



**MBA Hospital and Health Management
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TITLE:

**A STUDY ON DELAY IN DISCHARGE PROCESS IN A
MULTI-SPECIALITY HOSPITAL.**



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ROLL NO :- 1146 HM-25

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Last but not least, I'd like to thank my parents for their tolerance, perseverance, and love in helping me overcome obstacles in my life.Dr. Niharika bidani

MBA 2020-22

IIHMR, Jaipur

DECLARATION BY STUDENT

I hereby declare that this dissertation titled “A study on delay in discharge process in a multi-speciality hospital” is the Bonafede 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

Dr. Niharika bidani

MBA 2020-22

Certificate No – 2022/11059

CERTIFICATE

OF ACHIEVEMENT



Max Institute of Medical Excellence

Certifies that

Dr Niharika Bidani

has completed Internship in the department of

Medical Administration

at Max Super Speciality Hospital, Patparganj, New Delhi

from 28th March 2022 to 24th June 2022

A handwritten signature in blue ink, appearing to read "Vinitaa Jha".

Dr Vinitaa Jha

EVP Research & Education
Max Healthcare Institute Ltd

LIST OF ABBREVIATION

TAT- Turnaround time

MR- Medication Reconciliation

IPD- Inpatient department

OPD- Outpatient department

PSU- Public Sector Units

ICU- Intensive care unit

MICU- Medical Intensive care unit

SICU- Surgical intensive care unit

CCU- Cardiac/ Critical care unit

MS- Medical Superintendent

AMS- Assistant medical superintendent

GDA- General duty assistance

CNO- Chief nursing officer

INC- Infection control

HOSPITAL PROFILE

INTRODUCTIONS



Max Super Specialty Hospital, Patparganj is 400+ bed Healthcare facility and a division of Balaji Medical Diagnostic Research Centre that offers services in Cardiac Sciences, Oncology, Neurosciences, Obstetrics and Gynecology, Orthopedics, Urology and Kidney Transplants, Minimal Access, Metabolic, and Bariatric Surgery, among others. Max Super Specialty Hospital Patparganj, which has 116 ICU beds and 14 HDU beds, combines patient-centered care with the most recent medical technology innovations.

With over 510 medical experts and leading doctors on staff, as well as a nursing staff of over 770 nurses, the Max Patparganj family is dedicated to providing the highest standard of medical care in the world. We ensure that every patient who walks through the doors of Max Healthcare receives the holistic healing environment that they deserve by utilising cutting-edge technology, 11 high-end modular Operation Theatres, and a commitment to providing patient-centric care. We aim to provide the highest standard of healthcare through our NABL accredited Max Lab and NABH accreditation.

With over 28 clinical specialties, Max Super Specialty Hospital, Patparganj offers the advantage of integrated medical care in a multidisciplinary setting provided by a faculty of highly qualified doctors, nurses, and healthcare professionals. Comprehensive specialist

services are provided using advanced medical technology, making it a regional hub for complex procedures such as neurovascular interventional procedures, targeted cancer treatments, heart surgeries, orthopaedic surgeries, and fertility treatments. Max Super Specialty Hospital in Patparganj is a well-known healthcare provider that has won numerous awards and industry accreditations for its world-class infrastructure, cutting-edge technology, and health and safety standards.

OUR VISION

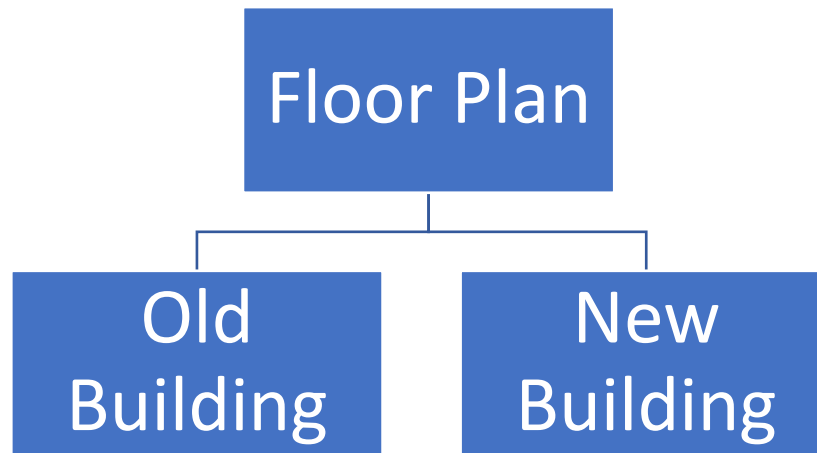
- **COMPASSION**-The organisation understands patients better and is always sympathetic to their needs. This fosters a culture of providing higher-quality patient-centered care. The organisation ensures that the needs of the patients are met with dignity..
- **EXCELLENCE**-There is a constant endeavor to achieve the highest standards of medical expertise and patient care. The organization understands being the best is a continuous journey of becoming better version of itself every day.
- **EFFICIENCY**- By being responsive to our patients' needs and delivering what they truly require with precision and timing, we have created a responsive healing environment. The organisation is centralised yet quick, advanced yet seamless in providing the precise care our patients require.
- **CONSISTENCY**- Organization always follows through on our commitments and ensures the highest level of patient care is provided at all stages, every time. Organization believes that only through consistency can we gain the trust of our patients and achieve our objectives.

SCOPE OF SERVICES

1. Trauma & Emergency
2. Anesthesiology & Cardiac anesthesiology
3. Blood bank
4. Cardiology
5. Cardiovascular & Thoracic surgery
6. ENT
7. Dentistry
8. Dermatology
9. Gastroenterology
10. G.I surgery
11. General & laparoscopic surgery
12. Internal Medicine

- ## ORGANOGRAM OF THE HOSPITAL





❖ **OLD BUILDING**

➤ BASEMENT

- CSSD
- Staff canteen
- Training Hall
- Staff Library
- Staff changing Room
- Physiotherapy and occupational therapy (6 Treatment rooms)
- MRR
- Uniform issue room
- IP Bill/TPA Desk
- AHU Room

➤ GROUND FLOOR

- Reception
- OPD
 1. Anesthesia and Reconstructive surgery (Plastic surgeon)
 2. Cardiac Surgery
 3. Cardiology
 4. ENT
 5. Anesthesia and Reconstructive surgery (Plastic surgery)
 6. Pulmonology
 7. Thoracic Surgery and robotic thoracic surgery
- Pharmacy

