00pm	12:30pm	1:00pm	1:30pm	3:30pm	3:45pm	30min	30min	3hrs
13/3/16	12:30pm	1:00pm	1:30pm	2:15pm	4:00pm	5:15pm	35min	45min	4hrs 45min

									n
14/3/16	12:45pm	1:45pm	2:00pm	2:35pm	nil	3:00pm	25min	35min	2hrs 30 min
16/3/16	12:30pm	1:00pm	1:30pm	1:55pm	nil	2:00pm	30min	25min	2hrs 30 min
17/316	11:20am	12:20pm	12:45pm	1:25pm	nil	1:30pm	25min	45min	3hrs
18/316	11:00am	11:3oam	12:00pm	12:25pm	nil	12:30pm	30min	25min	3hrs
19/3/16	10:00am	10:30am	11:00am	12:00pm	nil	12:15pm	25min	60min	2hrs 30 min
20/3/16	11:00am	11:30am	11:45am	12:25pm	nil	12:30pm	30min	40min	4hrs
21/3/16	10:30am	11:30am	11:55am	12:05pm	nil	12:15pm	30min	30min	4hrs
22/3/16	11:00am	11:30am	11:45am	12:15pm	nil	12:30pm	25min	30min	2hrs 30 min
23/4/16	12:30pm	1:00pm	1:30pm	2:05pm	nil	2:15pm	25min	35min	2hrs 30

									min
24/4/16	12:00pm	1:00pm	1:30pm	1:55pm	nil	2:00pm	30min	25min	3hrs
25/416	10:00am	10:30am	11:00am	11:20am	nil	11:30am	25min	20min	4hrs
26/4/16	10:45am	12:15pm	1:00pm	1:30pm	nil	1:45pm	30min	30min	4hrs
27/4/16	12:00pm	1:00pm	1:30pm	2:05pm	nil	2:15pm	30min	35min	3hrs
28/4/16	11:00am	11:30am	12:00pm	12:40pm	nil	12:55pm	25min	40min	2hrs 30 min
29/4/16	12:30pm	1:00pm	1:30pm	2:00pm	nil	2:15pm	30min	30min	2hrs 30 min
31/3/16	11:40am	12:15pm	1:00pm	1:35pm	nil	2:00pm	25min	35min	2hrs 30 min
31/3/16	10:45am	11:15am	12:00pm	12:35pm	nil	12:45pm	30min	35min	3hrs
31/3/16	10:40am	11:30am	12:00pm	12:45pm	nil	1:00p	25min	45min	3hrs
4/4/201	12:00pm	12:30pm	1:00pm	1:40p	nil	2:00pm	45min	40mi	4hrs

6				m				n	
5/4/2016	11:00am	11:30am	12:00pm	12:30pm	nil	12:45pm	25min	30min	3hrs
10/4/2016	11:30pm	12:00pm	12:30pm	12:45pm	nil	1:00pm	40min	20min	4hrs
11/4/2016	10:00am	11:00am	11:30am	11:55am	nil	12:00pm	35min	25min	3hrs
10/4/2016	11:00am	11:30am	12:00pm	12:35pm	nil	1:00pm	15min	35min	3hrs
8/4/2016	10:30am	11:00am	11:30am	12:15pm	nil	12:30pm	25min	45min	2hrs 30 min
6/4/2016	11:00am	11:30 AM	12:00pm	12:35pm	nil	12:40pm	20min	35min	2hrs 30 min
28/3/16	10:00am	10:30am	11:00am	11:30am	nil	11:35pm	30min	30min	2hrs 30 min
12/4/2016	10:30am	11:00am	11:30am	12:00pm	nil	12:15pm	25min	30min	3hrs
11/4/2016	11:00am	11:30am	12:00pm	12:35pm	nil	12:45pm	40min	35min	4hrs
6/4/201	12:00pm	12:30pm	1:00pm	2:00p	nil	2:15pm	40min	60mi	4hrs

6				m				n	
10/4/2016	11:30am	12:00pm	12:30pm	1:00pm	nil	12:45pm	25min	30min	3hrs

RED MARK- For Delayed Discharges.

