# Study on Discharge Process at Apollo Victor Hospital, Goa

***By***

Priyanka Solanki

*Dissertation submitted for the partial fulfillment of the*
*MBA Hospital and Health Management*

***Academic year, 2014-2016***

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**TO WHOMSOEVER MAY CONCERN**

This is to certify that **Ms. Priyanka Solanki** student of MBA Hospital and Health Management (PGDHM) from The IIHMR University, Jaipur has undergone internship training at **Apollo Victor Hospital, Goa** from **1st March, 2016** to **10th May, 2016**.

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

The Internship is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Col. (Dr.) Ashok Kaushik
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The IIHMR University, Jaipur

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The Certificate is awarded to

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In recognition of having successfully completed her

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**A STUDY ON DISCHARGE PROCESS AT APOLLO VICTOR HOSPITAL, GOA**

**Date: May 14th, 2016**

**APOLLO VICTOR HOSPITAL, GOA.**

She comes across as a committed, sincere & diligent person who has a

Strong drive and zeal for learning

We wish her all the best for future endeavours

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This is to certify that the dissertation titled ....A study on Discharge Process at Apollo Victor Hospital, Goa..... and submitted by (Name) ...Priyanka Solanki..... Enrollment No. ...IIHMR-U|01|2014-16|19-1601 under the supervision of ....Dr. (Col.) Ashok Kaushik..... for award of Postgraduate Diploma in Hospital and Health/ Pharmaceutical / Rural Management of the University carried out during the period from ...1st March... to ....10th May..... 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.

Signature

# ACKNOWLEDGEMENT

This report is the result of ten weeks whereby I have been accompanied and guided by many people. It is a pleasant opportunity to express my gratitude to all of them.

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# DISSERTATION

## INTRODUCTION

The process starts from intent to discharge by the admitting consultant & completes when the patient is permitted to leave the hospital. This process will be completed within the given set of timelines

Discharge is referred to as when the patient is free to return to home after his period of recovery at the hospital. It is the most significant moment for a patient as they are now free of the ailment which affected them and can return to their normal life and duties. It's also a crucial moment for the hospital as a hospital can make or break its reputation due to ill planned discharge process. For most people, the most significant moment of any hospital stay is when they are told they can leave and how carefully they prepared for this anticipated departure is in many ways as important as the treatment they received while under a doctor's care. Referred to as discharge planning, hospitals understand the importance of developing a careful and appropriate agenda to address that which will inevitably occur outside the hospital walls. Depending on the patient's condition, a good discharge plan may be as simple to execute as taking a few days off work to help at home or as complex as researching health care facilities and coordinating assistance among family members.

Admission to and discharge from hospital can be a distressing time for individuals, their families and friends. For most people, however, treatment will be successful and they will return to their usual way of life very quickly through the provision of an accurate diagnosis, treatment and rehabilitative service. Some people will need additional help to enable them to do so over and above their medical treatment.

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

- Unnecessary admissions are avoided and effective discharge is facilitated by a 'whole system approach' to assessment processes and the commissioning and delivery of services.
- The engagement and active participation of individuals and their carer(s) as equal partners is central to the delivery of care and in the planning of a successful discharge.
- Discharge is a process and not an isolated event. It has to be planned for at the earliest opportunity across the primary, hospital and social care services, ensuring that individuals and their carer(s) understand and are able to contribute to care planning decisions as appropriate.
- The process of discharge planning should be co-ordinated by a named person who has responsibility for co-ordinating all stages of the 'patient journey'. This involves liaison with the pre-admission case co-ordinator in the community at the earliest opportunity and the transfer of those responsibilities on discharge
- Staff should work within a framework of integrated multidisciplinary and multi-agency team working to manage all aspects of the discharge process
- Effective use is made of transitional and intermediate care services, so that existing acute hospital capacity is used appropriately and individuals achieve their optimal outcome.
- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services, their rights

and receive advice and information to enable them to make informed decisions about their future care.

## The benefits of effective discharge planning are:

1. **For the patient**
   - Needs are met.
   - Able to maximise independence
   - Feel part of the care process, an active partner and not disempowered.
   - Do not experience unnecessary gaps or duplication of efforts.
   - Understand and sign up to the care plan.
   - Experience care as a coherent pathway, not a series of unrelated activities.
   - Believe they have been supported and have made the right decisions about their future care.
2. **For the carer(s)**
   - Feel valued as partners in the discharge process
   - Consider their knowledge has been used appropriately.
   - Are aware of their right to have their needs identified and met.
   - Feel confident of continued support in their caring role and get support before it becomes a problem.
   - Have the right information and advice to help them in their caring role.
   - Are given a choice about undertaking a caring role.
   - Understand what has happened and who to contact.
3. **For the staff**
   - Feel their expertise is recognised and used appropriately.
   - Receive key information in a timely manner.
   - Understand their part in the system.
   - Can develop new skills and roles.
   - Have opportunities to work in different settings and in different ways.
   - Work within a system which enables them to do so effectively;
4. **For organisations**
   - Resources are used to best effect.
   - Service is valued by the local community
   - Staff feel valued which, in turn, leads to improved recruitment and retention.
   - Meet targets and can therefore concentrate on service delivery.
   - Fewer complaints.
   - Positive relationships with other local providers of health and social care and housing services.
   - Avoidance of blame and disputes over responsibility for delays.

## Contents of Discharge Summary

1. Demographic details
2. Final diagnosis
3. History and examination on admission-Possible diagnosis
4. Reason for admission
5. Follow up in hospital (procedure)
   - Key examination finding- Co relating with reports
   - Procedure performed
   - Cross consultation details and reason for asking the same

- Medication in hospital, any other treatment
- Key lab and imaging reports at admission

**6.** Discharge- Reasons and summary of outcome
- Treatment and advice on discharge
- Other advice post discharge
- Notification of next visit date and time
- When, Who, How to contact in emergency

**In case of death, the summary of the case will also include the cause of death (Not applicable in MLC)**

## LITERATURE REVIEW

### Prevention of delay in the patient discharge process:

This study by Ali Pirani says, planning for a patient's post discharge needs care does not begin on the day when decision is made to release the patient from the hospital. It is generally accepted that discharge planning should start before admission (for a planned admission) or at the time of admission (for an unplanned admission). A combination of individual factors, most notably age, medical factors such as presence of multiple pathology, and organizational factors such as lack of alternative forms of care facilities put patients at risk of delayed discharge.