- Patient cafeteria
- Blood Bank
- Oncology day care
- Admixture lab
- Economy ward
- Economy extension ward
- Anesthesia and Reconstructive surgery (Plastic surgery)
- Pulmonology
- Thoracic Surgery and robotic thoracic surgery

➤ 1st FLOOR

- OPD
 1. Nephrology
 2. Minimal access, Metabolic and Bariatric surgery
 3. Gastroenterology
 4. Endocrinology
 5. Dentistry
 6. Gynecology
 7. Ophthalmology
 8. Pediatrics
 9. Develop-Child Behavior preadolescent
 10. Dermatology and trichology
 11. Dietician
 12. Department of Orthopedics
- Dialysis Room (16 Beds)
- Sample collection Room
- Bhai Mohan Singh ward (21 Beds)

➤ 2nd FLOOR

- Endoscopy Room
- HDU
- General Ward (8Beds)
- Single Sharing rooms (10 Beds)
- Double Sharing Rooms (14 Beds)
- Economy ward (13 Beds)

- surgical Day care (6 Beds)
- Typing Room
- Doctors Room

➤ 3rd Floor

- NICU (18 Beds)
- Nursery (6Beds)
- PICU(8Beds)
- Labour Delivery room(10Beds)
- Operation Theatre(5Beds)
- Doctors room
- Patient Waiting rooms
- Pre/Post labour room
- Counselling Room

❖ **NEW BUILDING**

➤ BASEMENT

- Radiology
- Nuclear Medicine
- Day care
- IP Billing
- TPA Desk
- Corporate Desk
- MRI/CT scan /Ultrasound/X-ray

➤ GROUND FLOOR

- OPD
 1. Anesthesia
 2. Bone marrow transplant and hematology
 3. Medical oncology
 4. Surgical oncology
 5. Uro-oncology
 6. Gi-oncology
 7. Gynae oncology
 8. Orthopedic oncology
 9. Pead. Oncology
 10. Radiation Oncology

11. Onco Thoracic Surgery
12. Orthopedics
13. General and Laparoscopic Surgery
14. G.I. Surgery
15. Internal Medicine
16. Pediatrics
17. Neurosurgery/spine/Neuro Oncology
18. Neurology
19. Tobacco Cessation clinic
20. Urology
21. Vascular Surgery

➤ 1st FLOOR

- MICU-12 Beds
- CCU-10 BEDS
- NEURO ICU- 8 BEDS
- NSICU-8 BEDS

➤ 2ndFLOOR

- CTVS ICU -8 BEDS
- Wards (Classic Deluxe, Single, Double, Economy)

➤ 3rd FLOOR

- Wards (Single, Double, Economy)

➤ 4thFloor

- Wards (Single, Double, Economy)

➤ 5thFloor

- Wards (Single, Double, Economy)

➤ 6th Floor

- Wards (Single, Double, HCC)

- 7th Floor
 - Wards (Single, Double, Economy)

- 8thFloor
 - Wards (Single, Double, Economy)

- 9th Floor
 - MICU
 - A Wing-12Beds
 - B Wing-8 Beds
 - C Wing-5Beds
 - D Wing-5Beds

TITLE:

A STUDY ON DELAY IN DISCHARGE PROCESS IN A MULTI-SPECIALITY HOSPITAL.

CHAPTER 1: BACKGROUND

1.1 INTRODUCTION:

The NABH defines discharge as a procedure wherein a patient is removed from the hospital with all the medical reports concerned which guarantee stability. When the consultant advised discharge, the discharge process is said to have begun, and it concludes when the patient leaves the clinical unit. The goal of the study was to observe the 400 bed MultiSpeciality Hospital discharge, to comparison it with NABH AAC 13 and 14 standards, and to check for any possible bottlenecks.

Discharge of a patient from the hospital is a stage of care at which the patient either leaves the hospital premises at their own will or returns home after completing clinical procedures or is referred and shifted to another level of care such as to a rehabilitation center or to a nursing home for further follow-up.

1.1.1 Discharges could be of the following types:

1. Medically advised Discharges: It is the most common type of discharge seen in hospitals when the admitted patient is fully recovered and under the direction of the consulting doctor and ward doctors is discharged from the hospital. The IPD patient's discharge is planned ahead of time and does not require further stay in the hospital.
 - A) In **planned discharge**, the planning is done a night prior of the discharge after evening round by doctor (either verbal/written) and activities related to finances, pharmacy is started in the night itself and then the next morning patient is discharged. In planned discharges the patient should ideally be wheeled out before 11am the next day.
 - B) In **unplanned discharge** the discharge process is started spontaneously after the doctor's round and after that all the activities of the discharge are started.
2. LAMA: The acronym LAMA refers to Leaving against Medical Advice. In this case the patient requests for his/her own discharge without seeking any approval or permission from the doctor. This generally happens due to an unforeseen circumstance and leads to financial loss of the hospital as the patient opting for LAMA may not be in a position to bear the expenses of his/her treatment at the designated hospital.

The hospital and other healthcare professionals engaged in patient care may be able to simplify the discharge process and explore further methods to improve hospital services if an anticipated time for release is provided. The goal of this work was to discover the many factors that influence discharge TAT and

use machine learning to forecast it. The patient is generally informed that he or she will be discharged to final summary preparation, and then the bill is initiated and cleared. The hospital chosen for this study was no exception. Many activities and outstanding duties, such as last-minute investigations and cross-consultations, are involved in this process, resulting in unforeseen and unpredictable delays.

In many hospitals, the admission and discharge processes can both function as bottlenecks, reducing the efficiency of the facility. It is a critical indication of care quality and patient satisfaction. The demand on hospital beds is further increased by delays in discharge. Discharge delays are inefficient for both hospitals and patients. It raises healthcare costs and makes patients feel depressed. A significant delay in discharge raises the patient's risk of contracting a hospital-acquired infection.