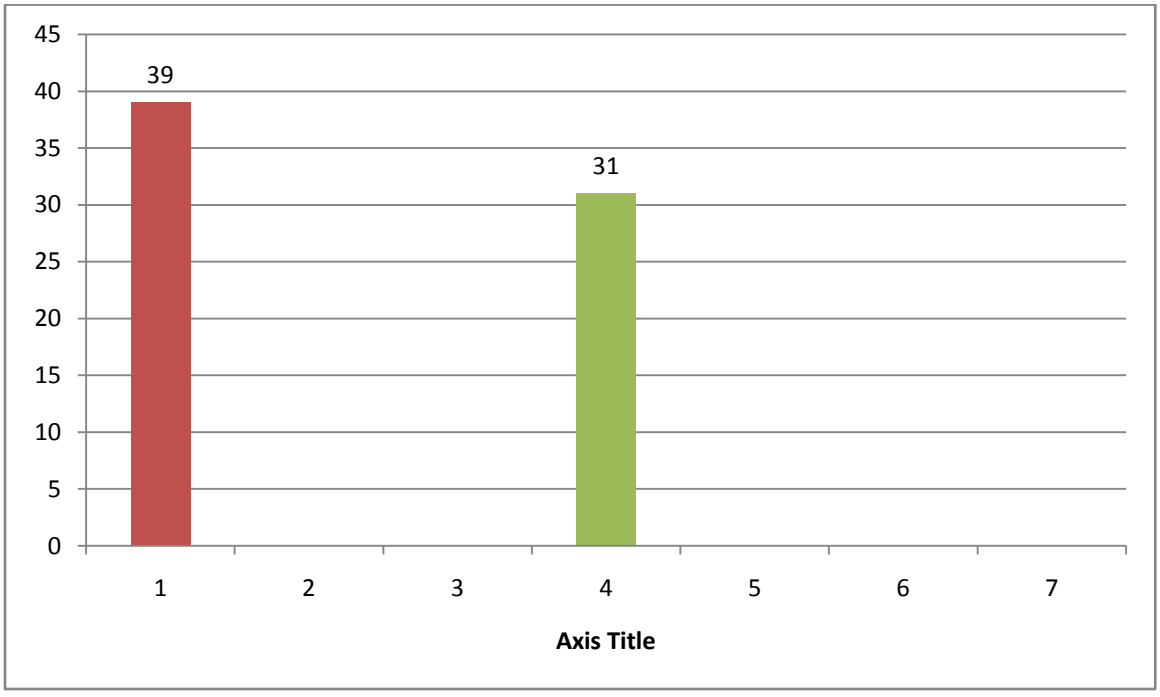
YELLOW MARK- For TPA patients.

GREEN MARK- For cash patients.

OBSERVATION:

- Out of 70 discharges 39 discharges were delayed while 31 were discharged well in time.

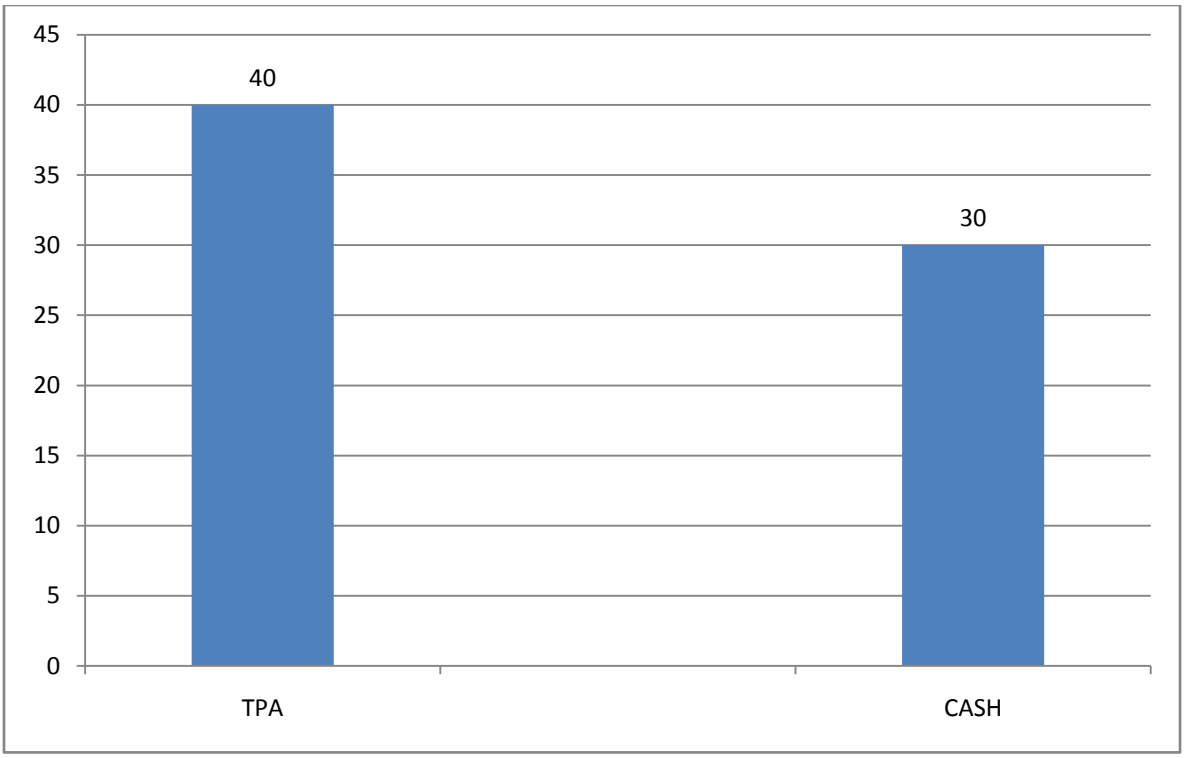
TOTAL DISCHARGES



RED- delayed discharges.

