

**Summer Training at
Fortis Memorial Research Institute, Gurgaon
(1st April -31st May 2014)**

- **To Gauge the Reason for Patients Who Leave an Accident and Emergency Department Against Medical Advice.**
- **A Study to Probe in the Reason for Delay in All Type of Patient Discharges.**
- **Training Need Analysis.**

**By
Aditi Yadav**

**Under the guidance of
Dr. Barun Kanjilal**

**MBA- Hospital & Health Management (MBA-HM)
2013-2015**



**The IIHMR University, Jaipur
2014**

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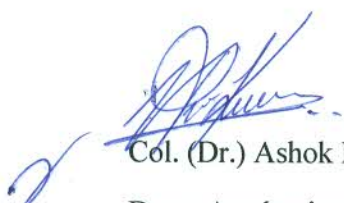
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CERTIFICATE

This is to certify that Dr. Aditi Yadav has undergone her summer training in **Fortis Memorial Research Institute, Gurgaon** from 01th April to 31st May, 2014. The candidate herself carried out all the studies related to her summer training. Her approach to the study has been scientific and analytical. This summer training is in the partial fulfilment of the course requirement recommended for awarding the POST GRADUATE DIPLOMA IN HEALTH AND HOSPITAL ADMINISTRATION. MANAGEMENT

I wish her success in all her future endeavours.


Col. (Dr.) Ashok Kaushik

Dean, Academics and Student Affairs

IIHMR University

Jaipur


Dr. Barun Kanjilal

Professor

IIHMR University

Jaipur

Certificate of Approval

This is to hereby acknowledge the efforts of **Dr. Aditi Yadav**, IIMR, Jaipur during her internship on the following project title. **“A Study to probe in the reason for delay in all type of patient discharges in FMRI”** This is approved as certified study in management, carried out and presented in a manner satisfactory. It is understood by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the Summer Training Project report only for the purpose it is submitted.

Signature of mentor


Ms. Shikha Rampal
Sr. Manager, GRO
Fortis Memorial Research Institute, Gurgaon

May 31, 2014

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Ms. Aditi Yadav** has undergone an internship in **Training**, commencing from **April 1, 2014 to May 31, 2014**.

During her training, Aditi exhibited a high level of professionalism and a tremendous zest for learning.

We wish Aditi all the best in her future endeavors.

With Best Wishes,


Umesh Gupta
Head-Human Resources

Certificate of Approval

This is to hereby acknowledge the efforts of **Dr. Aditi Yadav**, IIHMR, Jaipur during her internship on the following project title **"To gauge the reason for patients who leave an Accident & Emergency department against medical advice"**. This is approved as certified study in management, carried out and presented in a manner satisfactory. It is understood by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the Summer Training Project report only for the purpose it is submitted.

Signature of mentor


Dr. Subrata Gorai
SBU Head, Emergency department
Fortis Memorial Research Institute, Gurgaon



Certificate of Approval

This is to hereby acknowledge the efforts of **Dr. Aditi Yadav**, IIHMR, Jaipur during her internship on the following project title. **“Training Need Analysis”** This is approved as certified study in management, carried out and presented in a manner satisfactory. It is understood by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the Summer Training Project report only for the purpose it is submitted.

Signature of mentor



Ms. Raakhee Mahi
Sr. Manager, Training Human Resources
Fortis Memorial Research Institute, Gurgaon

ACKNOWLEDGEMENT

The successful completion of any given task requires a lot of hard work and sincere efforts. Hard work and efforts are only the building blocks of an assignment, but the plinth has to be inspiration, suggestion, support and guidance.

Experience in a hospital environment is an important part of my course and this I have achieved from one of the esteemed health care organization, Fortis Memorial Research Institute, Gurgaon. These two months of training has added a valuable and knowledgeable exposure in the development of my career and achievement of my objectives, for which I am highly grateful to the organization

Any attempt at any level cannot be a success without the support and direction of learned people. A heartfelt gratitude to Dr. Dilpreet Brar (Regional director,) for giving me the golden opportunity to work with the India's leading health care provider.

My heartfelt gratitude to Mr. Umesh Gupta (Head HR) for showing keen interest in my training, helping me to plan our agenda and guide me despite his busy schedule.

Foremost, I would like to thank **Ms. Rakhee Mahi**, Senior Manager Training, FMRI, Gurgaon, who was kind enough to spare her valuable time and provided several important suggestions at every stage of my study. Her impeccable suggestions have added loads of value to my knowledge base.

I would like to express my immense gratitude to Mr. Jitender Yadav (Head Sales), Ms. Shikha Rampal(Head GRO), Dr Subrata Gorai (SBU Head ED) for providing support and guidance not only for the project in the hospital, but for broadening my horizon and making me learn various other aspects of hospital functioning, which will definitely help me a lot in my career. And yes, and for directing my goals and objectives towards the attitude that derives to achieve and other aspects that one needs to be acquainted with. My learning here in two months is all because of their help. Sincere thanks to all the staff at all levels for helping me at each and every step of my work.

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ACRONYMS/ ABBREVIATIONS

- FMRI – Fortis memorial research institute
- ED – Emergency department
- CSSD- Central Sterile Services Department
- CT- Computerized Topography
- CTVS- Cardio Thoracic Vascular Surgery
- ECG- Electrocardiogram
- ED- Emergency Department
- FMS- Facility Management and safety
- F&B- Food & Beverages
- HAZMAT- Hazardous Material
- HR- Human Resource
- ICU- Intensive Care Unit
- IPD- In-patient Department
- IT- Information Technology
- MICU- Medical Intensive Care Unit
- OPD- Out-patient Department
- OT- Operation Theatre
- DICOM-Digital Imaging and communication in medicines
- RFID- Radio Frequency Identification
- CPOE- Computerized physician order entry
- EMR- Electronic Medical Record
- PHC-Preventive Health Checkup
- FOS- Fortis operating sytem

Introduction

Summer Training is an integral part of the Post Graduation Diploma in Hospital Management (PGDHM).

The main purpose of this summer training is to get an orientation towards the layout, operations and workflow of the hospital, in order to understand the processes and systems in the hospital.

After completing the first academic year of PGDHM, the students are supposed to undergo a two months training in a hospital, as a part of the curriculum.

Indeed I have got the golden opportunity to work in Asia's leading Healthcare provider, Fortis Group of Hospitals.