IP Touch Points, Activities and KPIs

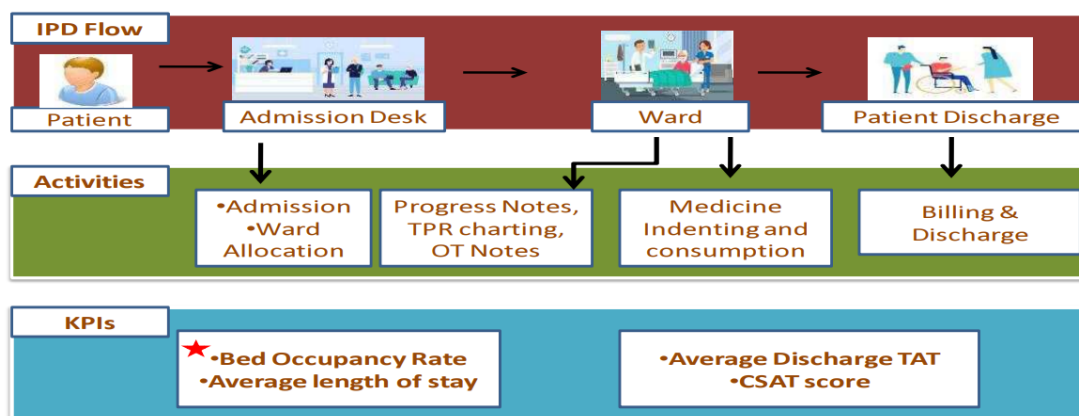


Fig.2

1.1.2DISCHARGE TURN AROUND TIME

Analysing workflows in hospital information systems can be aided by assessing turnaround times. The discharge TAT is calculated from the time of discharge advice to the time the room becomes vacant. When the consultants recommend discharge, the physician assistant enters the information into the HMIS. The second TAT for medical discharge is when the discharge summary is finalised, the pharmacy return is completed (by the ward secretary), and the OT clearance is obtained (in the case of surgeries), and the ward secretaries mark for medical discharge. The third TAT is for bill finalisation, in which the billing executives check and verify all entries, and the bill for insurance patients is created in accordance with the rate list of the insurance companies and the MOU. The billing executive then marks it as completed. The fourth TAT occurs when the patient vacates the rooms after paying the bill. Following the clearance of the bill, the bystander is given two pink slips to hand over to the nursing and the guard at the gate.

The NABH has established criterion for completing the discharge process of 180 minutes. As a result, maintaining an acceptable amount of discharge time gives the company a competitive advantage.

1.1.3 BED OCCUPANCY RATE

The occupancy rate is a metric that depicts the actual use of an inpatient health facility over a given timeframe. It is calculated as a percentage, and terms such as "percentage of occupancy," "percentage of occupancy," and "occupancy ratio" are frequently used interchangeably. The Department of Health Statistics determines and aggregates hospital and nursing home occupancy rates at the facility, county, and state levels on a regular basis. This information is extremely useful for health-care planning.

2 data items are required to calculate the avg. occupancy rate for a typical one-year study period. "Inpatient Days of Care" and "Bed Days Available" are two examples. These two items are defined as follows:

1.1.4 INPATIENT DAY OF CARE - For the whole year, add up each daily inpatient census. Simply add up all of the daily censuses for the 365 days of the year to get this figure. "Total inpatient service days," "occupied bed days," and "census patient days of care" are other phrases that are interchangeable.

1.1.5 BEDS DAYS AVAILABLE - The max. no. of inpatient days of treatment would have been delivered if all beds were fully filled throughout the year. If 60 beds were available for use everyday of the year, the number of bed days available would be $60 \times 365 = 21,900$. If the number of beds changed throughout the year, the number of bed days available would have to change as well, complicating the calculation. We'll go over this in greater detail in the following paragraphs. Bed days are also known as "potential days," "maximum patient days," or "total inpatient bed count days."

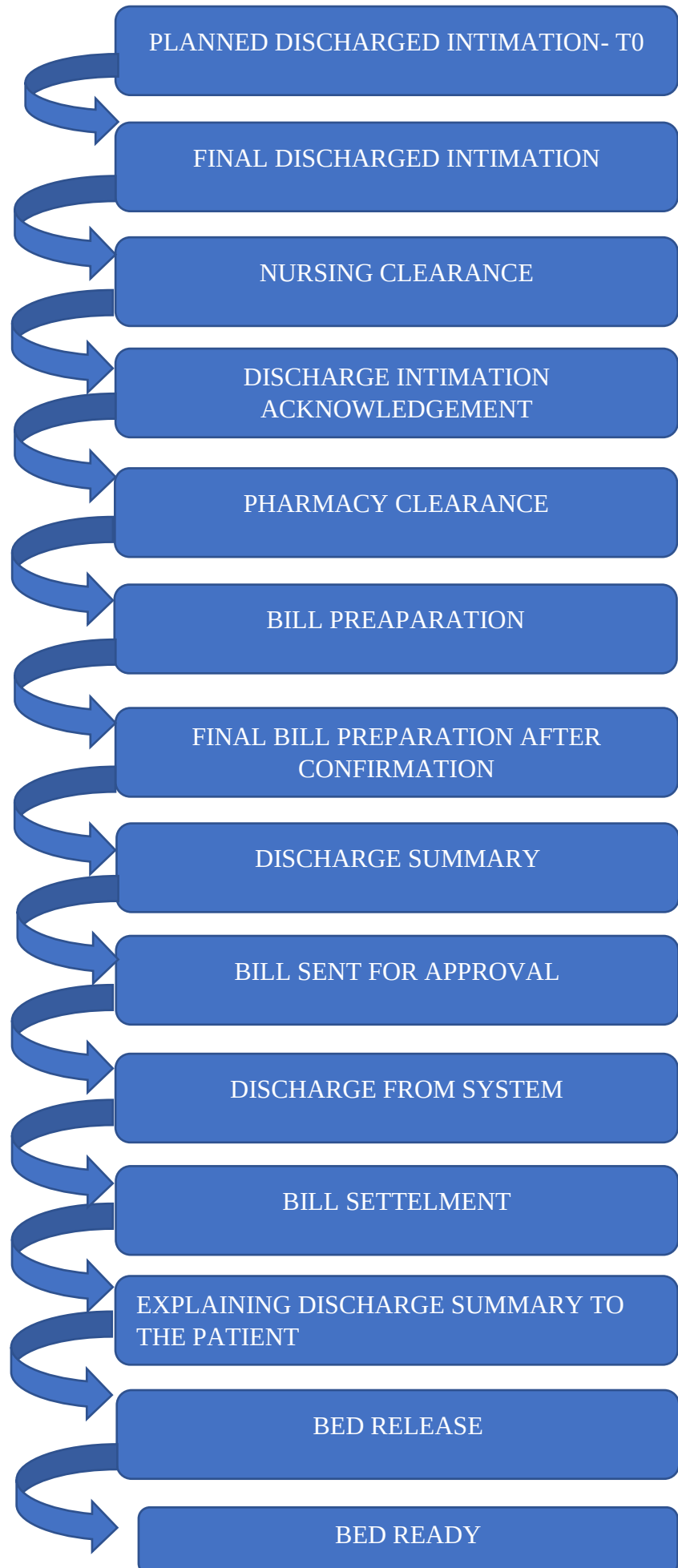
“Use the inpatient day of care and bed day available in this formula to calculate occupancy rate:

$$(\text{Inpatient Day of Care} / \text{Bed Day Available}) \times 100$$

The facility is not the only factor to consider when calculating occupancy rates. Occupancy rates are frequently assessed to determine how well a particular inpatient unit, such as obstetrics, psychiatry, medical/surgical, or other, is used. The occupancy rate is a valuable statistical metric that is calculated over time (month, year, etc.) rather than on a single day. Even if the number of beds changed during the study period, Calculating occupancy over a longer time period shows how much hospital beds are used.

DISCHARGE PROCESS

1.1.5



1.1.6 KEY SKATEHOLDERS OF DISCHARGE PROCESS

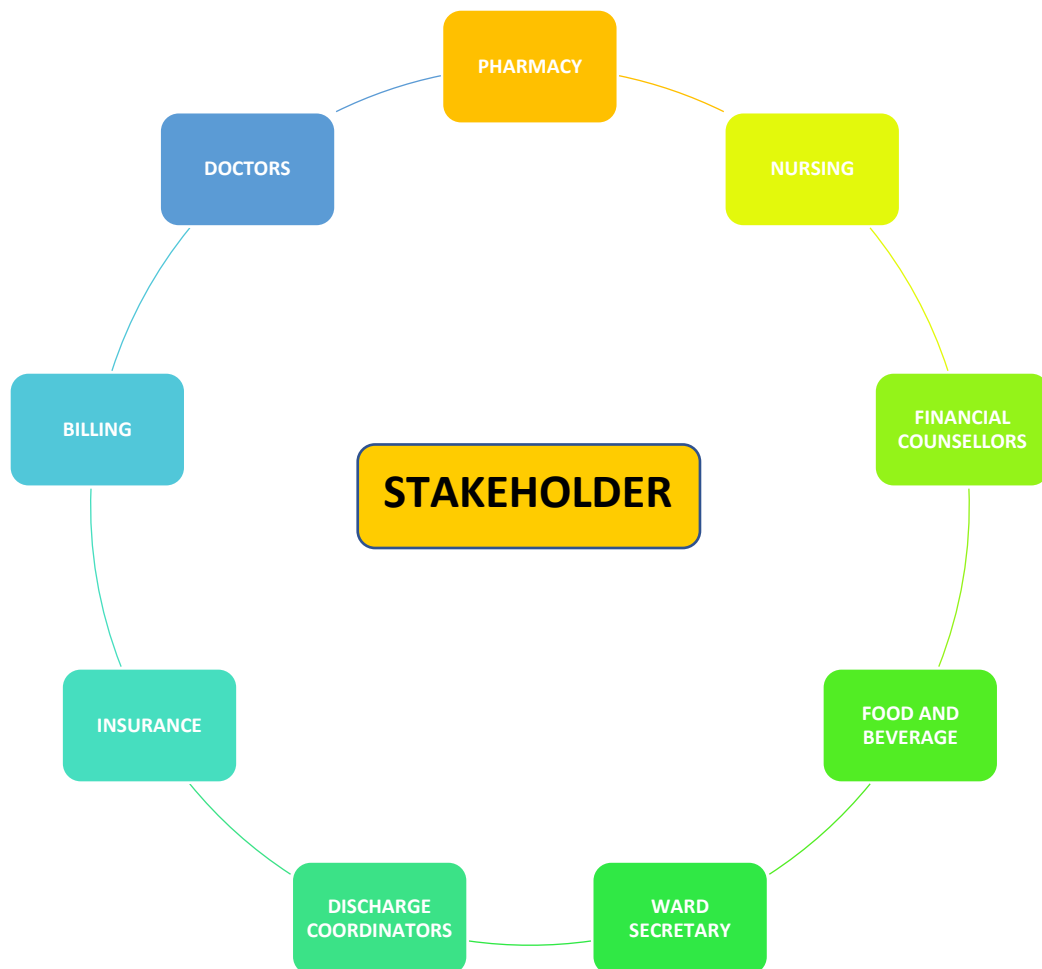


Fig. 3

1.2 RESEARCH QUESTION :

1. What is the Average TAT for CASH, TPA AND PSU patient discharged from the hospital?
2. What are the factors causing delay in the discharge process?
3. What are the bottlenecks resulting in delay of discharge of the Cash patients?

1.3 OBJECTIVES:

- ❖ To estimate the Average Discharge turnaround time of the patients in a multi-speciality hospital.
- ❖ To minimize bottlenecks in discharge process.
- ❖ To increase number of admissions by quicker discharging of existing patients.
- ❖ To identify factors causing delays in discharge time

- ❖ To study the bottlenecks causing delay in the discharge process
- ❖ To suggest strategies to reduce the TAT in discharge, if required

CHAPTER 2

LITERATURE REVIEW:

1. *Research led by Audayi Hayajneh et.al titled as 'Nurses Knowledge, Perception and Practice Toward Discharge Planning In Acute Care Settings:* A review seeks to identify and assess nurses' knowledge, perceptions, and discharge planning practices. A PRISMA-compliant systematic review was conducted. This study used nine articles to uncover nurse's knowledge, perspectives, and discharge planning practises. One of the difficulties was a lack of understanding about the patient's activity and discharge. An inability to define the Discharge Process; disagreements about the timing of starting, implementing, and preparing discharge; negative attitudes toward the Discharge Process by patients and their family members; and the perception of the Discharge Process as excessive, time-consuming paperwork for which the physician is responsible. Better time management has been discovered to improve the discharge process in acute care settings.
2. **Nancy Kurma (2009)** She used a variety of treatments in her research, the most beneficial of which was color coding patients based on bed occupancy. This intervention aided in calculating patient flow by estimating the patient's discharge date.
3. **Sima Ajami & Saeedeh Ketabi (2007)** They concluded that the early morning rounds should be distributed to maximize resource utilization and avoid queuing. A queue is a place where customers can wait for a server to become available. Because customer arrival and service times are unpredictable, different waiting times may occur; thus, the average waiting time may be used as a component in the system's performance analysis. The average number of line users, also known as average queue lengths, and the number of busy server times, also known as the utilization rate, are two key performance parameters for queuing systems. They also mentioned that the consultant provides a planned release date to avoid delays.
4. **Alper E, Malley O.A, Terrence, Greenwald J, 2015-** planning of discharge is the process flow of developing an individualized discharge plan for a single patient before leaving the hospital to ensure that patients are discharged in the given period of time and with adequate post-discharge services and follow up. Planning for discharge is a difficult process. This process should ideally begin at the beginning of the admission. The hospital operations manager should be contacted as early as the patient needs services at home with homecare facility or needs to be transferred to a higher level hospital for care.
5. **Alper E, Malley O.A, Terrence, Greenwald J, 2015 -** Medication reconciliation, also known as medication review, is the process of check patient's medication lists at a point of care , such as hospital discharge or admission, to determine which medicines have been included, or has stopped, or changed since admission. Accurate medication reconciliation is a important component of a smooth discharge process. A 2012 Review found that medication reconciliation was linked with a reduction in actual and possible adverse drug events in the majority of studies. Medication reconciliation may have a greater impact on lowering re-admissions due to possible adverse drug events.
6. **Swapnil Tak,2013,** The total time from discharge notification to finalized summary is

calculated as the time difference between the discharge notification and the finalized summary signed by the doctor. A time study is a direct and continuous observation of a task that uses a stopwatch, video-camera, or other device to record the time required to complete a task. When is time motion study used? There are short to long-duration repetitive work cycles in which a wide range of dissimilar work is performed or process control elements are included.

CHAPTER 3

METHODOLOGY

1. **DESIGN OF STUDY:** Observational cross-sectional descriptive study type.
2. **SETTING:** MULTI – SPECIALITY 400+ Bedded Hospital
3. **SAMPLE SIZE-** Total patients of CASH, TPA, and CGHS getting discharge from the hospital between 1 April- 31 May 2022)
TOTAL PATIENTS DISCHARGE:

a) CASH- 665 b) TPA - 2315 c) PSU-1521	}	4501
--	---	------
4. **DURATION OF STUDY:** 1APRIL 2022 TO 31 MAY 2022
5. **SAMPLING TECHNIQUE:** Convenience sampling
6. **DATA COLLECTION PROCEDURE:** HIS, TAT list, Observation and category wise list collection.
7. **DATA ANALYSIS PLAN-** MS EXCEL, computerized patient records in the his of the hospital.
8. **ETHICAL CONSIDERATIONS:** Data security, privacy, and confidentiality to be maintained.
9. **BASIC CONCEPTUAL FRAME**

Because of the increased competition in today's market and business climate, organizations must closely monitor, assess, and plan to gain a competitive advantage. Organizations must adapt their operations and structure in order to retain customers (patients) and maintain profitability in order to remain competitive, especially when the competitive market is associated with high costs and dissatisfied customers. Similarly, hospitals, as one of the largest service industries, frequently face scenarios in which available resources fail to produce the desired results, resulting in an increase in bed demand that exceeds available capacity. As a result, there will be a negative delay, treatment postponement or cancellation, patient dissatisfaction and loyalty damage, hospital revenue will suffer, and the competitive edge will be lost. The most important way to improve hospital bed availability is to focus on the patient discharging process. A better discharge process is essential for a hospital to ensure patient satisfaction, quality patient care & services, bed availability, and customer loyalty. The discharge process is the last & final step in a patient's treatment process, and if completed on time, the patient will be completely satisfied. A quick discharge process can ensure that patient beds are available early, which can reduce patient admission wait times or possibly reduce the risk of patient rejection due to bed shortages.

CHAPTER 4: DATA ANALYSIS AND RESULTS

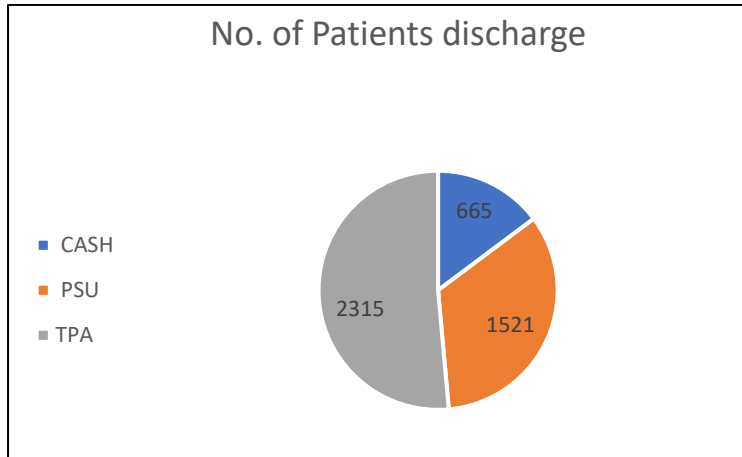


Fig. 4 Graphical representation of total no. of patients discharge in the month of April & May categorized in payee mode.

Above graph show that the No. of patients discharged in the month of April & May and are divided into three categories of mode of payment i.e. a) CASH b) TPA c) PSU.

Total patients discharge in these categories are CASH, TPA & PSU- 655,2315 &1521 respectively.

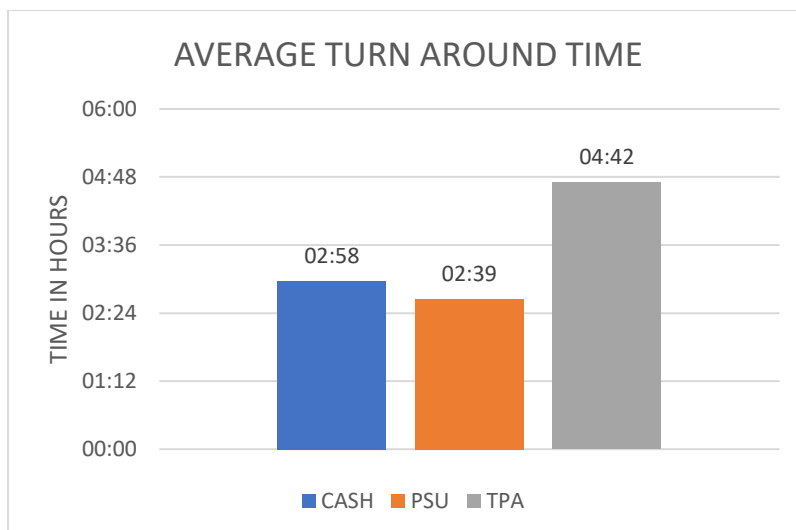


Fig. 5 Graphical representation of Avg. TAT of CASH, TPA & PSU patients.