GREEN- discharges within time

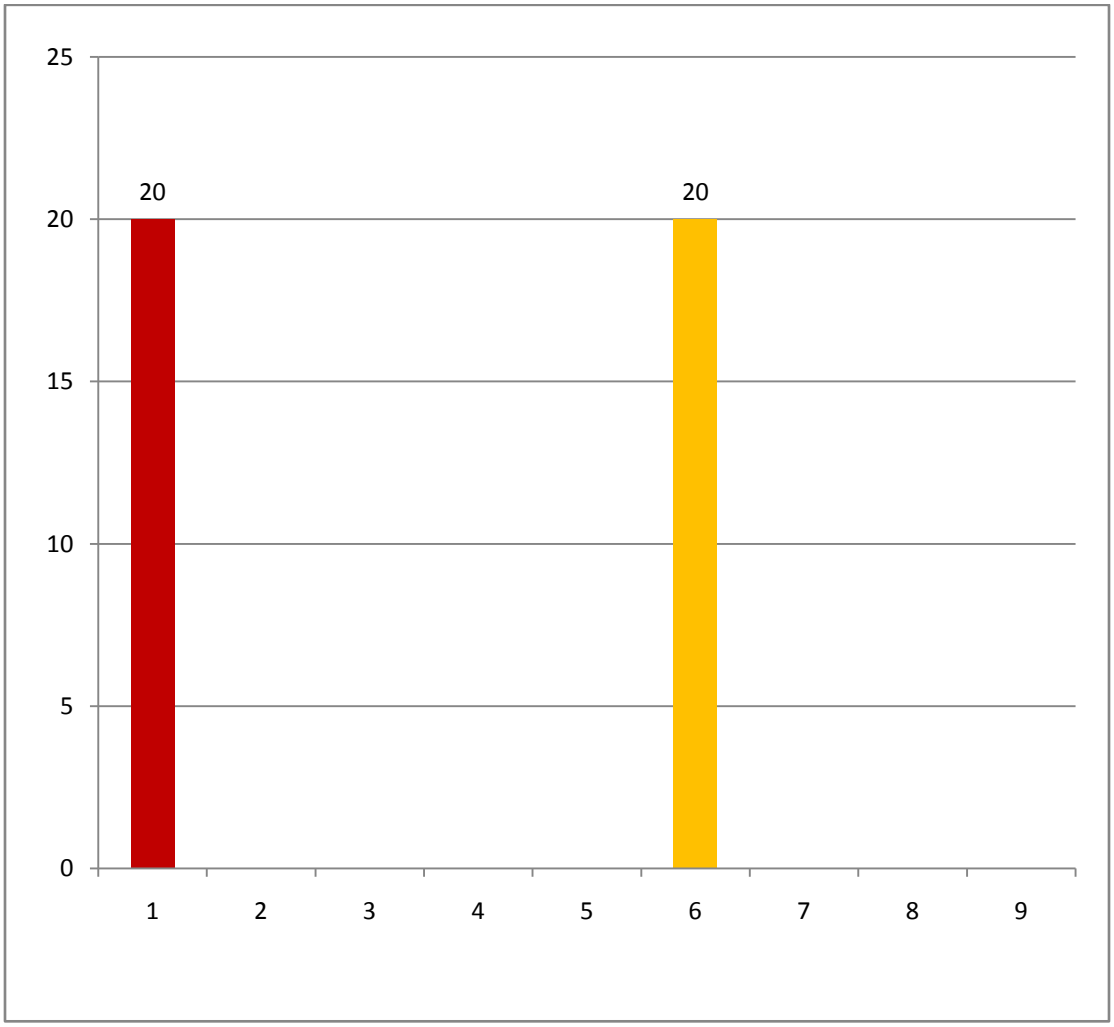
- Out of 70 discharges 40 were from TPA while 30 were cash patients.



- **TPA DISCHARGES** -
    - 20 were delayed out of 40 discharges.
- **CASH DISHARGES**-

- 19 were delayed out of 30 cash discharges.