I joined Fortis Memorial Research Institute, Gurgaon, from 1st April 2014 for summer internship. The duration for the summer training is of 2 months i.e. 1st April to 31st May 2014

AIM:

To have an overall orientation / induction of the hospital setting.

Objectives:

1. To get an overview and develop understanding of the hospital's functioning.
2. To gather knowledge about the process flows of major clinical and non clinical departments in a hospital.
3. To help the management study and address some issues/problems associated with some specific operational area/department.

SECTION-A

“Hospital Orientation

&

Departmental Study”

1.1 The Fortis Logo:

LOGO

“A HEALING PASSION”



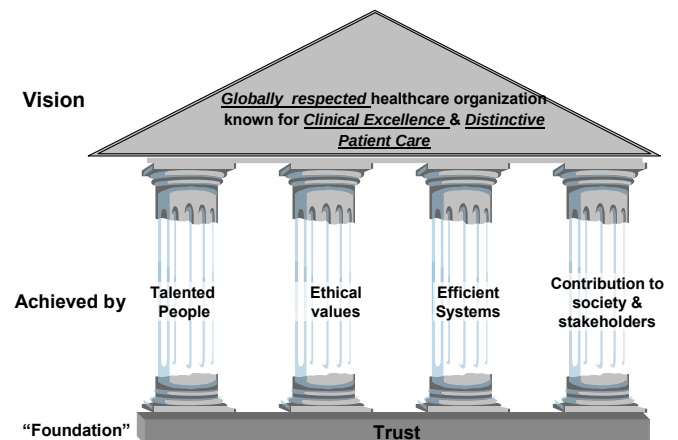
The Fortis Healthcare Limited Logo defines the commitment to patient care. The logo reflects their endeavour to achieve excellence in healthcare delivery system by bringing together the best of technology, medical expertise, and patient care. The logo also implies the human values that govern every facet of our organization.

The 2 nurturing hands along with a red dot on the top depicts- “nurturing hands caring for human life”

GREEN is a color of healing and depicts WELLBEING and **RED** is symbolic of steadfast focus, dynamic zeal and enthusiasm

Mission:

- To become an Integrated Healthcare delivering organization guided by quality, excellence, technology and compassionate patient care.



Vision:

Globally Respected Health care organization recognized for Clinical Excellence and Distinctive Patient Care.

Values:

They serve as a guideline for the routine conduct of each Fortisian. The core values of Fortis Healthcare are:

Patient Centricity	• Commit to 'best outcomes and experience' for our patients. • Treat patients and their caregivers with compassion, care and understanding. • Our patients' needs will come first
Integrity	• Be principled, open and honest. • Model and live our 'Values'. • Demonstrate moral courage to speak up and do the right things.
Teamwork	• Proactively support each other and operate as one team. • Respect and value people at all levels with different opinions, experiences and backgrounds. • Put organization needs' before department / self-interest.
Ownership	• Be responsible and take pride in our actions. • Take initiative and go beyond the call of duty. • Deliver commitment and agreement made.
Innovation	• Continuously improve and innovate to exceed expectations. • Adopt a 'can-do' attitude. • Challenge ourselves to do things differently.

INFRASTRUCTURE:

I) Basement consist of :

Engineering and Biomedical department

Contractual Staff Dining

Materials and Purchase department

PTS blower room

Stores : Pharmacy, Kitchen & General store

Radiation Oncology : ELEKTA's 2 Linear Accelerators with navigation system.

Synergy and Axesse.

First collaboration between Brain lab & Electa in radiation oncology department

MRD

Mortuary

Nursing training room

Parking for staff and visitors

II) Lower ground floor consist of:

Radiology with:-

- Asia's first Ingina's 3 Tesla MRI
- 256 Slice iCT scan with Skylight

NIC

Nuclear medicine with PET-CT & Gamma camera

Emergency

CSSD

In house Laundry

SRL's Open Laboratory

Swimming Pool & Sauna and steam

Fortis TotipotentRx

60 OPD's for Oncology, Paediatrics, Orthopaedics, Neurology and other medical and Surgical OPD's

Staff entry, Fire control room, mamamia

III) Upper ground floor consist of:

Spa, salon & Fitness centre

“Health 4 u” Preventive health Check

Retail Therapy-Titan Eye plus, Altitude Store and Fila,

Chicco, Bouncing Babies, Religare Wellness Pharmacy & Being

Human, Mom & Me

Tummy Luck-Subway, Haldiram’s, Baskin Robbins and Whole Foods,

Joost Food Ventures.

Fortiplex- 36 seater Mini Theatre.

VIP lounge

Mother and Child, breast clinic and IVF

Kitchen

Administrative offices

Clinical Infrastructure:

Operation Theatres 12

Cath Labs 2

LINAC 2

LDR 4

Delivery Rooms 2

Endoscopy Suites 3

Nightingale ward 40

Double Bed Rooms 88

Single Bed Rooms 47

Deluxe Rooms 8

Suites 4

Signature Apartment 1

NICU & Nursery 18

Dialysis 11

Chemotherapy 10

Pre & Post Cath 12

ER Beds 14

Labour beds 3

Pre-OP 6

Pre post Endo 5

ICU beds 98

Operating Rooms 12

Operating Beds (Internal

Info Only)288

Maharaja Suite 1

First, Second and Third Floor consist of:

4 Labour Delivery Rooms

Meditorium- A 111 seat auditorium

40- Bedded Nightingale ward

High Dependency Unit (HDU) with 9 beds

11 bedded Dialysis Unit

10 bedded Chemotherapy Unit

In-house blood bank

Pathology Lab

Rest and Relaxation (R &R) Lounge, with 76 recliners and 31 cubicles

13 bedded Neonatal ICU with a 5 bedded Well Baby Nursery

Intensive Care Unit: 8 ICUs with Philips' IntelliVue

Clinical Information Portfolio (ICIP) Operation Theatre: 10 Modular Operating Rooms

Catheterization Laboratory, Single Plane and Neuro cath lab (12

bedded, Pre/Post Cath) Six Transplant units. Three Endoscopy Suites , (5 bedded Pre/post

endo) 98 Beds in ICU's (Excluding Cath lab and endoscopy suites) 23 Single Beds on 3rd

Floor and 24 Single Beds on 4th

Floor, 44 Double Beds on 3rd Floor and 44 Double Beds on 4th

Floor, Nuclear Medicine Therapy room on 3rd floor

Discharge Area on each floor

Patient Attendant waiting Lounge on each floor

Three wings T1, T2 and T3

One Central Nursing Station on each Floor.

