EVALUATION OF TURNAROUND TIME OF DISCHARGE PROCESS

Dissertation Submitted to

The IIHMR University, Jaipur

For the partial fulfillment for the award of the degree of

Master of Business Administration (MBA)

In

Hospital and Health Management

By

Dr. Garima Singh

Under the Supervision and Guidance of

Mrs. Deepti Sharma

2020-2022

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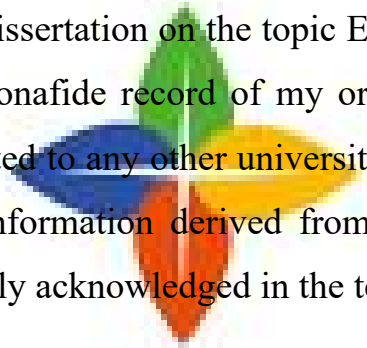
DECLARATION BY STUDENT

I hereby declare that this dissertation on the topic Evaluation of turnaround time of discharge process 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.



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Dr. Garima Singh

Date: 20/06/2022

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CERTIFICATE

This is to certify that Dr. Garima Singh in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at (Apex hospital, jaipur) during March 22, 2022 to June 19, 2022.

Jaipur

Date:20/06/2022

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CERTIFICATE

This is to certify that dissertation on the topic evaluation of turnaround time of discharge process is a record of the research work undertaken by Dr. Garima Singh 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 her approach to the research study has been sincere, scientific, and analytical.

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Faculty Guide :-	School Dean:-
Mrs. Deepti Sharma	Dr. (col) Mahendra Kumar
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Date :- 20/06/2022	Date:- 20/06/2022

ABSTRACT

The primary area in a hospital that requires streamlining is the patient discharge procedure, which is directly tied to patient satisfaction. The length of time it takes to complete the discharge process is a crucial sign of the care's quality. According to NABH, the discharge process should not take longer than 180 minutes to complete. The patient is more likely to recall the discharge procedure because it is the last phase of their hospital stay. Therefore, a delay in the discharge process might make patients feel down and put more strain on the beds in the hospital. Restructuring the hospital discharge procedure is becoming more important in order to cut expenses and needless readmissions.

The aim of this study was to give an overview of remedies that can assist providers and policymakers in improving hospital discharge, as well as insight into hospitalization challenges and their underlying causes. Additionally, it tried to pinpoint the primary causes of delays, pinpoint trouble spots, and make suggestions. The study was conducted at Apex Hospital over a period of three months. The time needed for the production of the patient record, conclusion of the discharge statement, billing submission, and patient evacuation from the ward comprised the total amount of time needed for the discharge procedure. The end things time was recorded using HIS. The duration of each step was determined using good tools, a basic average, and was noted and evaluated for patients with insurance as well as those paying cash.

The results of this study demonstrate that leaving the room is a significant contributor to delays, which increases the time that hospital patients must wait until receiving a bed. Numerous bottlenecks were discovered, ranging from the amount of time it took to finish invoicing to the length of time for nursing clearance and pharmacy clearance. The study's findings led to two recommendations for reducing the time it takes to release patients: adequate staffing and training in effective communication for staff. According to the report, delayed release and the unorganised hospital discharge process are two of the key issues that limit the ability to shorten waiting lists and provide healthcare effectively and efficiently.

AKNOWLEDGEMENTS

I owe a great deal of gratitude to a few people for their unwavering dedication to this job. Without the assistance of certain caring people, this study would not have been successful. My profound appreciation goes out to my role models, **Mr. Manish Sinha,** Unit Head of Apex Hospital, **Mr. Amit Kumar Saini**, Credit Cell Head of Apex Hospital**, Miss. Sonam Chandak,** Operation Manager, and the entire team of the operation department and credit cell department at Apex Hospital in Jaipur. They gave me the information I needed to do this assignment and I appreciate them spending their time with me. I should also express my gratitude to my colleagues for their ongoing assistance.

I also want to express my gratitude to **Mrs. Deepti Sharma**, my mentor at the IIHMR University, for helping me finish my project effectively and for sharing her insights into the project's operational challenges.

I want to express my appreciation to The IIHMR University in Jaipur for giving me the chance to start this project.

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Most significantly, I give thanks to my All-Powerful God for his abundant kindness and for keeping me healthy throughout the study.

CONTENT

ABREVIATIONS

ICU	INTENSIVE CARE UNIT
ALOS	AVERAGE LENGTH OF STAY
DAMA	DISCHARGE AGAINST MEDICAL ADVICE
OT	OPERATION THEATRE
TPA	THIRD PARTY ADMINISTRATOR
NABH	NATIONAL ACCREDITATION BOARD FOR HOSPITALS AND HEALTHCARE PROVIDERS
IPD	IN-PATIENT DEPARTMENT
OPD	OUTPATIENT DEPARTMENT
MRD	MEDICAL RECORD DEPARTMENT
MICU	MEDICAL INTENSIVE CARE UNIT
CGHS	CENTRAL GOVERNMENT HEALTH SCHEME
TAT	TURNAROUND TIME
GDA	GENERAL DUTY ASSISTANT
RMO	RESIDENT MEDICAL OFFICER
SOP	STANDARD OPERATING PROCEDURE

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

The standard of medical care is becoming increasingly crucial in today's competitive environment. The most crucial procedures connected to a positive patient experience in a hospital are the admission billing and discharge processes, among other elements affecting the health care system. From the time of admission until the time of discharge, a patient is considered to have been hospitalized.