### The Discharge planning process / process Improvement:

In the study by Shepperd S. et al, discharge planning is critical to ensuring rapid, safe and smooth transition from hospital to another care environment; it involves social work functions of high risk screening, social work assignment, counselling, locating and arranging services, consultation/ collaboration, patient and family education, patient advocacy and chart documentation. It is a complex activity requiring a wide range of clinical and organizational skills to address needs of patient, family and health care systems and to promote optimum functioning of patients, families and support systems. Delay factors may be internal like waiting for discharge summaries, external like convalescence, palliative care and psychological like social isolation of patient, inadequate support at home, lack of medical aids etc.

### Standardizing admission and discharge processes to improve patient flow: A cross sectional study:

A study by Berta Ortiga, Albert Salazar[†], Albert Jovell, Joan Escarrabill, Guillem Marca and Xavier Corbella aims at evaluating how hospital capacity was managed focusing on standardizing the admission and discharge processes. This study was set in a 900-bed university affiliated hospital of the National Health Service, near Barcelona (Spain). In this study they found that the standardization of admission and discharge processes are largely in our control.

There is a significant opportunity to create important benefits for increasing bed capacity and hospital throughput.

## A Tool for Improving Patient Discharge Process and Hospital Communication Practices: the Patient Tracker:

This artical was presented by Christopher G. Maloney, Douglas Wolfe, Per H. Gesteland, Joe W. Hales, and Flory L. Nkoy. It says hospital bed demands sometimes exceed 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. Establishing such strategies at academic hospitals poses serious challenges. We developed and implemented a web-based software application called "Patient Tracker" to manage the discharge process, minimize delays in admission and reduce surgical procedure cancellations. We also tested the effectiveness of the software on the work flow by comparing outcomes between the pre-implementation control group (2002–2003) and the post-implementation experimental group (2003–2006). Following the implementation of the software, the number of cancelled surgical procedures decreased. During the same period, the average number of inpatient admissions increased, and the median emergency department LOS decreased.

## Transition to Home From the Newborn Intensive Care Unit: Applying the Principles of Family-Centered Care to the Discharge Process:

A study by Griffin, says increasingly newborn intensive care units (NICUs) are embracing family-centred care principles. Family-centred newborn intensive care requires that families are welcomed as partners in care giving and decision making. Traditionally, discharge planning has been done without significant family involvement. In fact, parent participation in care giving may still be limited until discharge is imminent. By increasing parental involvement in care giving throughout hospitalization and working with families to facilitate the discharge process, parents may emerge from the NICU experience with increased competence and confidence in infant care giving. This article reviews common discharge practices and processes in the NICU and offers strategies to assist nurses in integrating a family-centred approach into discharge planning.

## Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professionals:

A systematic approach to develop the structure and key processes of the discharge planning system is critical in ensuring the quality of care and maximizing organization effectiveness. In this study by Eliza LY Wong, important views on barriers experienced in hospital discharge were provided. Suggestions for building a comprehensive, system-wide, and policy-driven discharge planning process with clearly identified staff roles were raised. Communication and coordination across various healthcare parties and provisions were also suggested to be a key focus.

## Improving patient discharge and reducing hospital readmissions by using Intervention Mapping:

A study by Gijs Hesselink, etal says that there is a growing impetus to reorganize the hospital discharge process to reduce avoidable readmissions and costs. The aim of this study was to provide insight into hospital discharge problems and underlying causes, and to give an overview of solutions that guide providers and policy-makers in improving hospital discharge. And the results were: Ineffective discharge is related to factors at the level of the individual care provider, the patient, the relationship between providers, and the organisational and technical support for care providers. Providers can reduce hospital readmission rates and adverse events by focusing on high-quality discharge information, well-coordinated care, and direct and timely communication with their counterpart colleagues. Patients, or their carers, should participate in the discharge process and be well aware of their health status and treatment. Assessment by hospital care providers whether discharge information is accurate and understood by patients and their community counterparts, are important examples of overcoming identified barriers to effective discharge. Discharge templates, medication reconciliation, a liaison nurse or pharmacist, regular site visits and teach-back are identified as effective and promising strategies to achieve the desired behavioural and environmental change.

**National estimates of the use of non-Federal short-stay hospitals in the United States during 1995:**

The study of Gillum BS says Estimates are provided by demographic characteristics of patients discharged, geographic region of hospitals, conditions diagnosed, and surgical and nonsurgical procedures performed. Measurements of hospital use include number and rate of discharges and days of care, and the average length of stay. The result was in 1995 there were an estimated 30.7 million discharges from non-Federal short-stay hospitals. These patients used a total of 164.6 million days of care and had an average length of stay of 5.4 days. Other data summarized in this report include estimates for diagnoses, procedures an expected source of payment, hospital deaths, and newborn infants.

**Improving Hospital Discharge Time: A successful Implementation of Six Sigma Methodology:**

Delays in discharging patients can impact hospital and emergency department (ED) throughput. The discharge process is complex and involves setting specific challenges that limit generalizability of solutions. The aim of this study was to assess the effectiveness of using Six Sigma methods to improve the patient discharge process. This is a quantitative pre and post-intervention study. Three hundred and eighty-six bed tertiary care hospital. A series of Six Sigma driven interventions over a 10-month period. Discharge time decreased by 22.7% from 2.2hours during the pre-intervention period to 1.7hours post-intervention. A greater proportion of patients left their room before noon in the post-intervention period, though there was no statistical difference in before noon discharge. Hospital LOS dropped from 3.4 to 3.1 days post-intervention. ED mean LOS of patients admitted to the hospital was significantly lower in the post-intervention period. Six Sigma methodology can be an effective change management tool to improve discharge time. The focus of institutions aspiring to tackle delays in the discharge process should be on adopting the core principles of Six Sigma rather than specific interventions that may be institution-specific.