Cutting Edge Specialities are:- Organ Transplant, Robotic Surgery, Stem Cell Therapy

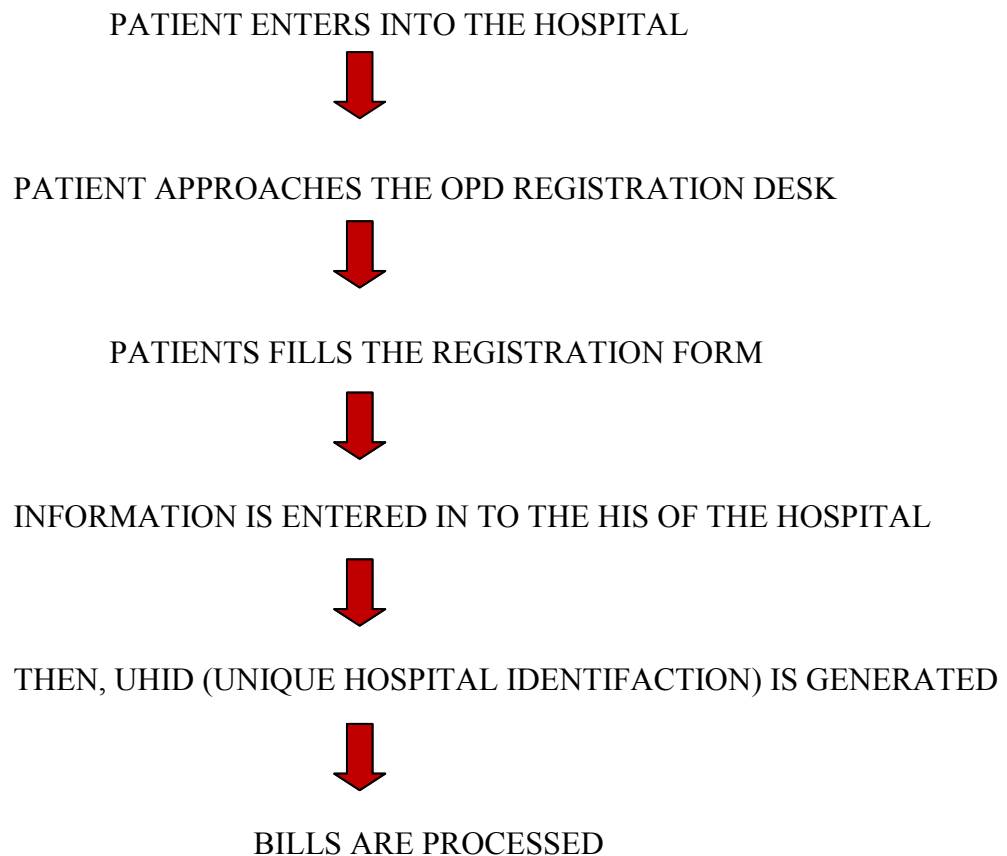
DEPARTMENTAL PROFILE-

OPD

Functions:

Reception/Information
Appointment
Registration-OPD, Diagnosis
Billing-OPD, Diagnostics, Emergency
Report/Document delivery
Customer Feedback

REGISTRATION PROCESS OF OPD



Human Resource Department:

Functions:

Development of HR policies and strategies

Manpower Planning

Recruitment and Selection

Employee Training

Salary Determination

Performance Appraisal

Personnel Data entry and record maintenance

Consultation and Advisory services to management and employees

Grievance Handling

Medical Records Department

Functions: Proper storage and maintenance of medical records. Maintenance of integrity and confidentiality of medical records. Submission of required data to government. Classify the medical files as per ICD-10. Obtaining missing patient files

IT Department

Functions: Maintenance of all the software's in the hospital. Modifications of the software are as per the requirements of the department. It covers the following modules:

IPD Billing

OPD Billing

Administration

House keeping

Ward/Nursing

Diet

Visitor's pass

Stores

Purchase

Laboratory Information System

Radiology Information System

DEPARTMENTS STUDIED IN DETAIL:

1. ACCIDENT AND EMERGENCY DEPARTMENT (ED)

The emergency department in a hospital plays a very important role for all people who are in acute need of immediate care like chest pain, stroke, accident cases, trauma cases etc. The ED at FMRI is 6 bedded along with 8 beds in the Observation room. Also, there is a procedure room to conduct simple surgical procedure.

ED has separate entry, far away from the general entry and is quite spacious in order to allow free movement of stretchers/trolleys from the ambulance to the Emergency room.

While bringing in the patient from the ambulance, TRIAGE is done beforehand by the staff nurse at the ER reception and so patients are placed according to the triage beds-

THE TRIAGE pattern followed here is-

- 1 red bed for category 1 patients i.e. critically ill
- 2 yellow beds for category 2 patients who need to be admitted
- Remaining category 3 patients are kept in observation room

There are centralized ambulance system in the Accident and Emergency department, the movement of which depends on the central emergency call centre at Fortis memorial research institute. The Fortis group of hospital in Delhi and NCR has a centralized ambulance call centre at Fortis Escorts, Okhla (105010) where all the calls for requirement of ambulance are received and depending on the location of the case, the nearby Fortis branch is contacted, a case id is given and then the ambulance is sent the required location. Even ambulance is dispatched from FMRI on direct call to emergency. A Crash Cart is available in the emergency which provides a one place storage of all emergency medications required which saves the precious time during treatment. A Code blue team is designated which consist of 2 teams

- a) Critical care Team
- b) Emergency Team
- c) Cardiology Team
- d) Anesthetist Team

ACCESSIBILITY WITH OTHER DEPARTMENTS-

The ER is located on the ground floor, making it quite accessible to the other departments. The diagnostic department is right next to the emergency department but the ICU and OT's are at the second floor and it takes 4-6 minutes to reach there.

Moreover, there is a direct inter- communication system between emergency department and other services like blood bank, lab, diagnostic, ICU etc. It is all linked thorough HIS and Intercom service.

The Staff in the emergency department is as:

- a) Nurses
- b) Doctors
- c) CMO
- d) Paramedical Staff
- e) Ground staff – GDA/ Housekeeping

Generally the patient to nurse ratio is 1:1, but team work approach is always followed whenever the emergency patient arrives.