TPA DISCHARGES

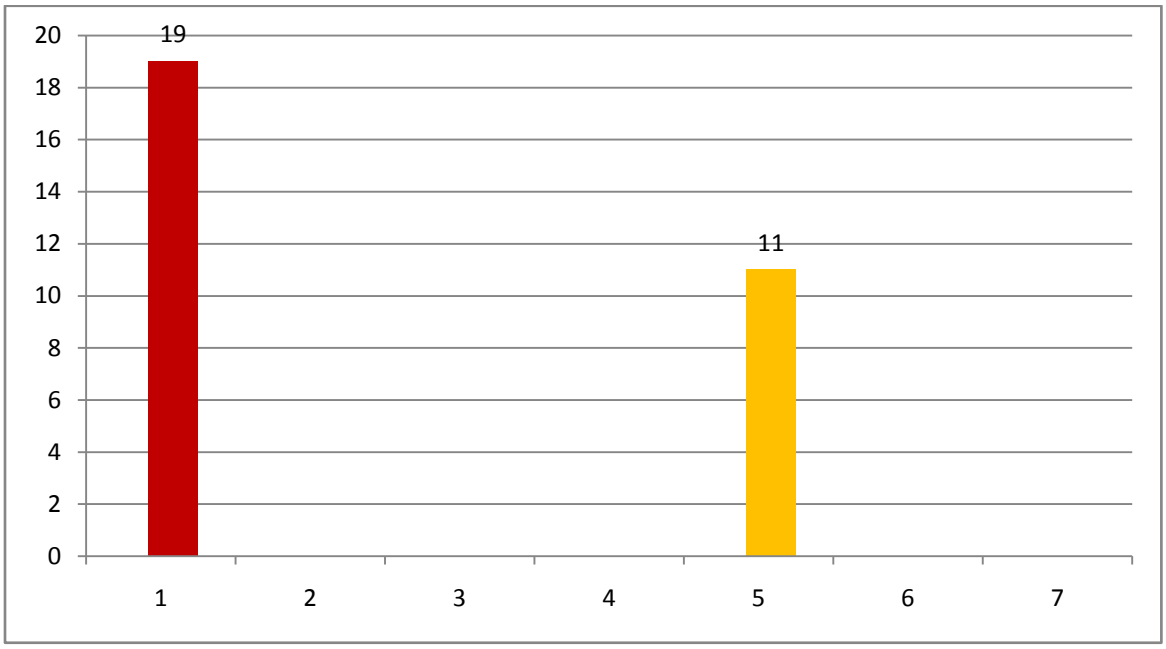


RED- delayed discharges in TPA

ORANGE- diacharges within time in TPA

i.e 50% are delayed

CASH DISCHARGES



RED- delayed discharges

ORANGE- within time discharges.

i.e 63.3% are delayed

Average time taken for discharge processes are -

1) Marked for discharge (includes summary preparation and file ready for TPA) –

   25 to 30 minutes.

2) Pharmacy clearance –

15-20 minutes

3) Billing

40-45 minute

4)Total Time

2 to 2 :30 minutes for cash

3-4 hours for TPA

OBSERVATIONS FROM DATA COLLECTED

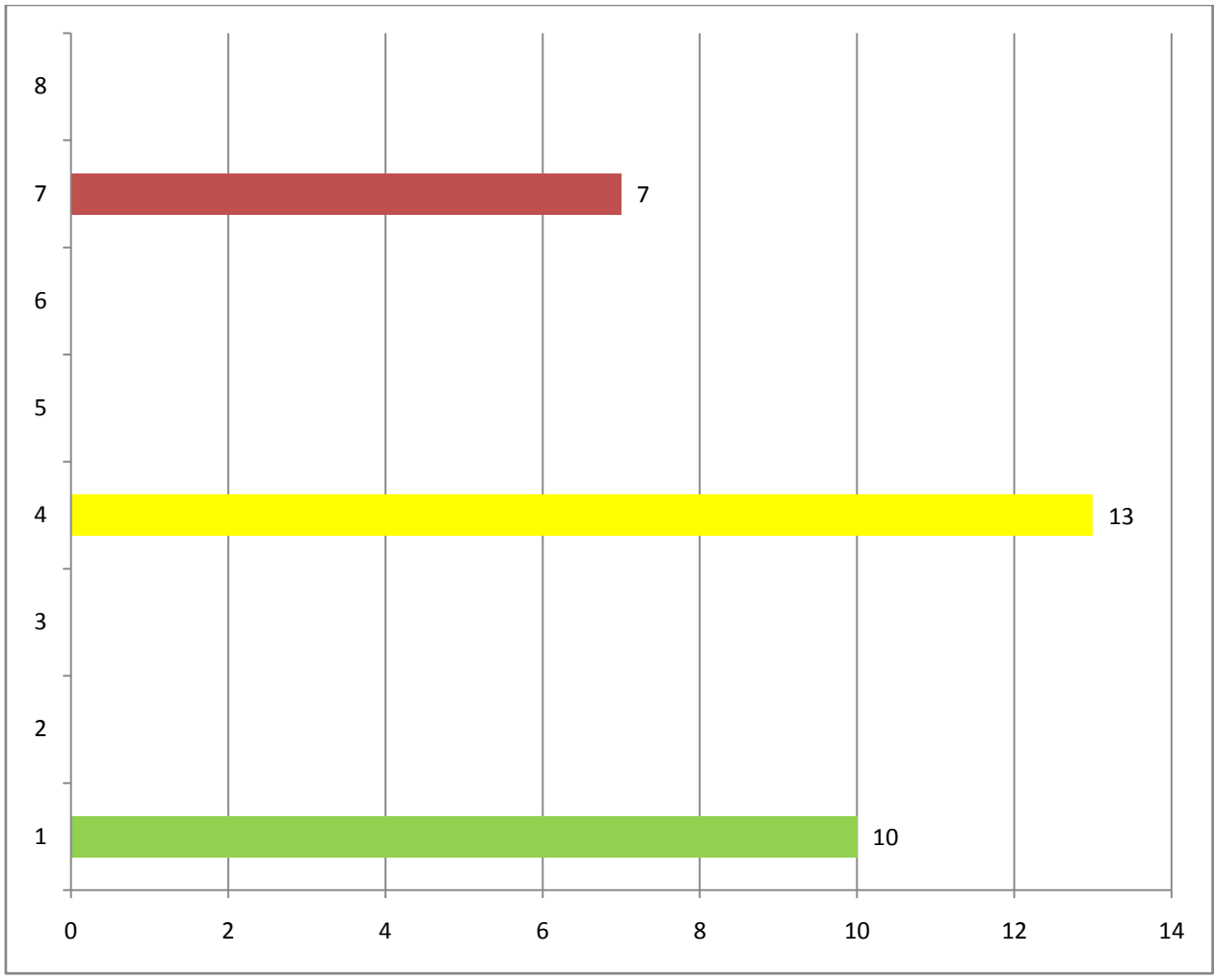
Out of **39 delayed discharges**-

10 delayed by marked for discharge (25.64 %)