**Analysis, Modelling and Improvement of Patient Discharge Process in a Regional Hospital:**

This thesis by Nancy Khurma presents results of a study conducted jointly with a regional hospital and concerned with the inpatient discharge process. A thorough mapping of the existing process flow and analysis of 1700 historical cases were conducted. Results revealed that in its current form the process is inadequately defined, lacks consistency, and its performance is hard to predict. These issues cause inpatient overstays past their prescribed acute care (so called Alternative Level of Care, or ALC days) and thus at least 8% of available hospital bed capacity is wasted. Key factors extending unnecessary patient stays were identified and used as predictors for individual patients. Another simulation model was created to explore the effects of standardizing parts of the discharge process. Obtained results indicate that organizational changes (e.g., early involvement of social workers, improved information flow, close collaboration with external facilities accepting patients, etc.) will lead to process improvement and substantial economic benefits

**Quality and safety of hospital discharge: a study on experiences and perceptions of patients, relatives and care providers**

The objective of the study of Gijs Hesselink was to identify barriers experienced and perceived at discharge by physicians, nurses, patients and relatives. He developed questionnaires based on focus group interviews with hospital and community care providers, and individual interviews with patients and relatives. A survey was conducted among patients, relatives and related nurses and physicians from hospital and community care. In the result he found that Information from the hospital to community care is often incomplete, unclear and delayed. Especially hospital physicians (52%) and general practitioners (GPs; 63%) experience the quality of information exchanged from the hospital to the GP as poor. Coordination of care is often frustrated by a lack of care provider knowledge and collaboration. Hospital physicians (47%) and GPs (71%) feel that hospital physicians are often not sufficiently aware of the patient's home situation. Respectively, 59 and 81% experience that the GP is often not clearly informed about expected tasks and responsibilities at discharge.

## JUSTIFICATION OF STUDY

A discharged focused Bed Strategy can increase patient volume without a subsequent increasing in cost of hospital which can be substantial improvement for the hospital and it can also helps hospital better market themselves. Long discharge times in hospital causes prolonged unnecessary bed occupancy in hospital. If the hospital decreases its discharge time then it could substantially increase its patient turnaround time and revenue as well as it can better serve the community by providing treatment to more number of patients. This can be achieved through proper discharge planning of the patients.

## AIM

To study and streamline the Discharge Process in Apollo Victor Hospital

## OBJECTIVE

1. To review the discharge process in the hospital
2. To estimate the Discharge Turnaround Time for Cash, Credit and Insurance Patients.
3. To identify the key reasons for delay in Discharge.

## METHODOLOGY AND DATA COLLECTION

**Study type:** Descriptive and Analytical study.

**Study Site:** Apollo Victor hospital, Goa

**Sample collection method:** Non probability convenience sampling

**Sample size:** 170

**Duration for data collection:** 70 days (1st March, 2016 to 10th May, 2016)

**Study Technique:** Observational

**Sample respondents:** Nurse, discharge staff, duty doctors and administrative staff.

**Methods of data collection:**

- Primary Data- Observation and Informal Interview
- Secondary Data- Records of Hospital

**Steps taken during Data collection**

- During the study all discharges occurring daily in hospital were followed.
- Informal interviews were done whenever required.

## ETHICAL CONSIDERATION

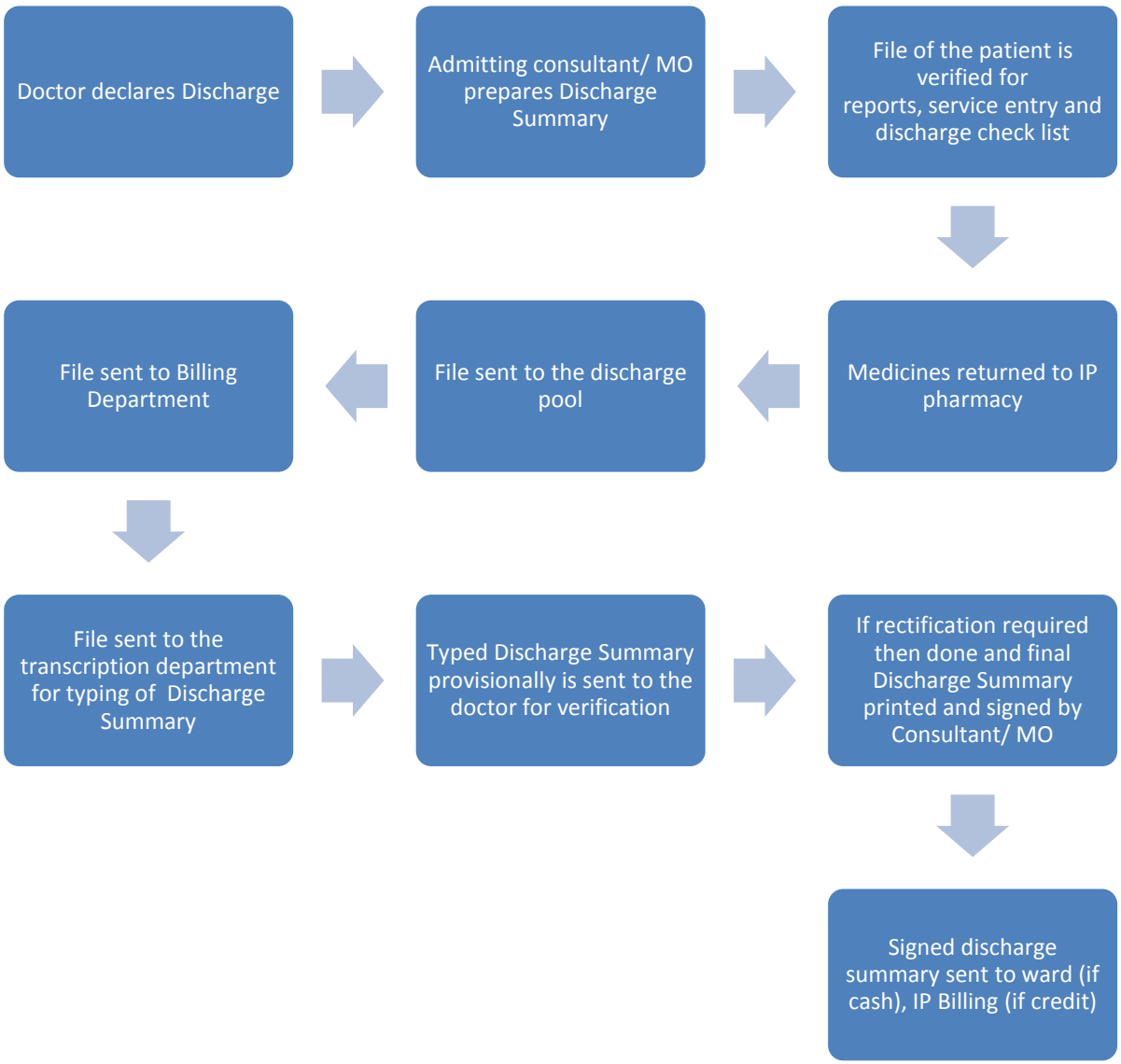
- The data collected from the records is kept confidential and anonymous.
- The anonymity, privacy and confidentiality of respondents were ensured.
- The collected data will only be used for research purpose.