In the modern day, lifestyle diseases have taken the place of communicable diseases, and as more individuals move into older age groups, the prevalence of lifestyle diseases is rising. Too many fatalities have been caused by automobile accidents in addition to other severe ailments. Additionally, as medical technology advances, diagnostic methods improve, and people become more conscious of their health, there has been a rise in hospitalizations throughout time, which hospitals must manage with their limited resources. Both the need for clinical care hospitalizations and the quality of all hospital services have increased. A health center/ hospital is a comprehensive structure with many detailed steps and a diverse range of qualified workers.

A patient's stay in the hospital is a significant event that includes three processes: admission, actual hospitalization, and discharge, as well as billing in the first and last steps. The best clinical treatment may be provided by a hospital having some of the top medical consultants and advanced medical equipment. However, one must go through additional procedural requirements in order to receive clinical care in a hospital. The patient wants to see the doctor as soon as possible and receive medical attention. The longer it takes a patient to contact a consultant in the hospital, the more dissatisfied that patient will be with the care they receive there. The patient, who is already under stress, is burdened by the intricacy of the procedural formalities at the time of admission, invoicing, and discharge.

1.1 . Definitions:

1.1.1. Discharge

Discharge is defined as the end point of hospitalization period after which patient either leaves the hospital or may be transferred to other facilities.

Mogli GD, (20001). In his book on Medical Record Organization and Management, defines: *"Discharge as the release of a hospitalized patient from the hospital by the admitting physician after providing necessary medical care for a period deemed necessary"*

Sakharkar B.M., (1998). In his book on Principles of Hospital Administration and Planning defines:

"Discharge as the release of an admitted patient from the hospital"

Goel S.L. and Kumar R, (2007). In their book on Hospital Administration and Management, defined discharge as: *"Discharge process is defined as the process of activities that involves the patient and the team of individuals from various discipline working together to facilitate the transfer of patient from one environment to another"*

The patient expects to be released from care as soon as possible after therapy is finished. Dissatisfaction and a negative impact on the hospital's reputation result from the discharge process's delay. As soon as a patient is admitted to the hospital, planning for them discharge can commence.

Discharge planning is a centralized, coordinated process that makes sure each patient has a predetermined course of follow-up treatment. It involves making decisions on the frequency of follow-up visits, the length of time and type of medications to be taken at home, the necessity for regular investigations, the need for physiotherapy or any other home care services, and other things. A multidisciplinary approach is required for the hospital discharge procedure.

The process begins with consultants recommending discharge based on the patient's condition. Other workers handling a discharge then take over the execution of the order. A robust planning process, which involves organizing specific elements from proper scheduling to corrective steps that must be taken if necessary, will aid in the discharge process's implementation.

The points that need to be looked in to for proper discharge planning are:

- Proper scheduling of round timings of consultants which is major cause of fluctuations that happen in discharge planning.
- The process of discharge is significantly assisted by careful planning of the human resource department, along with the resident physician, nurses, and others.

- Nursing staff play a very vital role in providing both inpatient care and formalities if any; and also in making arrangements with other departments for discharge.
- Supportive and other ancillary departments involved in provision of clinical care directly or in indirectly also have an impact on discharge process as a discharge process to run smoothly needs interdepartmental coordination.
- How to inform patients at the right time so that they efficiently participate in the discharge process and avoid any delays from their side

The procedure of being discharged from the hospital is the last stage and one that the patient is likely to remember clearly. Low patient satisfaction can occur even if everything else went well and the discharge process was lengthy and tedious. It is a crucial area since it affects how patients feel, the hospital's reputation, and patient satisfaction.

Major stake holders in discharge process are

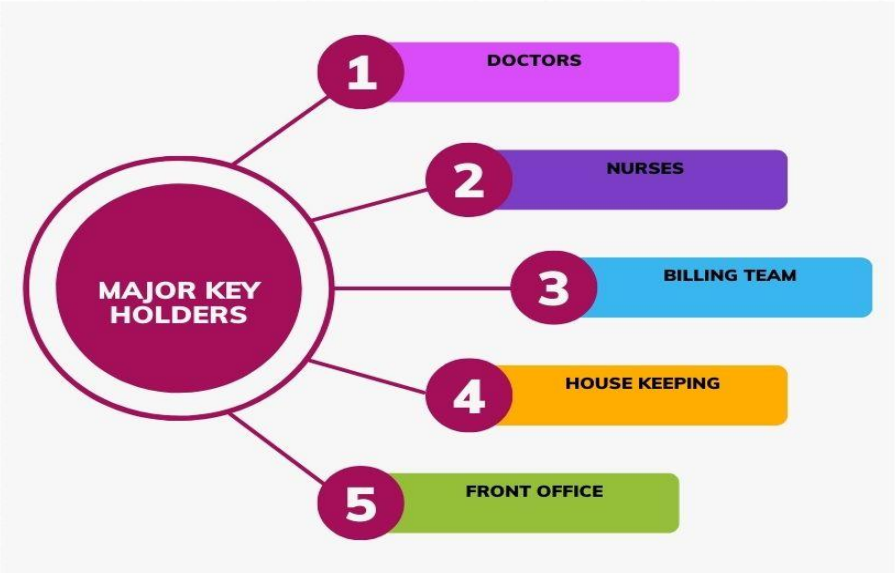

Figure:- 1 shows the major key stake holders involved in discharge process

1.1.1.1. Delay in discharge:

According to Karen Bryan (2010), "A Delayed discharge (sometimes called delayed transfer or bed blocking) refers to the situation where a patient is deemed to be medically well enough for discharge but where they are unable to leave hospital because arrangements for continuing care have not been finalized." 5 A delay in discharge after advise from the consultant will lead to further delay in admission of the next patient hence all the bottlenecks in discharge process and discharge planning are to be identified and corrected for a pleasant discharge process in the hospital.