13 delayed by pharmacy clearance (33.33%)

7 delayed by billing (17.94%)

9 combinations of above 3 factors (23.07%)

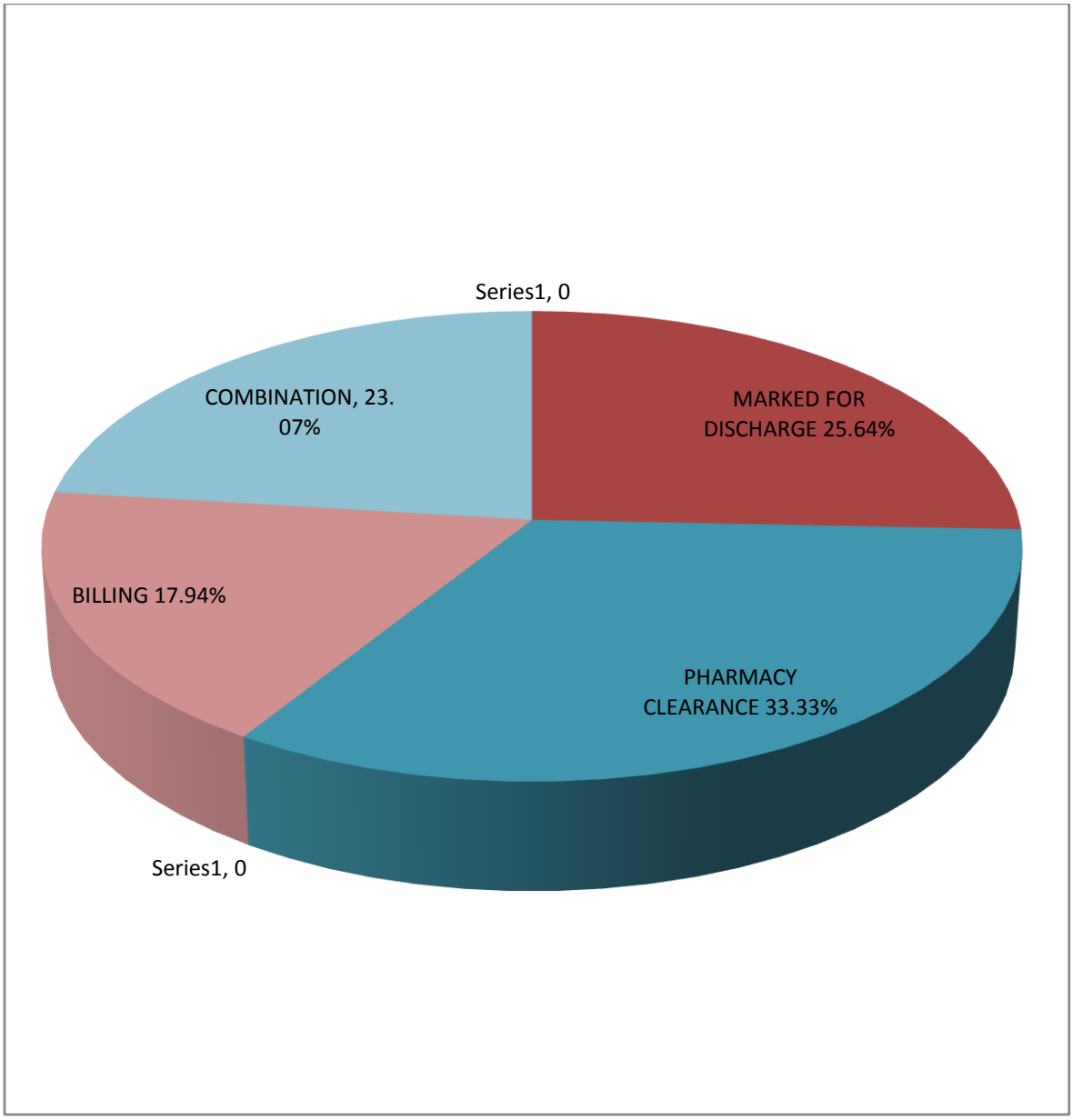


RED- delay due to billing

YELLOW- delay due to pharmacy clerance