# DATA ANALYSIS

## Objective 1: To review the discharge process in the hospital

As a first step of process, normal discharge process of hospital was studied from the SOP manual of the hospital and then the staff concerned was interviewed to get a better understanding of the process. The normal Discharge process was:

## NORMAL DISCHARGE PROCESS



On the basis of the above process we can derive the basic steps involved in discharge process:

- Doctor declares Discharge
- Doctor/ MO prepares discharge summary
- File verified for reports entries and discharge check list
- Medicine returned
- File sent to the discharge pool
- File sent to the billing department
- File sent to the transcription department for typing of Discharge Summary
- Typed summary sent to the doctor for verification
- Final summary made after approval and sign
- Signed summary sent to ward or IP Billing
- Patient Discharged

## Objective 2: To estimate the Discharge Turnaround Time for Cash, Credit and Insurance Patients.

After getting the idea of discharge process from the SOP of discharge process of the hospital the process was mapped and followed to get the thorough understanding of the discharge process and staff involved in the discharge process. Then the data was collected in the format given in the annexure. And then data was analysed. Informal interviews were also carried out time to time to get more understanding of the topics.

**EXPECTED OUTCOME:**

- The defined process will be completed within the given set of timelines
- To submit / inform the final bill to the cash and credit patients within 3 hours
- To send the discharge summary along with the final bill to the insurance company for approval or enhancement within 2 hours

In the Data Analysis derivation is observed which will be explained by the bellow diagrams:

In figure 1. the distribution of patients is shown where one can see that the total population studied is 170. In which 57 are cash patients 101 were credit patients and 12 were TPA patients.

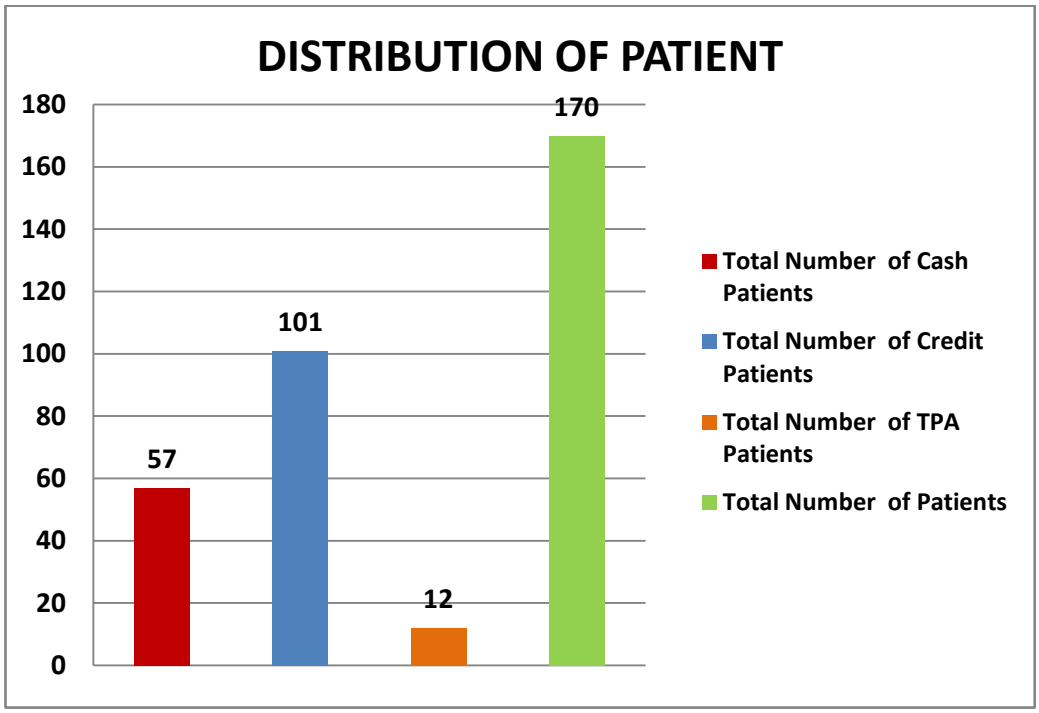
**CASH PATIENTS:**

Cash patients were those who paid their bills out of their own pockets.