1.1.1.2. Corrective measures:

There must also be effective interdepartmental communication and multidisciplinary approach in making admission and discharge as standardized as possible as team approach is better than solo approach towards effective discharge of process. There must also be well defined protocols for bed management and defined care pathways for each type of admissions or cases. The bed management process must also extend up to discharge of patient so that further bed allocation and admission are not affected.

The necessity for ongoing improvement in the majority of health care industry procedures is a result of the rising demand for high-quality medical care. To get the best performance out of the organization, patient safety and care quality must be carefully examined for improvements. It's crucial for a hospital to understand organizational analysis in order to enhance processes and make patients and their families more comfortable.

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CHAPTER 2

LITERATURE REVIEW

The increasing demand for high-quality medical treatment has necessitated continuing improvement in the majority of business practices. Patient safety and care quality must be closely analyzed for enhancements in order to obtain the best performance out of the organization. Understanding organizational analysis is essential for a hospital to improve operations and improve patient and family comfort.

A hospital must, in the words of Joint Commission (2010), "have organizational values such as good communication, patient and their related centered care, and tailored care according to associated diversity which must trickle down to multiple levels at hospital and not only clinical care. Because there's not a single solution to all patient-related problems, it is important to standardize the methods. Patients must be offered assistance while completing out admission paperwork and advised of their entitlements during hospitalizations in a tongue that is relevant to them. Patients' requirements must be taken into account during discharge and moves, and they must be involved in the decision-making processes. By determining any unmet needs, a complete follow-up plan should also be created.

Additionally, it is essential to comprehend how emergency rooms are managed in accordance with specializations, taking into account both regular hospital beds and acute medical beds as well as planned patients and extreme circumstances. Bed management becomes crucial in order to examine whether hospital patient influx may be controlled and to standardize admissions, invoicing, and discharge procedures. It is a highly sophisticated management method that enables the effective management of hospital and patient capacities through the utilization of material and human resources.

AccordingtoOrtiga,Bertaetal,(2012*). "With the use of information technology along with process management, a process can be standardized so as to have streamlined flow of patient in their care pathways."*

Therefore, in addition to offering patient care, a hospital needs to focus on standardizing the admission and departure procedures, which it may eventually manage by regulating the duration of stay and the quality of service provided. It is because the hospital has no influence over how clinical care will turn out.

P.R.Harper and A.K. Shahani, (2002) The complexity of hospital operations and the various unknown variables connected to them, claim the publishers of the journal Models for the Management and Planning of Room Capacities in Hospitals, necessitate a well-planned approach for successful bed management. A logistic regression or scenario can be useful in this circumstance.

"The strategic objectives that should be reached when engaging in patient care in a healthcare organization or in a hospital should be more defined, this would help in having a consistency in process of discharge," it is said in Health Strategy Implementation Project, 2003. Additionally, it sheds insight on the following topics:

• In order to provide good patient care, it is important to consider the environment surrounding the patient, including the patient's relatives, the medical staff, and others. Having excellent communication and technology would also be beneficial.

• The resources must be used as effectively as possible.

• Arranging elective and acute admissions so that both types of admissions receive the highest possible standard of care.

A hospital can be periodically reviewed against guidelines to determine its adherence to them and demonstrate its effectiveness when using a well-balanced collaborative process and by formulating better guidelines.

Richard Anthony (2005). explains that no one should take the hospitalization's endpoint for granted and that the patient should be followed up to the very conclusion of the hospital's care provision. The care and safety of patients upon discharge can be affected by severe bottlenecks, which can be identified through a thorough study of the discharge process that takes into account every area involved. The procedure can also be redesigned to improve patient care overall.

Karen Bryan (2010) offers a few views on the strategies that might be used in hospitals to reduce discharge delays in her paper on policies to reduce hospital discharge delays. Among them are:

- The top management's dedication to managing delayed discharges.
- A clear follow-up plan following discharge.
- The consultant's dedication to following the hospital's protocols.
- Determining discharge supervisors or a team of people who can help nurses during discharge planning or even during release, such as monitoring patients while in the hospital, patient information for withdrawal, handling medical interview transcripts, and help in the understanding.

• Aligning patient care with bill-paying procedures and other procedures, like claim processing.

However, consideration must be given to the patient's condition when aiming to reduce delayed discharges, not only to boost hospital throughput. If this is not taken into consideration, readmissions will indirectly have an impact on how efficiently the hospital operates.

David Anthony, VK Chetty, Anand Kartha, Kathleen McKenna, Maria Rizzo De Pinoli, Brian Jack As an illustration, the article on re - engineering the hospital release process from the Multifaceted Process Evaluation noted that discharge "may be seen as a risky position in which latent situations occur so that pointy end individuals are designed to fail. In their analysis, errors that really are aware at the moment of hospital discharge—both active and latent—are considered. Active errors here include that occur when a patient is being discharged from the hospital when making knowledge-based judgments at the point of care.

Errors occur when latent circumstances or system failures develop as a result of weaknesses in the structure or design of a technological system. For instance, nurses and the first residents at several hospitals conduct the discharge process. Due to the demanding nature of their jobs and competing priorities (such as new patients that require attention), they do not place a high premium on discharge, which could prolong the process. In order to understand the discharge planning as a whole and reverse engineer the process, flow chart of the discharge planning was done in this study. A failure mode and impact analysis was also carried out in order to identify the most likely mode of failure, the resultant problem, and the necessary steps.