The emergency department have the following equipments per bed':

Defibrillator, Suction machine, ECG, Cardiac Monitor, Oxymetry, Ventilator, Syringe pump
(for the accuracy of dosage)

2. BLOOD BANK:

Blood is a most important part of the human body. Around 5.5 liters is present in a person. It carries all the nutrients, oxygen and metabolites throughout the body, but sometimes a life may be at stake due to blood loss.

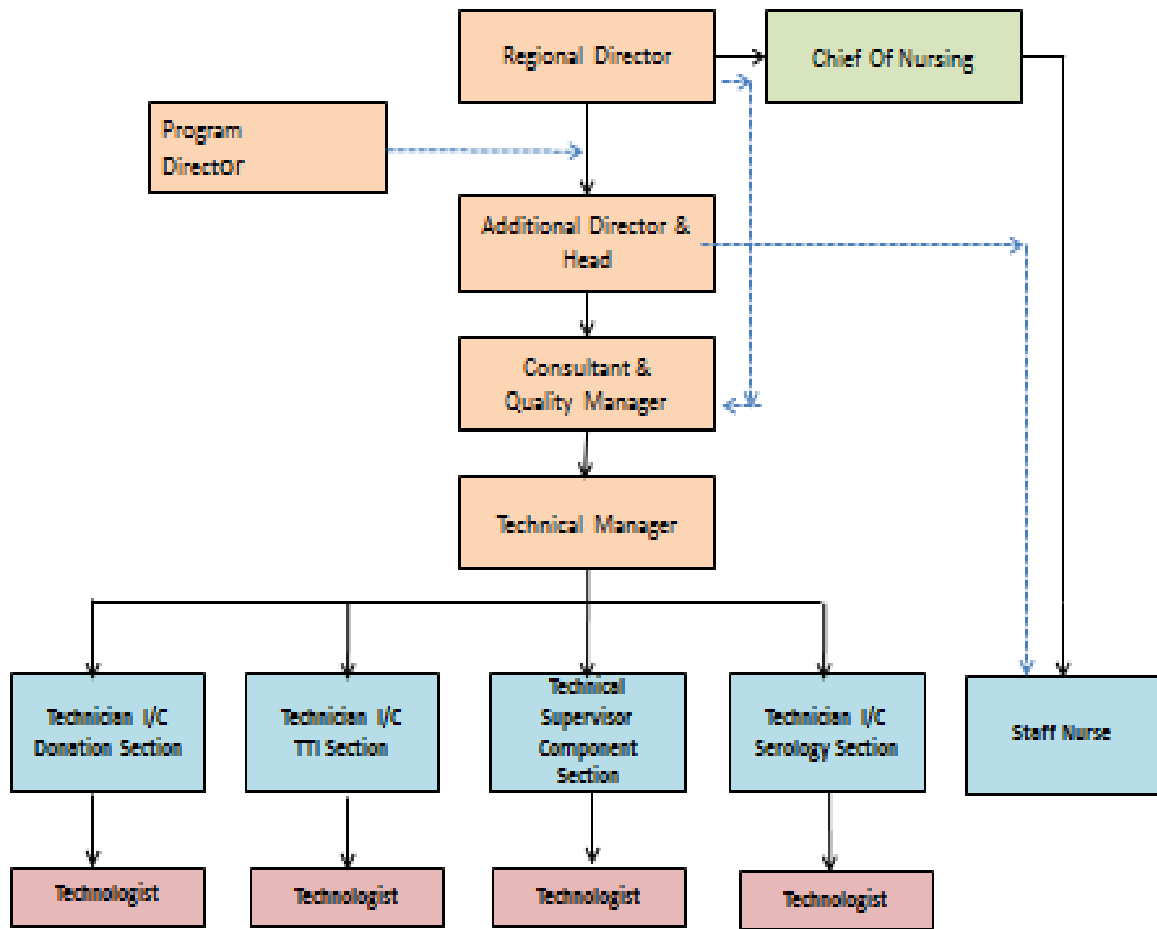
A **blood bank** is a bank of blood or blood components, gathered as a result of blood donation or collection, stored and preserved for later use in blood transfusion. The term "blood bank" typically refers to a division of a hospital where the storage of blood product occurs and where proper testing is performed (to reduce the risk of transfusion related adverse

events). However, it sometimes refers to a collection center, and indeed some hospitals also perform collection.

LICENSE: Blood bank of FMRI, Gurgaon is located on first floor. It is only department of the hospital which is NABH and NACO (National AIDS control organization) accredited, and was able to get the accreditation within **six months** of the functioning of the hospital. The blood bank has a valid license from Central Drugs Standard Control Organization (CDSCO) and approved by Drug Controller General (India), central license approving authority under Drug and Cosmetic Rules-1945 with further amendments.

The Blood bank is run by the Fortis Memorial Research Institute (A Fortis Group Hospital) in order to provide blood and blood Components to its patients and is licensed by the Drug Controller of India

Organogram for Transfusion Medicine Department



The blood bank area is of 181sqm & has separate rooms each for:-

- Registration and medical examination room (Air conditioned) - These are well lit rooms, fully furnished with adequate number of chairs and examination table.
- Donor motivation and counseling area (Air conditioned) with a counselor.
- Blood donation area is a well lit and air conditioned room having three fully motorized donor couches and having computerized bar coding system for donor data entry.
- Refreshment room (Air-conditioned).

- e) Component Preparation Room – Air conditioned room with maintained temperature of 20-25°C and humidity below 60% and having Quarantine refrigerator for untested blood.
- f) Lab for TTI markers is well lit air conditioned room having maintained temperature and humidity.
- g) Lab for blood group serology is air conditioned and having marked area for grouping and cross matching, antibody detection.
- h) Specified area for sterilization and washing.
- i) Store & Records room.