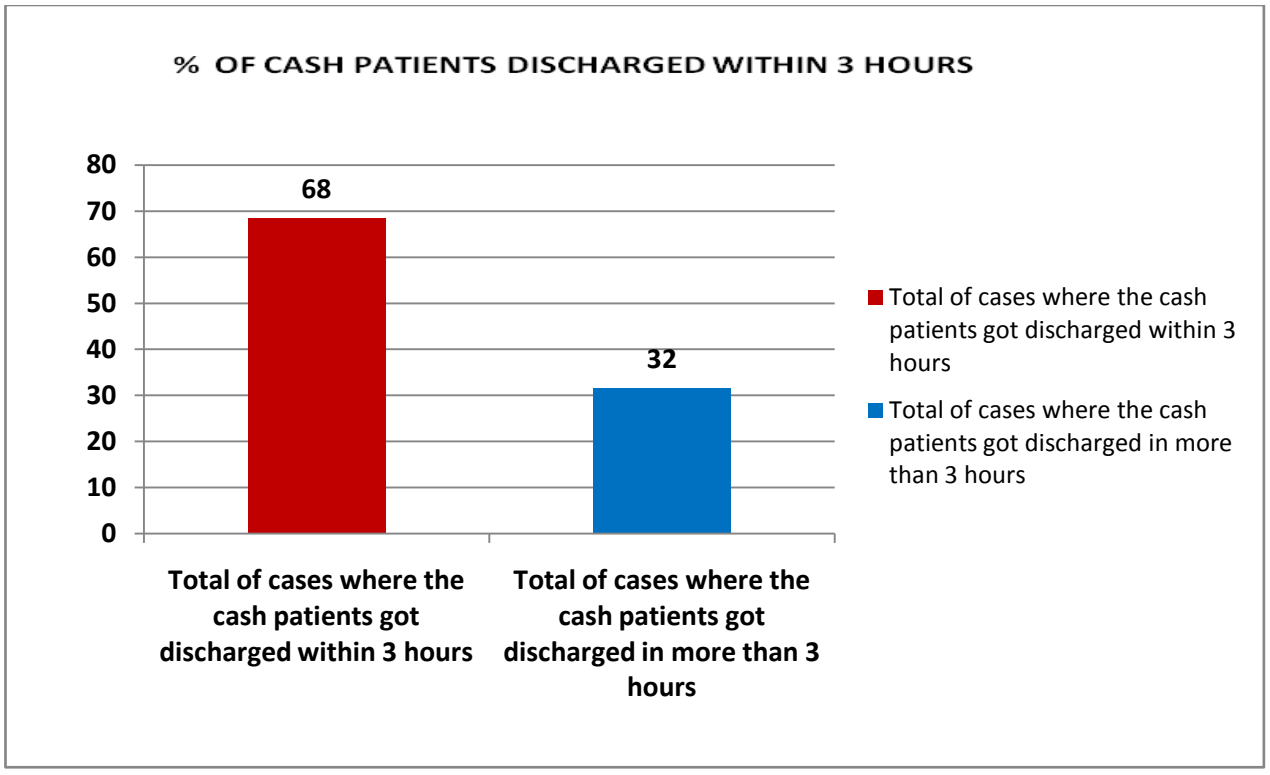
**CREDIT PATIENTS:**

Credit patients had to obtain approval from various organisations like TPA or Corporate etc. Which took 2-3 hours on average, this time was of significance as it was not in the control of hospital and could not be decrease by the hospital. Credit patients were those who were having an insurance (TPA patients) or from the corporate with whom the hospital had tie- ups for providing cashless treatment to their employees.