In their study, Forster et al, (2003). Identified "four systemic areas that the discharge procedure needs to improve on:

(1) Evaluation and communication of issues that is still present upon discharge
(2) Patient education about drugs and other treatments
(3) Following discharge, medication therapy monitoring; and
(4) Monitoring of the general state of health upon discharge. During the post-discharge phase, a lot of problems arise, and many of them might be avoided with the use of straightforward tactics.

A recent study by Janita Vinaya Kumari (2012) "Being the concluding phase of the care provided, the discharge as well as billing system is likely to be widely recalled by the patient," says one expert on the billing and departure procedures. Even when everything is perfect, a drawn-out, difficult discharge process can lead to low patient satisfaction. Thus, a study was done to find out how long it usually takes for the a patient to be released from a Karnataka teaching hospital that offers tertiary care. Registers were kept in the ward and invoicing office for archival purposes. The administrative staffs of the billing office and the nurses working in the ward were given instructions relating to the study as well as the needs for data entry.

Following the completion of the literature review, it became clear that, despite the fact that numerous prior studies had highlighted the significance of standardizing hospital discharge procedures and that accurate process mapping would aid in streamlining and even reengineering the procedure, a thorough investigation of discharge procedures had been lacking. In order to improve and standardize these processes and ensure that a happy and healthy patient is the result of the patient journey in the hospital, I would like to provide a clear understanding of all the steps in the process through this study. I would also like to address any issues that may have caused the discharge process to take longer than expected

CHAPTER 3

RATIONALE OF THE STUDY

Patients' unhappiness may rise as a result of a drawn-out discharge procedure. Additionally, it has an impact on hospitals' reputations and is a major contributor to hospital-related violence. A study was done to identify the main factors that contribute to the lengthy turnaround times for credit patients because Apex Hospital has also experienced delays in the discharge procedure. The process of discharge was discovered to be extremely time-consuming from the patient's perspective. Other than insurance and TPA patients, cash patients are certain that the operation will be completed throughout the extension period. Long waiting times for patients will have a bad impact on their satisfaction, and it becomes more difficult to admit new patients to the hospital because there aren't any beds available because of postmen who don't recognize that.

The study's goal is to determine how the discharge executive structure affects patient discharge. The study provides us with the benchmark for measuring the patient's discharge process over the previous three months and providing prospective solutions to address their escalating problems on a par.

Planned discharges from the hospital are only taken account if the official discharge report is created one day before the day of release. If the floor coordinator does not receive the final discharge summary in the morning, the discharge is taken into consideration to be unplanned, and the hospital had a higher percentage of unplanned cases than planned cases, which contributed to the discharge process's delay.

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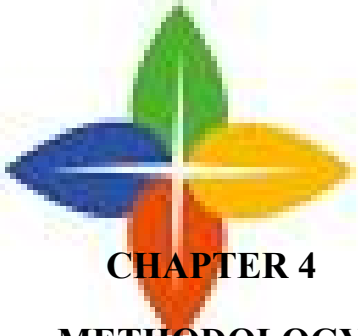

CHAPTER 4

METHODOLOGY

This chapter explains the methodology from the objective of the study till the scope and limitations that were kept in mind when this study was carried out.

4.1. Objectives of the study:

The objectives of the study of discharge process in a hospital are:-

- To research the hospital's discharge policy.
- To identify discharge process bottlenecks.
- To determine the causes of these process bottlenecks.
- To offer suggestions for enhancing these procedures.

4.2. Research Questions:

- What are the hospital's policies regarding discharges?
- What is the hospital discharge procedure?
- What issues are there during hospital discharge? What are the issues' main causes and bottlenecks?

4.3. Hospital setting under the study:

4.4.1. Apex Hospital:-

Figure: 2 Apex hospital, Malviyanagar jaipur

One of Rajasthan's most rapidly expanding chains of hospitals, Apex Health Group has facilities in Malviya Nagar, Mansarovar, Jaipur, Suratgarh, Sawai Madhopur, Jhunjhunu, and Bikaner. Beginning with a 50-bed facility, Apex Hospital later created a chain of 200-bed, multi-super specialty hospitals.

- Third hospital in Rajasthan to get NABH 2012 & NABL accreditation.
- Become the first hospital in Rajasthan to get ISO 9001:2008 certifications.
- Got Emerald Certification for excellent Emergency Care.
- Nursing Excellence certification.
- DNB-

The institution was designed with the goal of providing the best possible clinical research, education, and training at a reasonable price, as well as the highest standards of medical care in the fields of cardiology, cardio-thoracic surgery, neurology, oncology, neurosurgery, orthopedics, nephrology, vascular surgery, bariatric, gastroenterology, urology, and diabetics, among others. Apex is governed by the tenets of treating patients with consideration, compassion, and dedication. brings together a top-notch group of medical professionals, scientists, and clinical researchers to promote collaborative, multidisciplinary research, sparking original insights and findings, and more quickly transforming scientific advances into improved methods for disease prevention and patient diagnosis.

Vision: -

Delivering modern healthcare that is quality conscious, technology-driven, and patient- and staff-centered while making every effort to assure ongoing education and training for both multifaceted individual growth and linear organizational progress.