3. LABORATORY

The Laboratory here at Fortis Hospital is outsourced to SRL Lab and all the routine investigations are carried out here only. The staff strength is 30-40 with 3 people working during night. The samples are received from both OPD & IPD patients and a prescription is not always required to get a test done unless the history of the patient has to be traced back. This sample is received in boxes from respective OPD & IPD department and the housekeeping staff carries the same. Also, for emergency investigations, a red seal is marked on the sample as well as on the prescription of the patient so as to give it a priority. Also, all the equipment's in the lab are automated i.e. they are linked to computers and so all the test results are automatically transferred in the computer and a report is generated. The laboratory has a **Laboratory investigation system (LIS)**. This LIS is connected to the HIS of the hospital in which all the information like- patients name, IPID or UHID, test to be done and the reports is stored. Once the report is generated, it is reviewed by the authorized person and then only it is made available in the LIS or send to the patient. Moreover, there is no telephonic communication of reports results, only during urgent or emergency cases report is spelled out and that too twice to ensure proper communication Quality check and the calibration of the equipment's is carried out twice in a day for quality assurance. Also, to maintain employee safety i.e. prevent occupational hazard, when an infected sample or any chemical bottle breaks in the laboratory, HAZMAT (Hazardous Material) team is called and immediately the spillage is cleaned up.

List of equipment's used in the laboratory are-

Biochemical analyzer, Cell counter, Urine routine analyzer, Immuno assay analyzer, Centrifuge, Microscan, Bactec, Tissue processor, Microtone Balance Glycosylated hemoglobin analyzer (D 10), Sample mixer, Microscopes, Pipettes

4. CSSD

CSSD stands for Central Sterile Supply Department. It is the department that is solely responsible for sterilization of all the instruments used all over the hospital.

CSSD has 3 zones:

- a) Dirty/Receiving Area
- b) Clean Area
- c) Sterile Area

a) In Dirty Area all used instruments from IPD & OPD are received after they are washed and. This movement takes place manually, while it is received through a dumb waiter from the OT. Here, an **ultrasound cleaner** is located. This is a fully automatic machine in which the used instruments are dipped in a solution and are sterilized under 40 degrees Celsius for 10-15 minutes. This machine produces vibrations which sterilize the instruments. After the above procedure is over, the sterilized instruments are washed under running water. After this the instruments are dipped in Preserve solution for 10-15 minutes.

b) In Clean Area, the sterile instruments are kept packed in a double wrapped green colour cloth

c) In Sterile Area there is 1 autoclave machines that is used to sterilize the used instrument. It is a double door machine. Through one door the unsterile instrument is loaded and through the other door the instrument is de-loaded after the procedure is over.

- 2 temperature are set in this machine according to the instruments to be sterilized:-

- i. 120 degree Celsius -Under this temperature 20 min is the sterilizing time, 15 min is the dry time and 3 minutes is the pulsing time(Pulsing is an procedure by which the air present in the machine is moved out and steam is moved in)
- ii. 134 degree Celsius - Under this temperature, 7 minute is the sterilization time, 3 minute is the pulsing time and 10 minute is the dry time.

After the sterilization process is over, the sterilized instruments are packed and Batch Monitoring Labelling is done through a labelling gun .This labelling consist of:-

- ✓ Expiry Date
- ✓ Packaging Date
- ✓ Machine No.
- ✓ Loading No.
- ✓ Sterilization Date

5. ICU (INTENSIVE CARE UNIT)

ICU is located at the second floor of the IPD building making it accessible to all the outside services like lab, diagnostics, OT's etc.

There are 7 Different types of ICU's in the hospital which are as follows:-

- Neurology, orthopedic, polytrauma
- Cardiology & Transplant
- CTVS
- Medical ICU
- Bone Marrow Transplant
- Pediatrics ICU
- NICU

The nursing station is centrally located in the ICU and the nurse to patient ratio in ICU is 1:1.

Also, here at FHN, Barrier nursing is practiced in ICU's so as to minimize the risk of Hospital Acquired Infection (HAI).

Equipments used in ICU-a) Ventilator b) IABP (Intra Aortic Balloon Pump) c) Suction d) ICD (Inter Costal Drainage System) e) Portable Ultrasound-ray (when needed). f) DVT (Deep Vein Thrombosis) Pump g) Bi-pap to give oxygen to patient. There are 98 beds (52 ventilated) cubicals. There are 6 isolation beds

Quality Indicators are:

- CRBSI
- VAP
- SSI
- Returned to ICU within 48 hrs
- Needle Stick Injury

6. OPERATION THEATRES-

The operation theatres are located on the 2nd floor of the OPD building having a direct connectivity with ICU (2nd floor of IPD building) so that patient is easily & quickly shifted to and from the ICU.

At FHN, there are 8 OT's-

- 1) OT 1- Orthopedics & Liver Transplant OT
- 2) OT 2 & OT 3- Neurosurgery OT
- 3) OT 4- Major & General (All cleaned & planned cases are dealt)
- 4) OT 5 -Cardiac & Transplant
- 5) OT 6- Planned, cleaned & emergency cases
- 6) OT 7 -MIS(Infected, Minor, Day-care & Emergency cases)
- 7) OT 8 -Minor Surgeries

ZONING- Zoning is basically dividing the OT area according to the hygiene maintained in different zones. Here we observed 3 different zones-

- a) DIRTY ZONE i.e. outside corridor, changing rooms.
- b) CLEAN ZONE i.e. supply store, scrub area, pre-op room.
- c) ASEPTIC ZONE i.e. operation theatre, sterile preparation.

This zoning is very essential in OT's as it helps to prevent infection.

INFECTION CONTROL IN OT's-

OT being such a sensitive area of a hospital, proper infection control mechanisms need to be followed in there. So, for the same, after every surgery they mop & clean the OT with 0.4 % Virex 256 & for Fogging of OT they use 1% Virex For infected cases they use 2% Virex.

Also, to maintain proper hand hygiene, there are 3 Scrubbing Stations-

- 1) Scrubbing Station 1 is in between OT 6 & 7
- 2) Scrubbing Station 2 is in between OT 4 & 5
- 3) Scrubbing Station 3 between OT 1 & 2

For hand washing and scrubbing, Micro shield & Betadiene Scrub is used. For sterilization of instruments, CSSD (central sterile supply department) is there where all the instruments are properly sterilized and send back to the OT. To make this process more effective, a **DUMB WAITER** is used. DUMB WAITER is a lift which directly connects CSSD with the OT.

The used instruments are first cleaned in Instrument Processing Room at OT.

It is then packed in a double wrapped green cloth. This pack is placed on the dumb waiter in dirty area of OT. It is received in the dumb waiter in dirty area of CSSD

It is sterilized, packed in the CSSD and a biological indicator is placed in the pack.