GREEN- delay due to marked for discharge

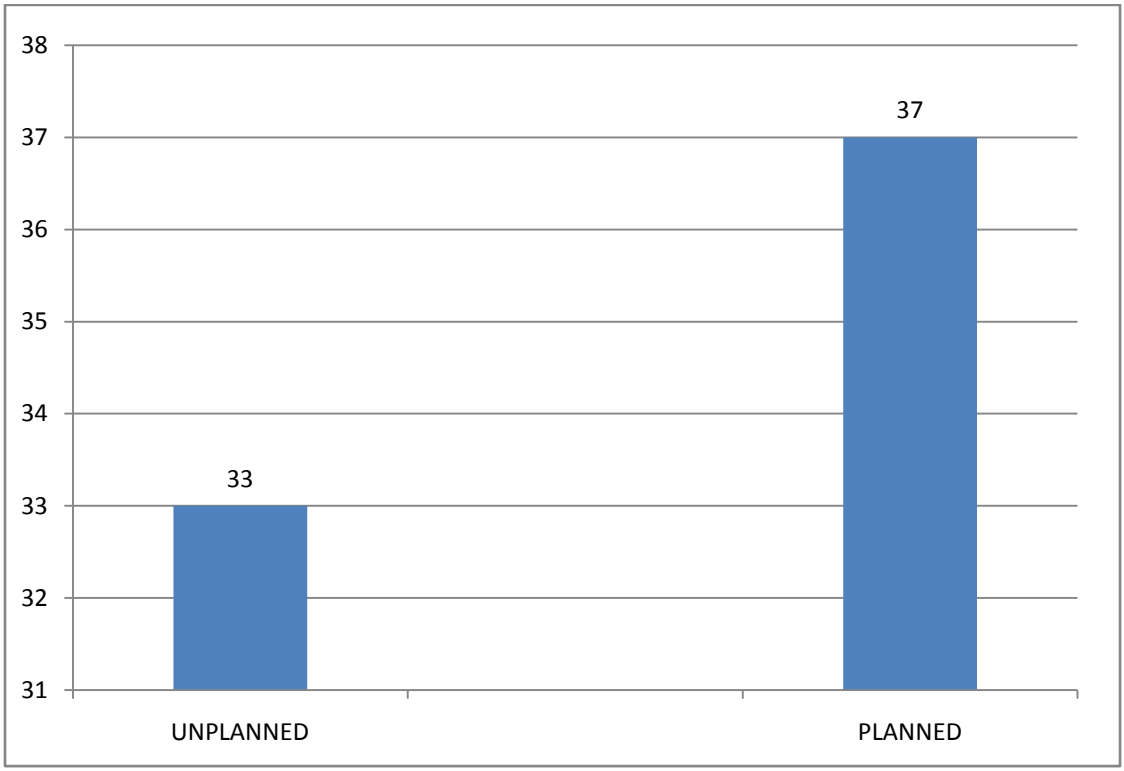
-



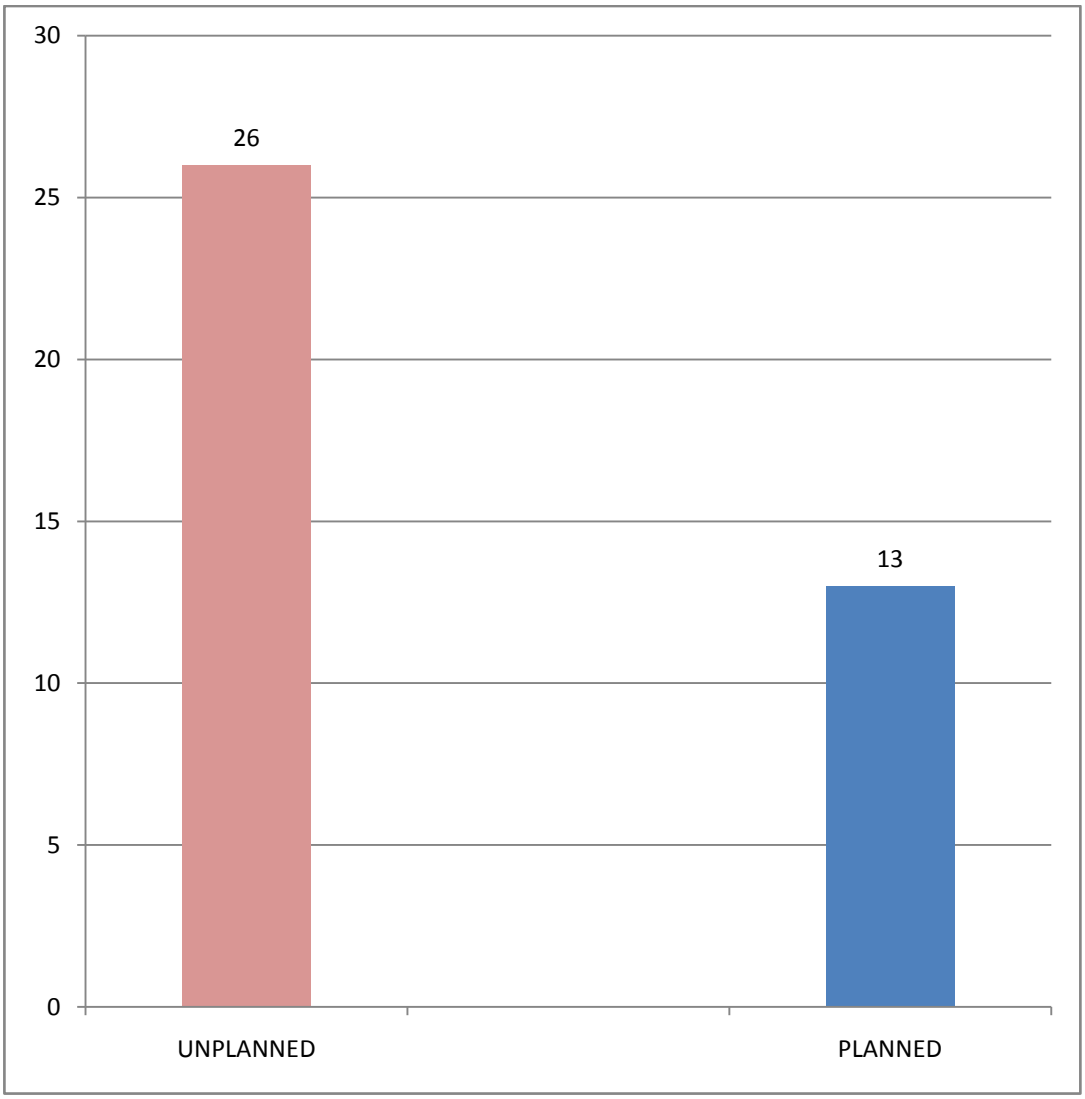
Pie Chart Showing Major Reasons causing delay in Discharges