Mission : -

To deliver comprehensive, high-quality treatment at a reasonable cost in a clean atmosphere with tenacity, devotion, and compassion

The hospital's infrastructure has roughly 180 beds, including about 60 ICU beds, 4 operating rooms, and cutting-edge digital flat panel monitors. Cath lab, a cutting-edge dialysis unit, and 16 more top-notch facilities All of these amenities may be found in the wings A and B, which have 7 floors each and 6 floors, respectively. Currently, approximately 160 consultants and 650 staff members collaborate to handle more than 11000 inpatients alone in a single year. With outstanding medical competence and cutting-edge facilities, this hospital is unquestionably one of the most popular healthcare facilities in the city, serving the needs of patients from all over the world.

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It provides good accessibility to both local and foreign patients thanks to its convenient location in the southern part of the city, around 12 kilometers from the main railway station and 13 kilometers from the domestic and international airport.

Additionally, this hospital has agreements with all of the main TPAs and insurance providers. Poor people registered in the chief minister's program receive treatment for any cardiovascular issues as well as for issues with other specializations. The multi-bed general ward, semi-private wards, private wards, luxury rooms, and ultra deluxe rooms are the several types of IPD beds. Every room has air conditioning, and suites come with a couch and an extra bed for the patient's family members. Additionally, this facility provides preventative health checkup plans such the Whole Body Check Up, Pre Employment Health Check Up, Executive Health Check Up, and Basic Health Screening. In order to offer specialized treatment to patients that are critical in nature, hospitals also have facilities like ICCU, cardio thoracic ICU, and medical ICU.

4.4. Sources of data collection:

4.4.1. Primary sources

• Employees of hospitals, such as ward coordinators, nurses, patient service administrators, floor managers, resident doctors, ward boys, insurance counter personnel, etc

4.4.2. Secondary sources

The information regarding the number of wards and anticipated discharges was gathered from hospital records.

• The hospital management information system supplied information on when bills were generated, when TPAs or insurance companies responded, etc.

• Information like pharmacy clearance time and billing card checking time, among other things, were collected via billing cards.

Hospital brochures were utilized to learn about the facilities and specifics of the hospital's infrastructure.

4.4.3. Non-participant observation process:

Discharge process was observed to comprehend the overall sequence of processes and from observing the behavior and occurrences without participating in this research in order to study the full procedure as well without affecting the response of the specimen and sources under the study while one is present and thus capturing the full procedure whenever the event or activity is happening. This method involves observing happenings, activities, and connections in order to actually understand things in their natural environment. Since they're not actively taking part in this event being seen, the spectator is a nonparticipant.

4.5. Sample method and size:-

- The sample was chosen using a purposeful sampling technique.
- For the discharge process, 1150 patients from the cash category—those whose entire hospital stay was billed through cash payment—and the credit category—those who underwent cashless hospitalization—were studied from the point they were told for discharge until the time they left the hospital. The patients were either members of some insurance company or those who were part of some government scheme program.

4.6. Data analysis tool: MS excel is being used as data analysis tool for the study purpose

4.7. Scope of study:

This research was done at the Apex Hospital in Jaipur. Research on hospital discharge has always been ongoing, and efforts to speed up discharge have also been made. If a patient is unhappy, it has been found that the main cause of their unhappiness is a protracted discharge procedure. In this study, the hospital's discharge procedures have been monitored and examined. This type of study allows for the identification of flaws and useful lessons learned, and it also allows for the consideration of those lessons while establishing these procedures in any new hospital in order to make them as continuous and stress-free as feasible.

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CHAPTER 5

DISCHARGE PROCESS

5.1. Discharge process:-

"The process of actions that involves the patient and the team of individuals from several disciplines working together to assist the transition of patient from one environment to another," according to the definition of discharge. A timely discharge is defined as "when the patient is discharged home or transferred to an appropriate level of care as soon as they are clinically stable and fit for discharge." The patient discharge process is defined as "the final step of the treatment procedure during a patient's length of stay."

5.2. The fundamental ideas for successful discharge are:-

- A complete system approach to the evaluation processes, the commissioning of services, and the delivery of those services helps prevent unnecessary hospitalizations and promotes efficient discharge.
- • Discharge is a process, not an isolated incident. It must be prepared for as soon as feasible throughout basic, hospital, and social services systems, guaranteeing that patients and families understand and are eligible to participate in treatment decisions as appropriate. A designated person who is in charge of organising every stage of the "patient journey" should be in charge of overseeing the discharge planning process. Interaction with pre-admission case manager in the public is necessary as soon as feasible, and those responsibilities are passed on discharge
- Employees should work within a coordinated framework managed by a multidisciplinary team with representatives from multiple agencies.