It is then send from the dumb waiter in sterile area of CSSD. It is received in the dumb waiter in sterile area in OT

Moreover, for equipments required during emergency in OT, an Autoclave and Ultrasound machine is there, wherein the instruments are sterilized and used. The surgeries are generally conducted from 08:00 AM to 08:00 PM, but in case of emergency, surgery can be conducted anytime. Also, the time duration for a patient to be kept in pre-op room is half an hour and is one hour for post-op room. This is as per the FOS, but it may vary with the severity of the case.

7. RADIOLOGY

- Asia's first Ingina's 3 Tesla MRI
- 256 Slice iCT scan with Skylight

5 ULTRASOUND MACHINES:

3 Ultrasound Machines on upper ground floor, 1 Ultrasound machine in health for u, 1 Ultrasound machine in gynecology department , 3 X-RAY Machines (Phillips, semens) ,3 Portable x-ray machines, 1 CT SCAN(256 Slides) ICT Phillips, 1 MRI Machine with different themes like beach, night etc (Phillips, 3 tesla) ,1 CRI , 1 MAMMOGRAPHY , 1 Bone Densometry, 3 Printers (AGFA), 1 Technologist room, 1 Reporting room , X-Ray console room (DR AND CR System), 1 Patient Lounge ,1 HOD room, 1 Fluoroscopy room,2 Changing room

MANPOWER:

1 Chief technician, 1 Supervisor, 17 Technician

SECTION B

PROJECT I

**To Gauge the reason for patients who leave an accident and emergency department
against**

INTRODUCTION

Patients leaving an Accident & Emergency Department against medical advice are often considered a high-risk group.

Although common hospital practice for an LAMA discharge involves the patient being asked to sign a form stating that he or she is aware that they are leaving the facility LAMA, the hospital is generally not legally required to use it. Rather, the legal and ethical requirement is that the authorized health care professional has an informed consent discussion with the patient regarding his/her choice to leave the hospital before it has been recommended. This discussion which includes disclosure of the risks, benefits, and alternatives to hospitalization, as well as the patient's understanding, should be documented in the patient's chart. . Clinical practice of designating a discharge as LAMA, doesn't follow professional standards, lacks evidence of its utility to improve patient care, and may harm patients by reducing their likelihood of following up. Finally, there is widespread ethical consensus that even when patients decline recommended treatment, health care professionals still have a duty to care for and support patients.

Emergency Department of Fortis Memorial Research Institute

2. EMERGENCY DEPARTMENT-

The emergency department in a hospital plays a very important role for all people who are in acute need of immediate care like chest pain, stroke, accident cases, trauma cases etc.

The ER at FMRI is 6 bedded along with 8 beds in the Observation room. Also, there is a procedure room to conduct simple surgical procedure.

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A Crash Cart is available in the emergency which provides a one place storage of all emergency medications required which saves the precious time during treatment.

A Code blue team is designated which consist of 4 teams

- e) Critical care Team
- f) Emergency Team
- g) Cardiology Team
- h) Anesthetist Team

The dial code for individual disaster is 55 and as soon as the information is reached to the code blue team, the team reaches the required place in less than 5 mins with “Emergency life saving kit”.

ACCESSIBILITY WITH OTHER DEPARTMENTS-

The ER is located on the ground floor, making it quite accessible to the other departments. The diagnostic department is right next to the emergency department but the ICU and OT's are at the second floor and it takes 4-6 minutes to reach there.

Moreover, there is a direct inter- communication system between emergency department and other services like blood bank, lab, diagnostic, ICU etc. It is all linked thorough HIS and Intercom service.

The Staff in the emergency department is as:

- f) Nurses
- g) Doctors
- h) CMO
- i) Paramedical Staff
- j) Ground staff – GDA/ Housekeeping

Generally the patient to nurse ratio is 1:1, but team work approach is always followed whenever the emergency patient arrives.

The emergency department have the following equipments per bed':

- Defibrillator
- Suction machine
- ECG
- Cardiac Monitor
- Oxymetry
- Ventilator
- Syringe pump (for the accuracy of dosage)

RATIONALE

FMRI has a emergency department with a monthly patient admitted is 226 with number of LAMA cases 28 in month of april' 14. It has been observed that in few months no. of LAMA cases has increased in comparison to no. of patient admitted. This study aims for finding out the reasons in increase in no. of LAMA cases and to make recommendations for it.

AIM- To analyze the reason for increase in LAMA cases comparatively to last month and to make recommendations for reducing their number .

OBJECTIVES :

- (1)To analyze the current situation of LAMA cases for the month of in comparison to the last one.
- (1) To Determine the patient's reasons for leaving AMA, and
- (2) To give the recommendations

Review of literature

Patients in a private hospital in India leave the emergency department against medical advice for financial reasons

Sassan Naderi¹, John R Acerra^{12*}, Kathryn Bailey¹, Pinaki Mukherji¹, Taraknath Taraphdar³, Tirtha Mukherjee³, Abin Pal³, Mary Frances Ward¹, Kathryn Miele¹, Maxwell Mathias¹, Richard Tan¹, Myriam Kline¹, Kumar Alagappan¹ and Robert Silverman¹

With nearly 1.2 billion people, India is one of the most populous countries in the world [1]. India's rapidly growing economy has expanded its role in the global marketplace, although the development of its health system appears to be lagging behind its economic development [1]. The total expenditure on health per capita is \$132 in a country where the gross national income per capita is only \$2,930 [2]. According to the World Health Organization (WHO), newly emerging non-communicable diseases associated with an improving standard of living are adding further strain to the health system, along with the persistence of communicable diseases [2-4]. In addition, there is wide variability in the wealth distribution, demographics, and politics, which also influences access to health care [5].

The Indian health care system is a complex integration of the national public health system, private hospitals, and alternative medicine practitioners [3,4]. Approximately 70-80% of health spending nationwide is from individual out-of-pocket payments [5,6]. The public health care system is free for people below the poverty line, yet despite the demands on this system, it lacks resources and accountability [3]. India's public health system constitutes only 1% of its total gross domestic product, placing it below most low-income countries and in the bottom 20% of all countries [6]. Because the public health system is perceived to be poorly equipped to provide quality care, the majority of Indians seek health care in the private system and pay out-of-pocket [3,5].