➢ **FIGURE 1: DISTRIBUTION OF PATIENTS**

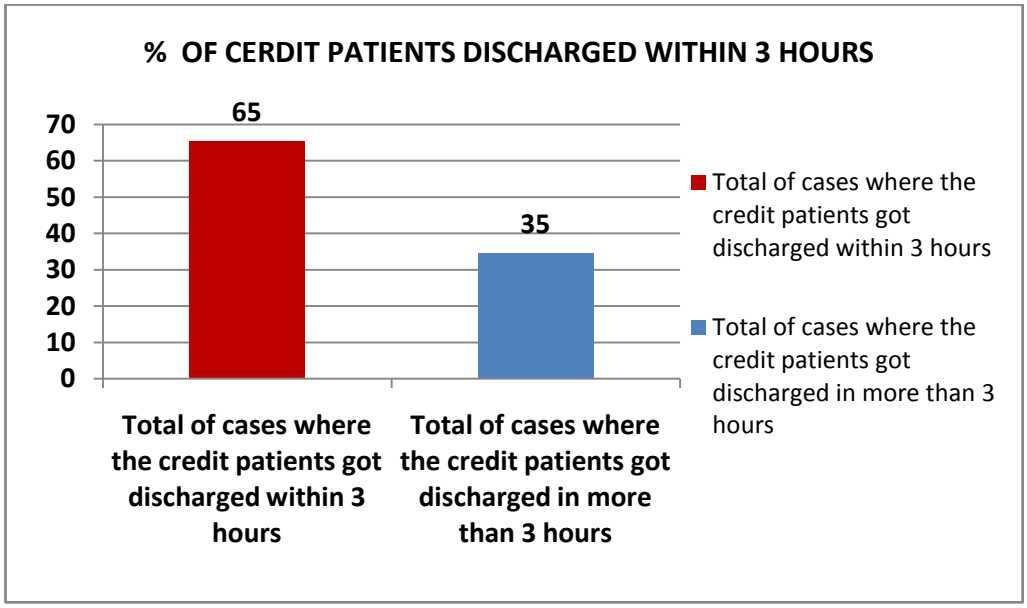



➢ **FIGURE 2: PERCENTAGE OF CASH PATIENTS DISCHARGED WITHIN 3 HOURS**



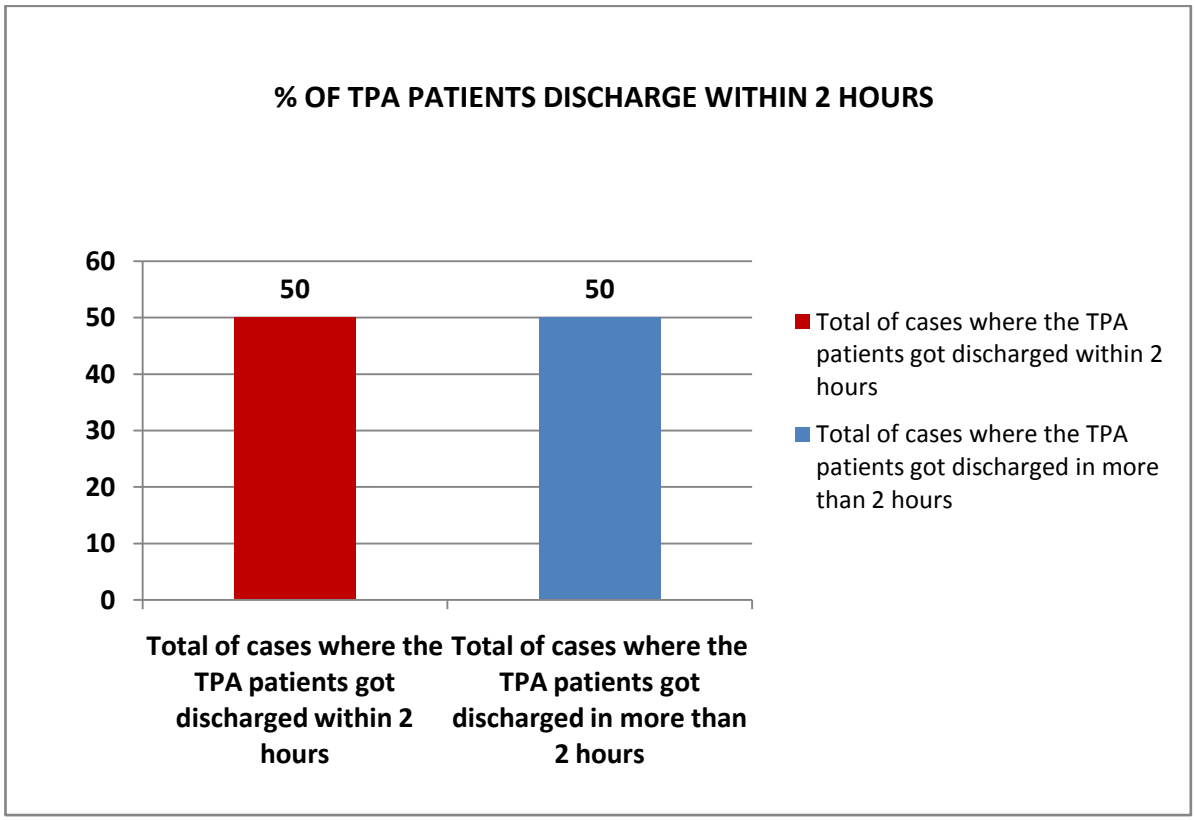

In the case of cash patients 68% patients got discharged within 3 hours which is standard time for cash patient's discharge where as only 32% patient's discharge took more than 3 hours time.

- **FIGURE 3: <u>PERCENTAGE OF CREDIT PATIENTS DISCHARGED WITHIN 3 HOURS</u>**



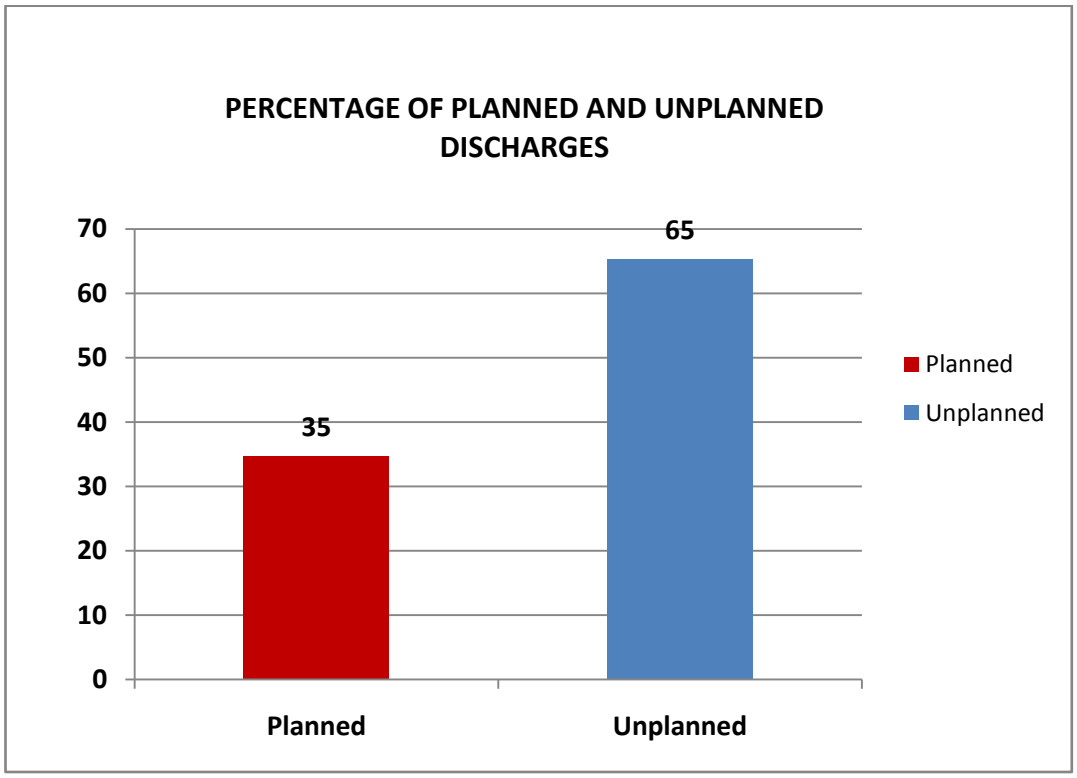

In case of credit patients 65%patients got discharged within 3 hours which is standard time for credit patients where as 35% patient's discharge process took more time than the standards.