Above graph shows that each category has different Avg. TAT, as it differs due to mode of payment. Avg. TAT of cash payees -2hr 58min, TPA – 4hr 42 min & PSU- 2hr 39min.

It is observed that TPA patients takes the most time to gets discharge from the system is because the timely company approval is necessary due to the same reason TAT become high.

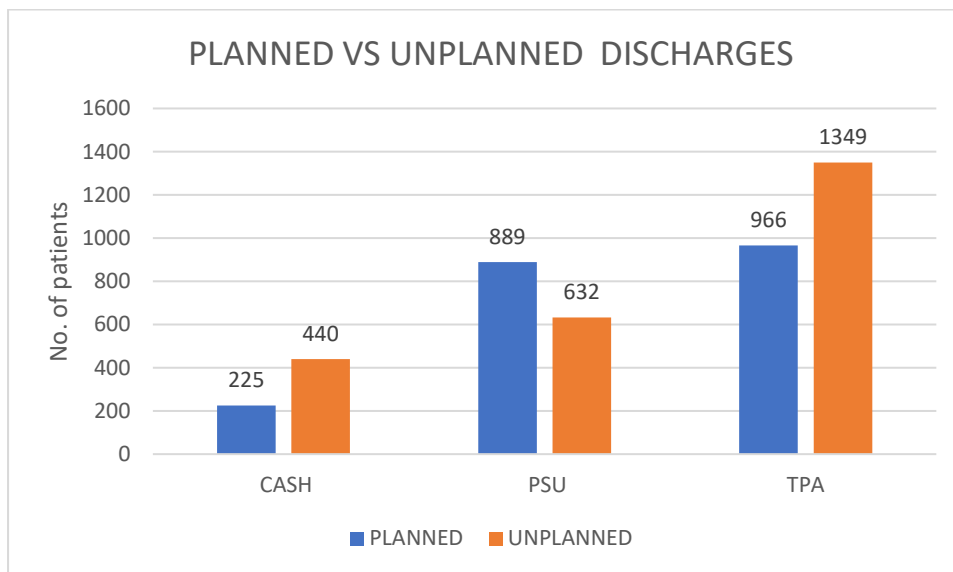
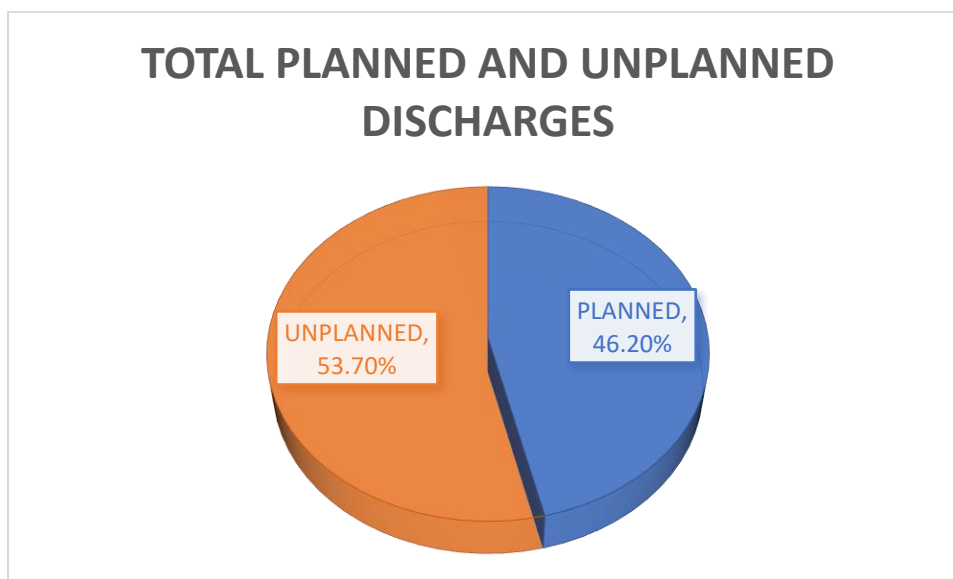


Fig. 6 Graphical representation of Total no. of planned & unplanned discharges in the period to study categorized acc. To the mode of payment.



There are total 4501 discharge out of that 46.2% are planned and 53.7 are unplanned. And from Fig. 9 we can say that unplanned discharge has greater AVG.TAT than planned.

Fig. 7 Graphical representation of total percent of planned and unplanned discharges.

Above graph shows that unplanned discharge are more than 50% due to Avg TAT is affected. Due to which patient satisfaction is difficult to reach the benchmark.

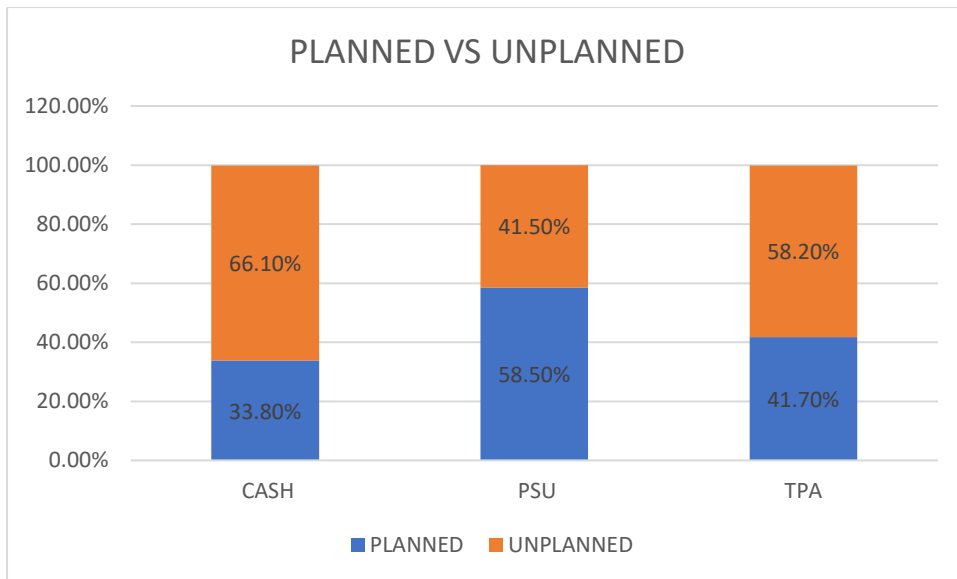


Fig. 8 graphical representation of percent of patient discharged were planned and unplanned in the study period categorized by the mode of payment.