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Discharge Process Flow

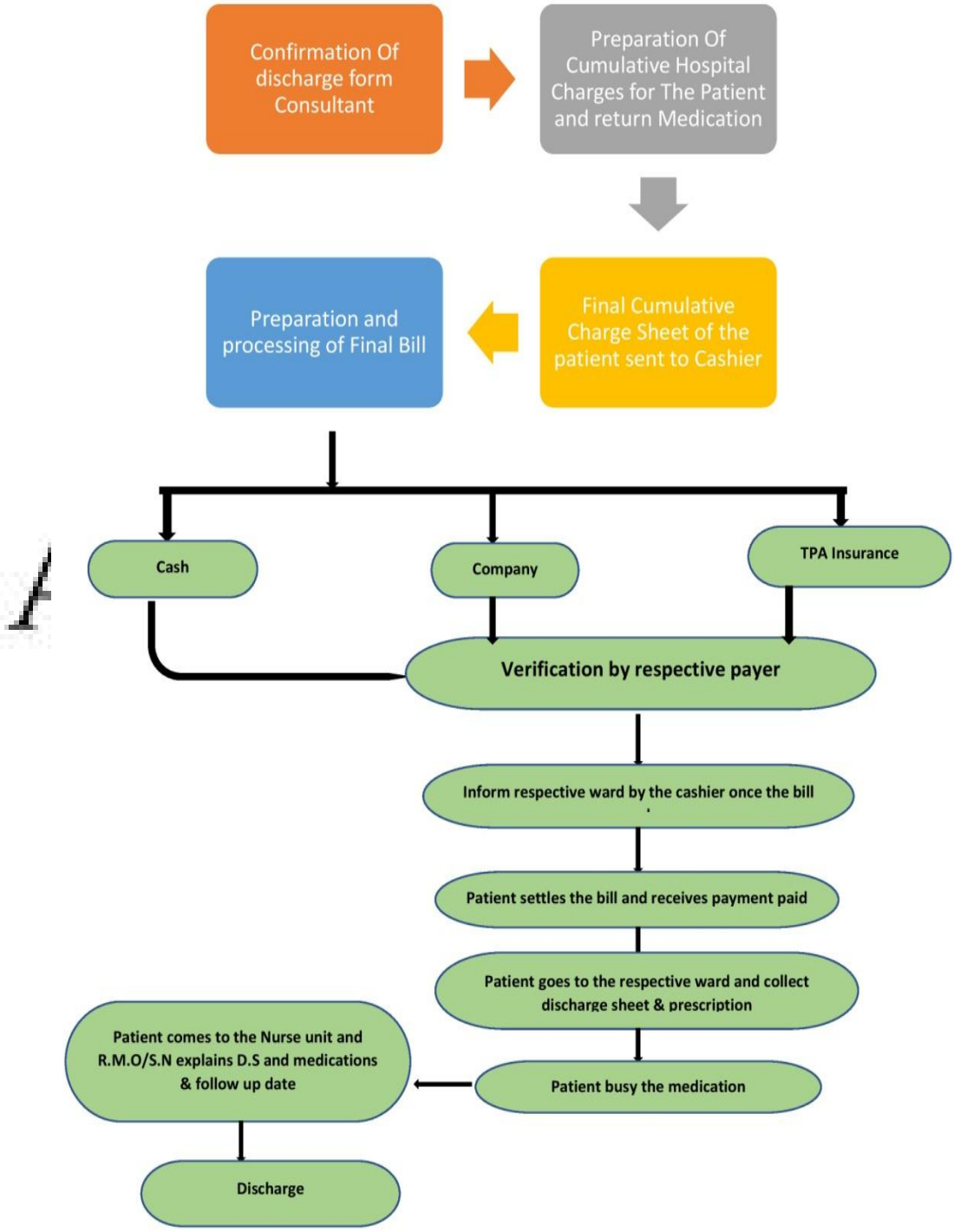

Figure 3: schematic representation of entire discharge process flow

5.3. Effective discharge planning:-

❖ **Advantages for the patient**

- Satisfaction is achieved
- • Possesses the greatest degree of flexibility.
- Feel engaged as a partner inside this care process, a part of it, and
- Not left useless.
- Avoid unnecessarily long gaps or
- Double up on work
- Recognize and accept the care plan.
- Think of caring as a logical, rather than an impulsive, mental process.
- A string of unrelated events.

❖ **The caregiver**

- Experience value as collaborators in the release process.
- Consider that their expertise has been well applied.
- Recognize their legal entitlement to have their needs recognized and satisfied.
- • Have confidence in getting help so they may continue providing care and get help before a problem emerges.
- Possess the necessary knowledge and guidance to support people in their job as caregivers.
- Given the option to take on a caring role.

❖ **For the staff**

- Feel that their knowledge is valued and applied properly.
- Get important information as soon as possible.
- Recognize their place in the system.

❖ **For industries.**

- Resources are utilized effectively,
- the community values the services provided
- Staff members feel respected, which improves hiring and retention.
- Reach goals, allowing the delivery system to focus (Department of Health, Health and Social Care Joint Unit, 2003).

The planned research will be carried out in order to observe and evaluate the evacuation process flow for hospitalized patients at Apex hospitals in Jaipur.

5.4. Discharge of cash patient (direct payment):

Interdepartmental coordination is needed during the discharge process to ensure that the patient has a simple and straightforward experience. When the consultant issues a written or verbal order of discharge, the discharge procedure begins. On the patient IP document in the admission file, the consultant writes the time and date. In front of the resident medical officer, the ward secretary then types the discharge summary. At the nursing station in the hospital where the study was conducted, an RMO was always on duty. As a result, the ward secretary prepares the discharge report in front of them rather than the RMO. The ward secretary checks the patient's billing card when preparing the discharge report. The patient is now ready to be discharged.

When the discharge summary is prepared, the RMO reviews it once more before taking a hardcopy of it. After the consultant has approved discharge, the nurse at the nurse station completes the pharmaceutical clearance. In the HMIS, the nurse completes all the information regarding any unfinished prescriptions and sends it to the pharmacy module. Additionally, she completes the patient's daily chart, checks all of their vital signs, and records them there. The billing card is sent to the discharge counter before 12 o'clock in the afternoon once the ward secretary has filled it out and verified it, as this is the time for discharge in the hospital under most circumstances.

Thus, the majority of the discharges occurred about 8:30 a.m. after the doctors' morning rounds. The completed billing card is communicated to the ward boy, who then sends it to the discharge counter. The billing card is carried by ward boys from various wards to the ground-floor discharge counter. For this, they can lift or take steps. Therefore, the ward boy's choice of mode

will also affect how long it takes to submit the billing card at counter 36 for discharge. Ward boys occasionally bring the billing card to the discharge counter while also transferring patients.