- **FIGURE 4: <u>PERCENTAGE OF TPA PATIENTS DISCHARGED WITHIN 2 HOURS</u>**




The standard time for discharge of TPA patients is 2 hours. In the above diagram we can see that 50% patient got discharged within 2 hours and rest 50% patients took more than 2 hours.

➢ **FIGURE 5: PERCENTAGE OF PLANNED AND UNPLANNED DISCHARGES**



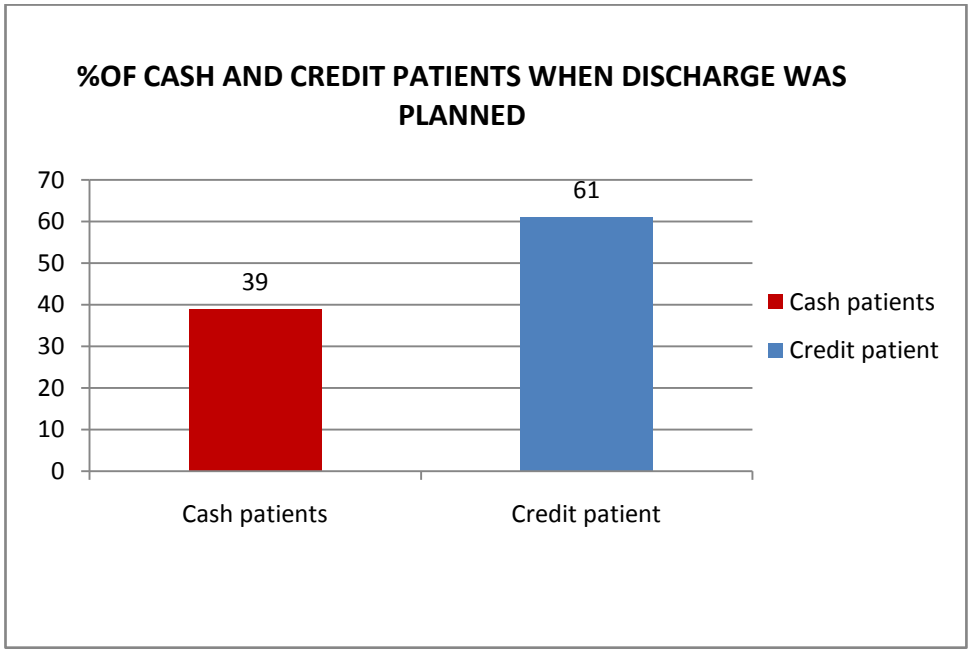

## Planned discharge:

Planned discharges are those discharge in which the estimated time of patient's stay in hospital is decided at the time of admission and thus the discharge dates are estimated at the time of admission only.

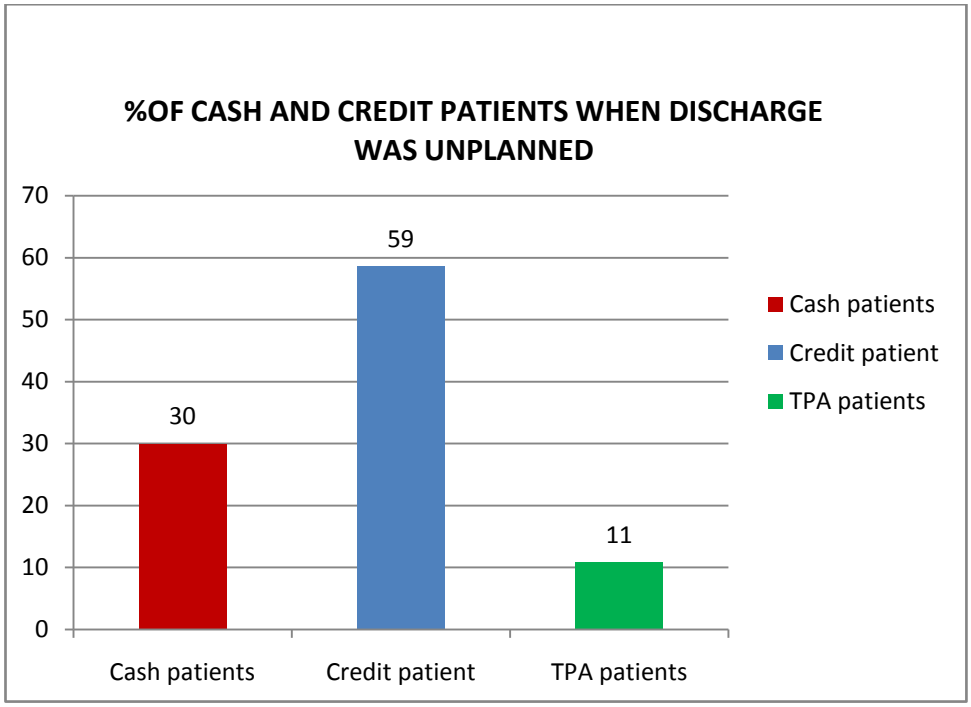
## Unplanned discharge:

In unplanned discharges the average length of stay of patient is not know at the time of admission and thus the discharge is declared by the doctor at the time of routine rounds. Sometimes the discharge is requested by the patient's end.

- **FIGURE 6: PERCENTAGE OF CASH AND CREDIT PATIENTS WHEN DISCHARGE WAS PLANNED**




- **FIGURE 7: PERCENTAGE OF CASH AND CREDIT PATIENTS WHEN DISCHARGE WAS UNPLANNED**



**Objective 3: To identify the key reasons for delay in Discharge.**

- No proper co-ordination among the staff.
- One ward boy required at the discharge summary room for the purpose of movement of file to different department.
- Doctors not coming on time for their rounds.
- Staff required at billing counter.
- Some doctors not giving the tentative discharge that creates the burden on nursing staff.
- Patient's attendant not present sometimes for clearing the dues at counter.
- Lesser planned discharges.
- No proper time recorded in registers.