As outlined in Article 21 of the Constitution of India, the State is obliged to safeguard the right to life of every person, and the judicial system mandates the delivery of timely medical treatment by all hospitals regardless of a patient's ability to pay or their medico-legal status [7-9]. This mandate is similar to the Emergency Medical Treatment and Labor Act in the US, which protects patients from being turned away from hospitals because of their inability to pay for care [10]. However, considering the cost of care at private hospitals and the limited availability of free care for the poor in the public system, it is not clear whether patients emergently presenting to a private facility are able to obtain acute care or whether they leave an acute care facility without treatment because of economic constraints. Often, patients presenting to a private emergency department have initial cardiac and respiratory stabilization performed, but further management cannot continue if patients are unable to pay for services.

Leaving the emergency department without treatment or against medical advice (AMA) is associated with poor outcomes, including an increased risk for mortality and readmission [11,12]. Among wealthier nations, there is a wide range of reasons that patients sign out AMA, while in a limited number of studies from poorer nations financial constraints are the more common cause. In two Nigerian hospitals, research found that 29-33% of patients leaving AMA left for financial reasons [13,14]. No studies to date have assessed the reasons why patients in India leave the ED AMA. Based on limited data from other developing countries and the infrastructure of the Indian health care system, we hypothesize that financial constraints will be an important reason for refusing emergent care in a private hospital in India.

Methods

This was a prospective ED-based cross-sectional study of patients leaving AMA and was conducted at a private hospital with approximately 10,000 ED visits per year in eastern India. At the study site, most patients visiting the hospital have some form of private health insurance that covers the cost of admissions in the wards and intensive care unit but does not cover the cost of ED care. An anonymous, 13-item survey, available in English and the predominant local language, was given to a convenience sample of patients who left the ED AMA from 1 October 2010 to 31 December 2010. The survey included patient diagnosis as

well as demographic information such as patient religion, age, gender, and occupation. It also included questions concerning leaving AMA, some of which are summarized in Table 1. Potential subjects were excluded if they were unable to communicate in the language of the survey (verbal and written), had an overt psychiatric illness preventing them from completing the study, left the ED before the completion of the survey, were a prisoner, or declined participation. Patients filled out the survey anonymously and dropped it in a box in the emergency department. Those who were unable to read or write could request assistance from staff members who were not study investigators to read the survey questions to them and record their responses. The survey was conducted with the patients alone unless they specifically requested a family presence. IRB approval was obtained from the Investigational Review Board of the North Shore-LIJ Health System with a written agreement from the participating hospital establishing the collaboration. The sample size was based on availability of surveyors to obtain information at the hospital.

Results

Among the 1,854 patients seen in the ED during the study period, 71 (3.8%) left the hospital AMA, and of the 71 patients who left AMA, a total of 55 (71.4%) completed the survey. The overall average age of patients who left AMA was 41 years, and five patients were under 18 years with four of the five under 1 year of age. There were 36 (65%) male respondents, and the majority of respondents were Hindu (51, 92%). The range of diagnoses were diverse, with infectious disease (13, 24%) and trauma (13, 24%) the most common (Table 2). The majority of the 55 respondents were homemakers (12, 22%), students (10, 18%), and service workers (10, 18%), with other patients being laborers, retired, and professionals. Fifty-three (96%) study participants stated that they would seek medical attention elsewhere, and all respondents stated that doctors did explain the consequences of leaving AMA.

3. A retrospective analysis of patients who leave Against Medical Advice (AMA) from a community emergency department: What do these patients tell us about patient demographics, insurance coverage, and patient readmission within 60 days?

Abstract:

Approximately 2% of all hospital discharges are Against Medical Advice discharges,²⁻⁴ however, little research exists on patients who leave AMA from an emergency department setting. Little is known with regards to the chief complaints with which emergency department patients present and what sort of complaints are most common amongst AMA emergency department visits. There has also been a common belief amongst medical providers as well as patients that visits with AMA dispositions would not be paid for by insurance companies. The purpose of our analysis is to provide statistical data of patients who leave AMA from the emergency department.

Objectives: Our primary objective is to use a systems-based approach to identify the most common chief complaints of patients who leave against medical advice (AMA) from a community hospital emergency department. Our secondary objectives are to identify the demographics and insurance characteristics of AMA patients readmitted within a 60 day period and to see if patients who leave AMA are at increased risk for

readmission in 60 days when compared to patients who complete their plan of care while in the emergency department. We also set out to answer whether insurance companies covered emergency department visits with an AMA disposition and subsequent emergency department visits or hospital admissions within a 60 day period regarding a similar chief complaint.

Methods: [X] System is the largest healthcare provider in [LOCATION] and [LOCATION]. Eligible patients for this study included all patients who visited one of three [X] System hospital emergency departments for care between January 1, 2010 and December 31, 2010. Ineligible patients included all patients who did not leave Against Medical Advice from an [X] System emergency department during 2010 and who had completed their plan of care while in the emergency department to include either discharge home, inpatient hospitalization, death, or transfer from the [X] System emergency room to another facility. Patients who left without being seen from the emergency room were also not included in this study. Of the patients who left AMA from the emergency department, a retrospective data analysis of demographics, insurance coverage, and systems-based chief complaint was performed on those patients who returned for hospital readmission within 60 days to an [X] System campus.

Results: A total of 119,188 patients were seen in an [X] System emergency department in 2010. Of these patients, a total of 24,267 were admitted for an inpatient stay at [X] System, 2,905 were transferred to another facility, 1,761 left AMA, and 234 expired while receiving care within the emergency department. The remaining 90,021 patients were either formally discharged or left

without being seen (LWBS). Of the 1,761 patients who left AMA, 43 (2.44%) were readmitted within 60 days for an inpatient stay at an [X] System campus.

The most common chief complaints of those patients comprised of 22.15% cardiovascular, 17.66% neurological, and 16.13% musculoskeletal. Of the 1,761 patients who left AMA, 43 returned within 60 days for hospital readmission. A retrospective chart review of these 43 patients demonstrated that 11 (25.58%) were under the age of forty, 19 (44.19%) were in their fourth or fifth decade of life, and 13 (30.23%) were above the age of sixty. There was almost twice as many males (62.79%) than females (37.21%) and a total of 11 out of 43 of these patients (25.58%) had admission chief complaints identical to their AMA chief complaint. The disposition status of patients who were readmitted within 60 days of an AMA visit from the emergency room showed that 3 of the 43 patients (6.98%) expired during their admission course. When looking at insurance demographics of the 43 patients who were readmitted to the hospital within 60 days, we noted that only 1 of the 43 patients were self pay without insurance. Through phone calls made to the individual insurance providers of these patients who returned for inpatient admission within 60 days following an emergency department AMA visit, we found that the insurance companies did provide coverage for AMA visits from the emergency department.