As soon as the billing card is presented at the counter, the HMIS in the discharge counter totals it, and the staff at this counter generates a bill. Once a bill is generated, either a call to the nursing station or a direct call to the patient's relative is placed to tell them of the development of the bill. The following list of factors affects how long it takes a patient or patient's relative to get at the discharge counter:

- Whether people use stairs or a lift depends on their means of transportation.
- It could take some time for patient relatives to put money aside for the final bill.
- Unknown motives for the patient's relations leaving the hospital.
- When a patient relative arrives at the discharge counter, he is informed of the total cost and given a break-up bill to review and ask questions about if necessary.
- The patient's relative or patient then pays the balance of the final bill at the cashier's counter. The patient or a family member receives a receipt for full payment, which must be shown at the discharge counter.
- • If a deposit refund is required, it is only processed at this time, and the patient or a close relative receives a tenancy deposit slip in instead of the full payment slip.
- The patient or relative is given a clearance receipt after witnessing this full payment or deposit receipt.
- After receiving the clearance slip at the nurse station, the patient or a family member must carry it to the ward, where the nurse will take care of the rest of the formalities. Details like the quantity of tests performed and the quantity of reports sent are recorded in an acknowledgment book.
- The patient is then educated and given the discharge summary by a nurse, who also takes the patient's papers and records to the patient room.
- After the patient has received a thorough explanation of all the details, the patient signs the acknowledgment book.

  The IP band is then taken off, enabling the patient to go home. There are instances when patients decide to leave the designated room late after the IP band has been severed, lengthening the overarching discharge time. This is because the time of release throughout this study is measured from the present time the doctor grants discharge till the patient vacates the assigned room.

CHAPTER 6

DATA ANALYSIS

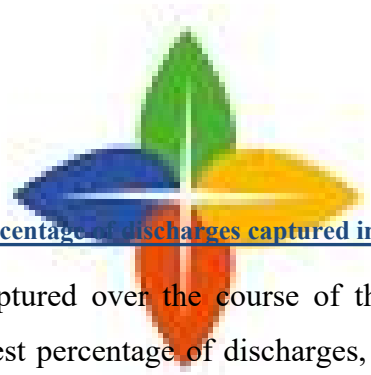

Figure 4: Percentage of discharges captured in respective months

The percentage of patients captured over the course of three months is shown in the above mentioned figure: 4. The highest percentage of discharges, was recorded in the month of May, followed by 33 percent in the month of June, and the lowest percentage, or 28 percent, in the month of April.

Figure 5: Payor wise distribution of planned and unplanned discharges

Distribution of scheduled and unplanned patient discharges by patient category and non-category is shown in Figure 5.

Figure 4 clearly demonstrates that at Apex Hospital, the bulk of discharges—whether they include credit patients or patients who pay with cash—are unexpected. Only 16 percent of cash patients have planned discharges, and only 8% of credit patients do. There were more unexpected discharges, 43 percent in the credit category and 33 percent in the cash category.

Figure 6: Percentage distribution of speciality wise discharges

Figure 6 displays the percentage distribution of discharges broken down by specialty. The above statistic clearly shows that the Department of General Medicine handled the majority of discharges.

The least number of discharges came from departments like ENT, Plastic surgery, and Pulmonary medicine, which were then followed by cardiology, general, and GI surgery.

Figure :7 Distribution of discharges from credit category before and after 12:00pm

The percentage distribution of patients with credit categories who were discharged before 12:00 p.m. and after 12:00 p.m. is shown in the above mentioned figure:7. The image makes it abundantly evident that the majority of credit category discharges—i.e., 77 percent of all credit discharges—take place after 12:00 p.m., which has a significant effect on the patient release process. The delay in discharge is brought on by the lengthier time required for awaiting permissions from the relevant insurance provider and by the double verification of the credit documents.

According to the ideal discharge criterion, just 23% of patients are discharged before 12:00 pm.

Figure 8: Total time taken during discharge intimation to room vacancy

The total amount of time needed is calculated using the period of time between the patient's physical vacancy of the room and the discharge notice to room vacancy. Figure 8 shows that, on average, for 319 cash patients, it takes between one and two hours until a room becomes available, while for 106 cash patients, it takes between two to three hours, for 51 cash patients, it takes between four to six hours, for 39 cash patients, and it takes more than six hours for only As a result, 319 patients had a total time gap between receiving their discharge notice and having a room available, whereas only 21 patients had a total time gap of more than 6 hours.

Additionally, it has been noted that for credit patients, 287 patients are discharged within the first two to three hours, followed by 88 patients who were discharged within the third to four hours,

58 patient were discharged within the fourth to sixth hours, and 34 patients were discharged within the seventh to twelfth hours.

Due to challenges obtaining authorization from their specific organizations, patients who paid with credit had to wait up to 2-3 hours longer to be discharged than those who paid with cash.

Figure 9: **Total time taken during discharge intimation to pharmacy clearance**

The total amount of time needed for pharmacy clearance is calculated using the delay between discharge notifications for medications cleared by IP Pharmacy. Figure 9 depicts the total time needed from discharge notice to pharmacy clearance. It reveals that for the majority of patients (1017), this time period is between two and four hours, with only 13 patients—or 1% of the total—having a discharge gap of less than an hour. Furthermore, there was a delay of more than 6 hours for 24 patients.