Above graph shows that unplanned discharge of Cash payee is greater in comparison to other payees, reason of this is observed to be financial issues, attendant not satisfied with patient recovery, or the patient wants second opinion. Sometime this leads to LAMA discharges.

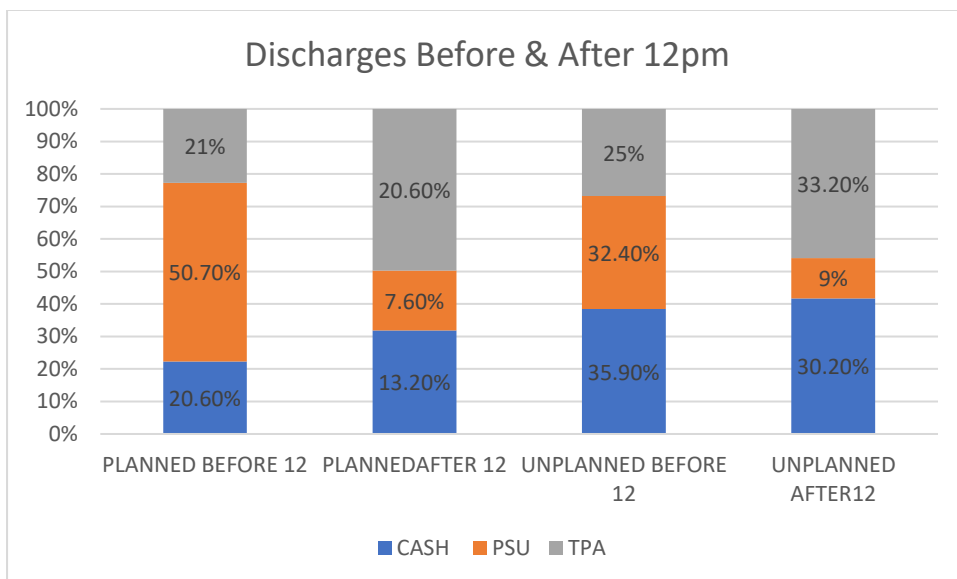


Fig. 9 Graphical representation of percent of discharges before and after 12pm.

Above graph shows the most patient discharged before 12pm is PSU payer in comparison to other payees. The hospital works on discharge the patient before 12pm as the benchmark set for the hospital. However, achieving the same has obstacles like Cash payers arranging the funds, delay in pharmacy clearance, delay in nursing clearance, TPA patient waiting for the approval, denial of TPA approval then patient paying through cash, etc.

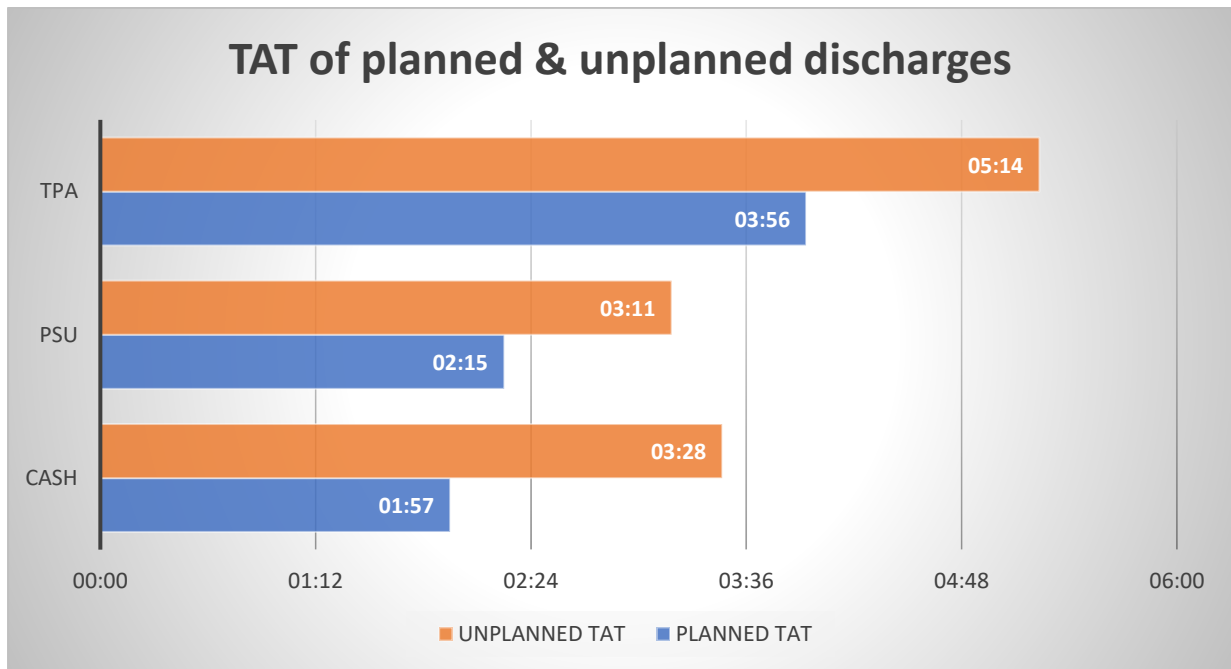


Fig. 10 Graphical representation of Avg. TAT of Planned and Unplanned discharges acc. To mode of payment.

Above graphs shows that unplanned discharge tends to delay in discharge process due to which TAT is higher in comparison to planned discharge. Delay in unplanned discharges can be caused by any various reasons such as delay in finalizing the discharge summary, consultation pending from secondary specialty, delay due to last min investigation, etc.