In the above pie chart we can observe that maximum delay is cauused due to late pharmacy clearance followed by delay in marked for discharge from the system , billin delays and combination of all three factors .

Out of 70 discharges 33 were unplanned whereas 37 discharges were planned .



hyperlink2.xls



Out of 39 delayed discharges 26 were unplanned whereas 13 were planned discharges

DISCUSSION:

Effective hospital discharge and patient readmission rates are influenced by behaviors of care providers and patients and their environmental context. The findings of present study demonstrate the existence of large number of determinants for (in) effective discharge that underscore the complexity of discharge process. Therefore hospital discharge requires an observational approach. Our study is supported by earlier research and discharge programs in The United States i,e,, The RED Project.

REASONS FOR DELAY IN DISCHARGE PROCESS ACCORDING TO THE ABOVE DATA AS I OBSERVED

- Sometimes Delay in discharge process occurs due to the delay in feeding discharge intimation in HIS by nursing staff as they are not fully dedicated towards their work.
- Patients relative are not present in the hospital at the time of billing.
- Discharge summary not prepare on the time by data entry operator.
- Sometimes consultant confused regarding discharge of the patients due to some complications.
- Due to lack of coordination delay in pharmacy returns causes delay in discharge process.
- Sometimes consultant visit become late which causes delay in discharge process.

SOME OTHER CAUSES OF DELAY IN DISCHARGE PROCESS.

- **DELAY OF RETURN ITEMS**

  - The pharmacy store/department takes a lot of time to take returns of unused medicine.
  - Sometimes pharmacy staff seemed to be taking more than the required time for finishing a task.

  .

- **Sometimes Lack of dedication towards work among nursing and typist staff.**

  - Sometimes DEO (typist) did not seem to be finishing the appointed tasks on time allotted.
  - A delay in the starting up of the discharge process after the doctor's departure was seen.

- **Sometimes Lack of communication**

  - Delay in making of discharge summary sometimes occurs due to confusion of instructions.
  - The nurses sometimes miss on the assigned work.
  - Need for a better communication between the nurses and the billing staff was felt.

- **Sometimes Discharge summary not prepared on time by Data entry operator.**
- **Absence of patient's relative at the time of billing.**
- **Delay in feeding discharge intimation in HIS by nursing staff.**
- **Ignorance of phone calls by nursing staff, this call may be from IP billing for discussing about the discharge of the patient.**

❖ DISCHARGE PROCESS IMPROVEMENT

Discharging a patient is an activity common to every hospital. The discharge process can have an impact on numerous factors, such as patient satisfaction, bed availability, timely tests and procedures needed for discharge. No matter what type of patient is being discharged (medicine, orthopedic, neurologic) numerous activities must be completed for each before the patient can be released. This work toward discharge day should begin upon admission.

To successfully implement the discharge process improvements, the following four components are needed

1. **Communication:**

   This is probably the most critical component and the most difficult for large divisions with numerous care givers throughout the patient's hospital stay. The specific method of communication must be customized according to the culture and situation of the division. One division accomplished communication with physician, nurse and case managers conducting daily rounds in patient rooms. Another division with more geographic location challenges used posters and letters to communicate plans for discharging patients. Separate

communication strategies must be established for physicians, patients and family members, care giver staff and ancillary departments. Once the discharge time has been established, this expectation must be communicated to everyone including the patient's family. A poster was placed in each patient's room to announce the time of discharge expected on the day they will leave.

1. **Physician Discharge Orders:**

Physicians are expected to write an order with "intent to discharge next day". If the discharge approval is contingent on any condition, this is also included in the order. Then one day of discharge, the order should be written at least two hours before the established discharge time.

2. **Discharge Board:**

Categories for patient procedures and tests must be customized according to the requirements of each division. A discharge board is a visual tool that is most successful if it is located in a high traffic area that is convenient for numerous care givers. Ideally each care giver that completes a required activity will update the board to communicate the status of that requirement. The board must be flexible and easy to change. For example if a procedure is not required for a specific patient a blue magnet is placed in the blank so everyone knows it is not needed at this time for this specific patient.