Figure:10 Percentage wise distribution of reasons for delay in discharge

Figure:10 displays the percentage-wise breakdown of the causes of discharge delays at the top hospital. The majority of delays, or 49%, are driven on by a patient's diagnostic report. These are followed by double verification for patients with credit, which causes for 25% of delays, and

pharmacy clearance, which accounts for 16% of discharge delays. Roughly 6% of all discharges are delayed since this discharge summary was not prepared a day in advance.

CHAPTER 7

FINDINGS & RECOMMENDTION

Major findings:-

- The discharge procedure is not formally taught to new nurses.
- For IP and OP, there is only one billing counter.
- Insurance patients can no longer request clearance from their separate firms because it is too late.
- The primary reason for inpatients' delayed discharge is the need to provide medications on the ward or collect medications from the pharmacy before to discharge.
- The drafting of the discharge summary takes more time.
- • Patients who pay with cash are not informed in advance of the outstanding balance, which causes the cash payment to be delayed. Each patient's bill should be tracked at the ward secretarial/cash desk, which should also frequently ask visitors to pay any remaining sums.

- The time needed handling bill compilation can also be cut down by closing all open bills before alerting the accounts team of its discharge and by keeping lines of communication open among department whenever a bill is closed.
- The Medical Officers and Consultants mentioned that the lateness of the Laboratory reports caused a delay in the start of the patients' treatment. The laboratory workers, for their part, said that despite the reports being ready, typing them was challenging because of the heavy workload and staff scarcity.

Discharge planning:-

The discharge timing can be improved most significantly by adhering to an appropriate discharge planning activity. The rules should be put forth in detail for the same. Beginning the day the patient is admitted to the hospital, the patient's discharge planning should begin. A proper discharge report should be created, and the summary should be updated the same night with daily updates regarding the essential action and therapy given to the patient.

A transcripter must be given the night shift in order to accomplish this. If the doctor advises the patient be discharged the next day, the discharge summary must be provided to print and should be validated and checked by the consulting doctor in during consultant's early rounds. This will permit all of the files to be based on previous at the end of the day.. If the discharge summary has an error, it should be corrected right away, only be signed by the floor RMO, and then be sent to the billing department.

There are some discharge summaries that the visiting consultant must review upon their request; this lengthens the overall time required because it must be transferred to the consultant and then brought back. This needs to be taken care of right away, and the floor duty RMO should handle the final clearance. The time needed for file verification and consultant error correction would be greatly decreased as a result. Additionally, by doing this, fewer discharges would be made during the afternoon hours and more would be made during the morning rounds of the doctors.

Daily doctor’s morning round:-

Before 11 a.m., all consultants should be informed in full about the morning rounds to ensure a fair distribution of work at the data operator's desk during his working hours.

Transfer of files:-

All departments manually transfer the discharge file. Instead, the data operator can review and double-check the files via the mail system. As a result, the ward boys would be less dependent on the move, and the system would become more effective.

Automation:-

As little physical labor as feasible. The nursing system can use bar code technology to collect and retrieve pharmacy supplies. This would allow for a reduction in the amount of time wasted on organizing pharmacy refunds and open up the nurses' attention for patient-related responsibilities. RMO Since doing so would aid in preparing the discharge summary, as well as minimize any inaccuracies that were not necessary and the operator's requirement to modify the same file, the data input operator should be positioned close to the ground's RMO.

Pharmacy:-

It has been observed that pharmacy processing takes longer than the billing time. This must be observed. The unprofessional attitude of the pharmacy staff is a big contributor to the delay. It has been noted that irresponsible behavior is the cause of the delayed pharmacy bills. As the patient visits the billing department to inquire about the charge, the billing department keeps calling the pharmacy department for the final bill. The billing department receives the final pharmacy bill only after that. The billing time is significantly delayed as a result of this. The head of the pharmacy department must take care of this, and suitable procedures should be followed while processing pharmacy bills and giving out regular updates.

Good diagnostic service:-

Make sure the clinical team receives the diagnostic reports on time so that the patient can begin receiving treatment as soon as feasible.

Manpower planning:-

Since there was a shortage of data operators who could create discharge summaries and there were vacancies despite a data operator departing the department, a suitable personnel planning exercise must be carried out. A data operator should be assigned to night duty, just as while preparing the discharge, to update and finish all of the admitted patients' daily files. The time it

takes the operator to create the discharge statement in the morning—which he only begins when the doctor orders the patient's discharge—would be cut down thanks to this. There should be a different data operator on each floor during the morning shift, as well as one during the night shift and another in the Cath lab. Their shifts should be cycled, and they should receive monthly or quarterly evaluations.

APEX HOSPITALS

CONCLUSION

One significant area in need of improvement in hospitals is patient discharge. The hospital needs the right collaborative efforts of other department staffs in order to decrease discharge delays.

A satisfied consumer will spread the news about the hospital to two people, whereas an unhappy customer would disseminate their cries to eight, ten, or even more people.

As a result, having suitable and effective processes and a protocol in place is crucial for any hospital. The greatest customer relations management. and realistic benchmarks are crucial for every hospital to have, for all the procedures they can strictly adhere to. Employees in hospitals should coordinate their individual goals. They will then devote all of their time to improving the organization in line with its aims.

Through this study, the amount of time needed for patients with insurance and cash payments was examined and compared to NABH criteria. The reasons for the delay were determined, and recommendations were made to shorten the time needed to assign a bed to the subsequent patient, improving the hospital's reputation and decreasing patient wait tim

APEX HOSPITALS

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