FISH BONE ANALYSIS (ROOT CAUSE ANALYSIS)

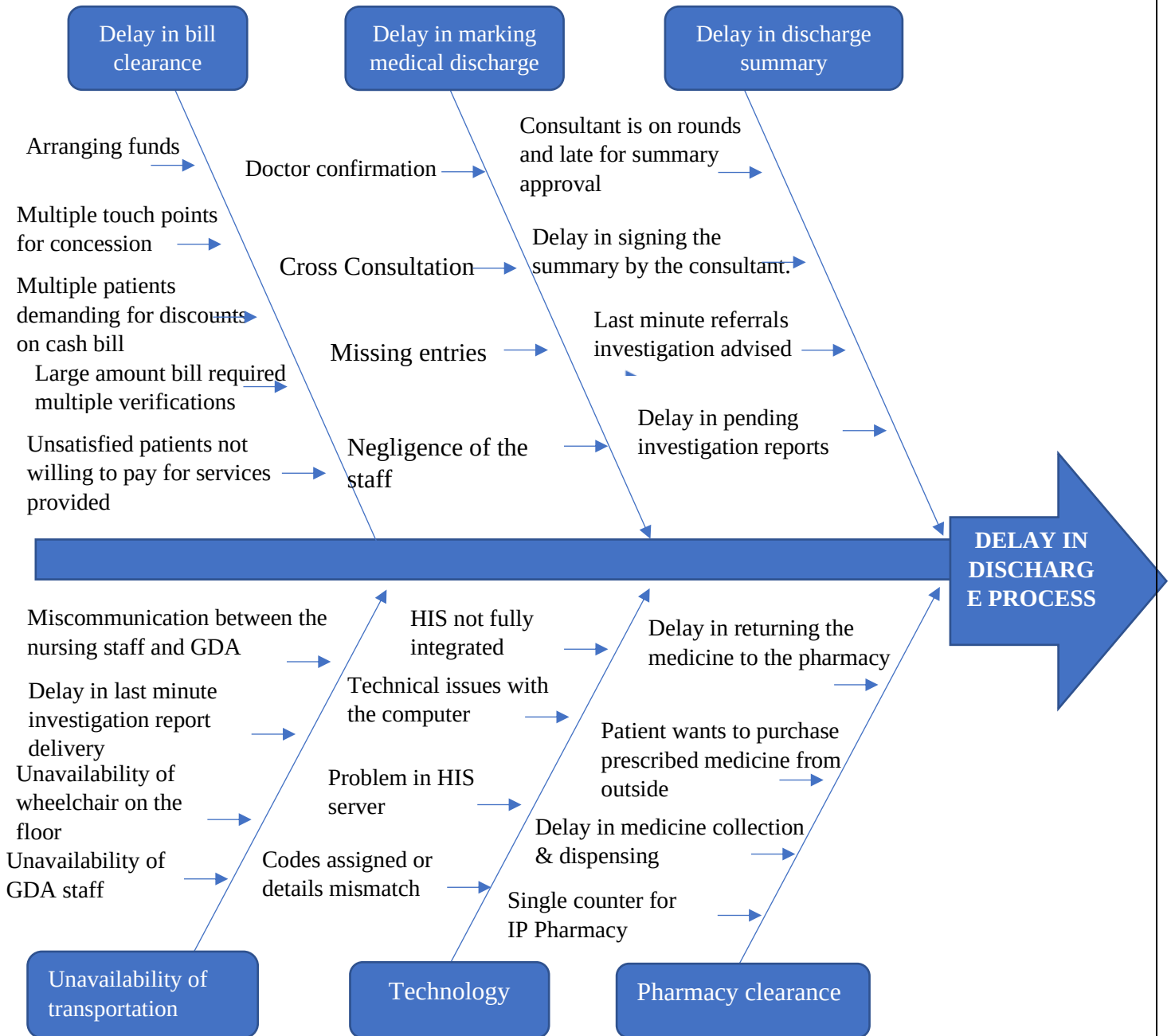


Fig. 11

The fishbone diagram resembles a fish's skeleton. The problem-effect is written in a box on the extreme right of the diagram to build this diagram for a quality of care concern. A central line (spine) is drawn to the left of the box containing the problem. Following the central line are diagonal lines (fish bones) (spine). These diagonal lines represent several groups of causes that creates problem.

During the observation period, the factors depicted in Fig. 11 were discovered and classified into six categories based on the categories typically classified using the Ishikawa diagram method. The Ishikawa cause diagram allowed for the consideration of organizational variables such as standardization and process, communication issues, and workload, all of which can have an impact on discharge TAT.

Chapter-5: RECOMMENDATIONS

For successful discharge planning, administrative personnel, doctors, and nurses must collaborate; performance criteria should be reviewed on a regular basis; and creative ideas should be encouraged.

Based on the findings, it is suggested that for all types of discharges, the turnaround time of the discharge process be reduced and the discharge procedure be made more patient friendly.

- Increase in planned discharges will reduce the impact of factors such as medicine return, nursing delay, pending orders, and missing entries.
- Pending investigation referral cause delays its should be done a day before for planned discharges.
- Timely finalization of discharge summary.
- Checking each patient's IP billing at night and motivating duty doctors to promote before the morning shift, they can contribute to the discharge summary preparation.
- enhancements to the summary
- Financial counselling should be done in the Hospital information system as the option is available .
- The Administrative staff may get the advance payment for admission through an online payment gateway, so that cash limit can be maintained, it would make discharge easier than before.
- Planning of discharges being increased to ensure more plan discharges and avoid unnecessary bulk of unplanned discharge.
- Billing team to prepare bill for the plan discharge patients during night and patient attendant to be informed about outstanding bill.
- On the same day, the nursing team should update order entries.
- Collection of Investigation reports should be done on the same day from respective departments, or the department can send reports to respective floors.
- For planned discharges, Doctors must prepare discharge summaries ahead of time in order to reduce discharge delays.
- To reduce discharge delays, nurses, ward secretaries, pharmacists, billing executives, floor managers, and doctors must be coordinated.
- Staff hired for these departments should be trained in the discharge process and have effective communication skills to interact with patients/relatives.
- As the bill is being prepared, bystanders can be sent reminder messages/emails, and online payments should be encouraged.

CONCLUSION

According to the findings of this study, a greater No. of planned discharges can help reduce total discharge process time and avg. TAT.

As a result, an effort should be made to plan more possible discharges in order to improve the discharge process flow. The major problem that was identified was that no. of unplanned discharges is more than 50%, which leads to delay in the discharge process as it increases Avg. TAT that has been standardized by NABH to be 180mins. It has been noticed that planned discharge of cash patients fall under the standards of the same.

Doctors rounds causes delay in finalizing the discharge summary, a daily basis track is done, recommended the hospital for same.

In conclusion, we have a lot of say over admission and discharge standards, as well as length of stay. There is enormous potential to restructure patient routes and improve patient flow, resulting in significant benefits for bed management and hospital administration.

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