4. Data Collection, Entry into Database, Analysis:

There must be a method to track success of the new discharge process. Time of discharge for the patients must be recorded. (See data entry screen from access data base in if a patient is discharged after the established target time, the reason for delay must also be tracked. Weekly or monthly trends must be evaluated so solutions can be developed to resolve the most common delays andprevent them from happening again.

RECOMMENDATIONS

- By improving the sub processes involved in these we can improve as well as smoothen the discharge process like-
    - Proper communication between doctors and staff
    - On time round of consultantas well as availability of MOD on time
    - Well trained nursing staff as well as promptness and dedication of all staff together can hasten the discharge process like preparation of file if TPA patient or preparation of discharge summary by DEO as early as possible especially of planned discharges.
    - Making pharmacy people more trained to hasten the process of cleraance as well as processing the discharge medicine
    - In discharge board mention the time of declaration of discharge by consultant.
    - Dr. should inform about the patient discharge in the evening round itself if patient is well.
    - Nursing and typist Staff should be trained to handle a number of discharges simultaneously.
    - Implement of a web-based software application called “Patient Tracker” to manage the discharge process, minimize delays in admission and reduce surgical procedure cancellations.
    - FMEA is a proactive process that acknowledges that errors are inevitable and predictable, anticipates their occurrence, and designs systems that will minimize their impact. If employed before new processes are implemented.

CONCLUSION

Health care sector is one of the most rapidly growing sectors now days. Level of competition is increasing day by day so any corporate hospital which wants to survive and for wealth maximization has to maintain a standard quality in the organization. Quality consciousness and competitiveness must be developed in the organization by constant monitoring, counseling and training, to achieve desired result.

From the above study it can be concluded that more number of delayed discharges were unplanned as compared to planned discharges hence we should focus and work more towards making more number of discharges as planned and minimizing the number of unplanned discharges. This study provides a comprehensive overview of patient discharge problems and underlying causes. It provides a guiding framework including theory based strategies and practical tools to support care providers and policy makers. Discharge tracker is a powerful tool for care providers and policy makers to assess and prioritize observational strategies and tailor them to the needs of individual facility and healthcare system.

REFERENCES

1. Storch, J., "Country Profile: Canada's Health Care System", Nursing Ethics, Vol. 12: No. 4, 2005, pp. 414-418

2. Pearson, P., Procter, S., Wilcocksonk, J., Allgar, V., "The Process of Hospital Dicharge for Medical Patients: A Model", Journal of Advanced Nursing, Vol. 46, No. 5, 2004, pp. 496-505.

3. Health Canada, "Canada's Health Care System (Medicare)", Available at http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php, 2004 [Accessed 15 March 2009].

4. Health Canada, "Canada's Health Care System", Available at http://www.hcsc. gc.ca/hcs-sss/pubs/system-regime/2005-hcs-sss/index-eng.php, 2005 [Accessed March 16].

5. Sanmartin, C., Shortt, S., Barer, M., Sheps, S., Lewis, S., McDonald, P., "Waiting for Medical Services in Canada: Lots of Heat but Little Light", Vol. 162, Issue 9, 2000,

6. PMcKenna, H., Keeney, S., Glenn, A., Gordon, P., "Discharge Planning: An Exploratory Study", Journal of Clinical Nursing, Vol. 9, No. 4, 2000, pp. 594-601.

7. Evans, R., Hendricks, R., "Evaluating Hospital Discharge Planning: A Randomized Clinical Trial", Medical Care, Vol. 31, No. 4, 1993, pp. 358-370.

8. Duffin, C., "Early Discharge Fuels A&E Visits", Nursing Older People, Vol. 20, No. 10, 2008, pp. 8-10.

9. Hou, J., Hollenburg, J., Charlson, M., "Can Physicians' Admission Evaluation of Patients' Status Help to Identify Patients Requiring Social Work Interventions?", Social Work in Health Care, Vol. 33, Issue 2, 2001, pp.17-27.

11. Bull, M., "A Discharge Planning Questionnaire for Clinical Practice", Applied Nursing Reseach, Vol. 7, No. 4, 1994, pp. 193-199.

12. Rosswurm, M., Lanham, D.," Discharge Planning for Elderly Patients", Journal of Gerontological Nursing, Vol. 24, Issue 5, 1998, pp. 14-21.

13. Rothwell, T., "Integrated Working Puts Discharge Delays to Bed at the Countess of Chester Hospital", The British Journal or Healthcare Computing and Information Management, Vol. 24, No. 2, 2007, pp. 18-20.

14. Department of Health, "Hospital Discharge Workbook: A Manual Hospital Discharge Practice. London", Department of Health, 1994.

15. Department of Health, "National Services Framework for Older People", Crown, United Kingdom, 2001.

16. Department of Health, "Discharge from Hospital: Pathway, Process and Practice". Department of Health, London, 2003.

17. H.M.Government "Community Care (Delayed Discharges etc.) Act", H.M.S.O, London, 2003.

18. The ALC Expert Panel "Appropriate Level of Care: A Patient Flow, System Integration and Capacity Solution". December, 2006.

19. Canadian Institute for Health Information, "Alternate Level of Care in Canada", Canada, 2009.

20. Finger Lakes Health Systems Agency, "Non-acute Patients in Acute Care Beds". New York, 2005.p. 1305-1310.