## FINDINGS

- In the case of cash patients 68% patients got discharged within 3 hours which is standard time for cash patient's discharge where as only 32% patient's discharge took more than 3 hours time.
- In case of credit patients 65%patients got discharged within 3 hours which is standard time for credit patients where as 35% patient's discharge process took more time than the standards.
- The standard time for discharge of TPA patients is 2 hours. In the above diagram we can see that 50% patient got discharged within 2 hours and rest 50% patients took more than 2 hours.
- In 170 patients the percentage of Planned Discharge was 35% where as Unplanned Discharges were 65%.
- For planned Discharge 39% patients were cash patients and 61% patients were Credit patients.
- For Unplanned Discharge 30% patients were Cash patients, 59% patients were Credit patients and 11% patients were TPA patients.

## RECOMMENDATIONS

- Consultants should be included in the discharge process and efforts should be taken to increase planned discharges
- Duty doctor should supervise so that rough discharge summary is written correctly so that the discharge pool staff doesn't has to re check the entries in the system,this saves time of discharge pool.
- The discharge summary can be updated in every 2 days so that time can be saved on the day of discharge.
- Inter departmental co-ordination can be increased so that all the concerned departments know about the discharge of patient before and can be prepared with the formalities and documentation for the discharge.

- Duty doctor can sign the rough summary along with its notes at the time of discharge. This can be used by the junior doctors and they can sign the final discharge summary.
- Resident doctor at the summary room can solve the queries.
- Two staff at the billing counters.
- Fixing the time for doctors round in the morning.

## CONCLUSION

After a thorough analysis of the collected data, I hereby conclude that long waiting time of the patients is annoying and causes inconvenience to both patient and department. Also it increases the dissatisfaction level of the patients. Lack of co-ordination among employees is also a major problem creator is the hospital. It can be corrected by proper training of Employees. The delay if minimized can significantly reduce long waiting time of patients. This will help the department to function with optimum efficiency and provide quality care to patients.

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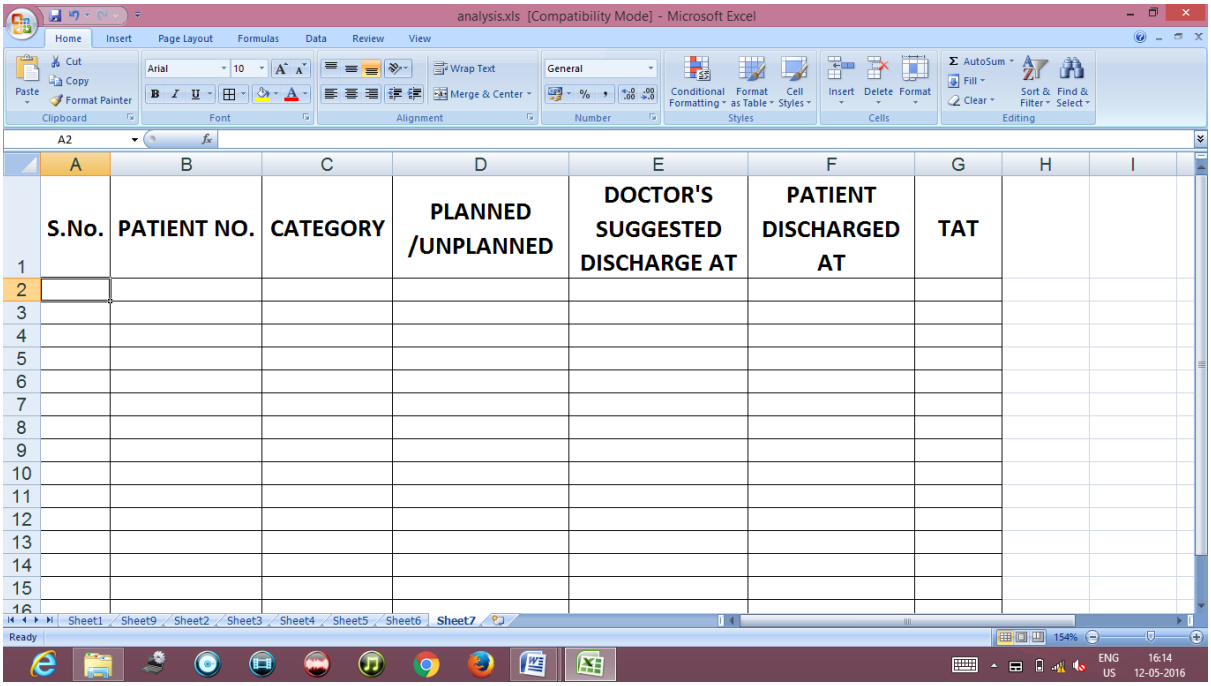
4. Standardizing admission and discharge processes to improve patient flow: A cross sectional study by Berta Ortiga, Albert Salazar[†], Albert Jovell, Joan Escarrabill, Guillem Marca and Xavier Corbella.
5. A Tool for Improving Patient Discharge Process and Hospital Communication Practices: the Patient Tracker, by by Christopher G. Maloney, Douglas Wolfe, Per H. Gesteland, Joe W. Hales, and Flory L. Nkoy.
6. Transition to Home From the Newborn Intensive Care Unit: Applying the Principles of Family-Centered Care to the Discharge Process, by Griffin.
7. Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professionals, by Eliza LY Wong.
8. National hospital discharge survey.
9. Improving patient discharge and reducing hospital readmissions by using Intervention Mapping by.
10. Quality and safety of hospital discharge: a study on experiences and perceptions of patients, relatives and care providers of Gijs Hesselink.

# ANNEXURE

## 1. Format for collecting data




## 2. Checklist for Informal Interview

- **Do you think that the existing discharge process is adequate?**
- **What is the Average Discharge Time of the hospital?**
- **What is your role in Discharge Process?**
- **What are the problems that you face in completing your duty in Process of Discharge?**
- **What are the suggestions to correct these difficulties?**