Conclusions: Following a retrospective analysis of patients who leave AMA from [X] System emergency department, the three most common chief complaints pertain to the cardiovascular system, the neurological system, and the musculoskeletal system. Of the 119,188 patients seen within an [X] System emergency department in 2010, 1.48% left AMA, while, excluding the 234 patients who expired in the emergency department, the remaining 117,193 patients completed their emergency disposition course, with dispositions of discharge, admission, transfer or LWBS. The relative risk of an [X] System patient returning within 60 days for admission after an AMA visit is 43/1,761 (2.44%) when compared to the relative risk of an [X] System patient returning within 60 days for admission after a completed emergency disposition being 14,383/117,193 (12.27%). Surprisingly, patients who left AMA from an [X] emergency department were not at higher risk for readmission within 60 days when compared to patients who properly completed their emergency disposition course.

With regards to insurance coverage of patients who leave AMA from the emergency room and are readmitted within 60 days, we found that the majority have insurance coverage. Through phone conversations with the various insurance companies covering the patients who were readmitted to the hospital following an AMA emergency department visit within 60 days prior, we found that insurance companies do indeed cover for AMA emergency department visits.

3. A study of patients who leave an Accident & Emergency department against medical advice

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Patients leaving an Accident & Emergency Department against medical advice are often considered a high-risk group. A prospective study was carried out in an Accident & Emergency Department (ED) to determine the characteristics of this distinct group of patients, their reasons for leaving against medical advice (AMA), and their subsequent outcome. Telephone or personal interview of patients by a clerk was attempted within 48 hours of the visit for all patients who left Against Medical Advice (AMA) based on a pre-set questionnaire. A follow-up call was used to ascertain health outcomes after the discharge. There were 210 AMA cases during the study period giving an incidence of 0.95%. Interview was successful in 186 (88.6%) patients. The mean age of the AMA group was around 36 year but there was no significant difference in sex. The major reasons for AMA

included wanting to observe symptoms at home (78 of 186, 42 %), non-medical personal reason (64 of 186, 34%) and symptoms have abated (21 of 186, 11%). Eighteen (9.7%) patients left AMA because they wanted to seek treatment from other providers and among them three had private insurance coverage. Of the 5 (2.7%) patients who were dissatisfied with the management in ED, four disagreed with the diagnosis and treatment offered and the remaining one was unhappy with the attitude of the attending physician.

About 12% (22) of patients returned within 48 hours for further treatment and 8 (36%) were admitted.

The remaining 22% (40 of 186) sought further medical treatment from other sources. No formal patient complaint was received during the study period from this group. (*Hong Kong j.emerg.med.* 2000;7:22-26)

METHODOLOGY

A . STUDY AREA:

Accident & Emergency Department (ED)

Fortis Memorial Research Institute, Gurgaon

B. STUDY POPULATION:

226 ER patients

C. SAMPLE SIZE :

28 LAMA Cases

D. STUDY METHOD:

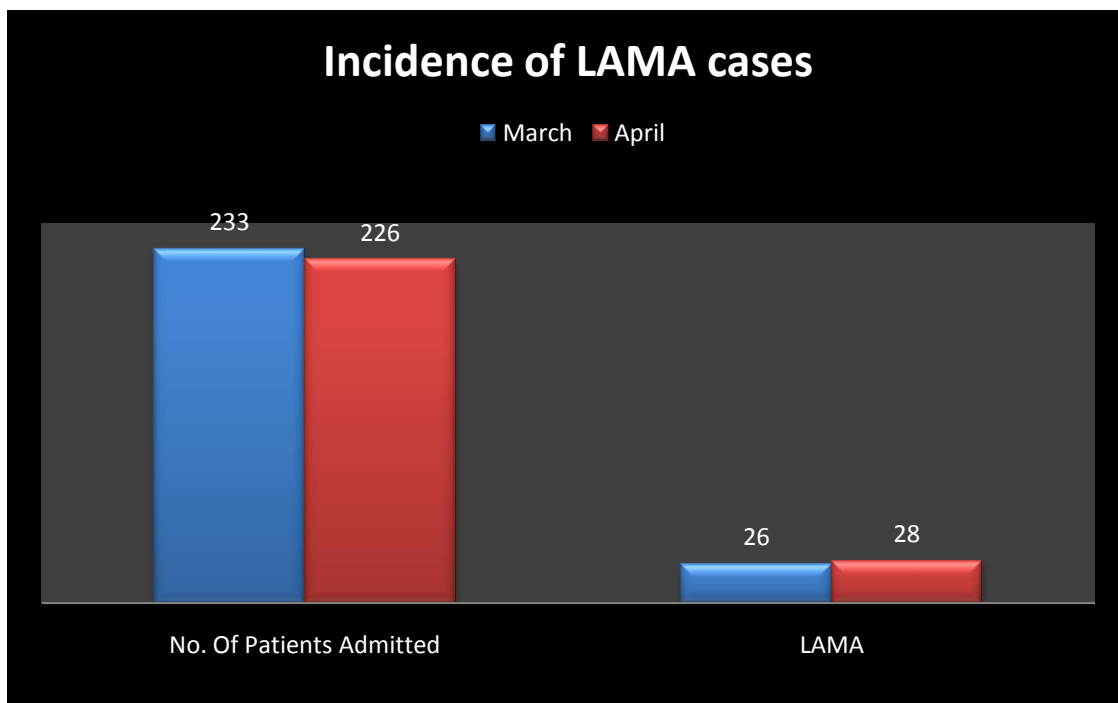
A prospective study was carried out in an Accident & Emergency Department (ED) to determine the characteristics of this distinct group of patients, their reasons for leaving against medical advice (LAMA), and their subsequent outcome. Out of 226 ED Cases 28 were LAMA cases. Tools used were ER Lama form, ER daily report and counseling of patients who left Against Medical Advice The analysis was done with the help of Microsoft Excel.

E. STUDY TOOLS:

Tools used were ER Lama form, ER daily report of last month and counseling of patients who left Against Medical Advice The analysis was done with the help of Microsoft Excel.

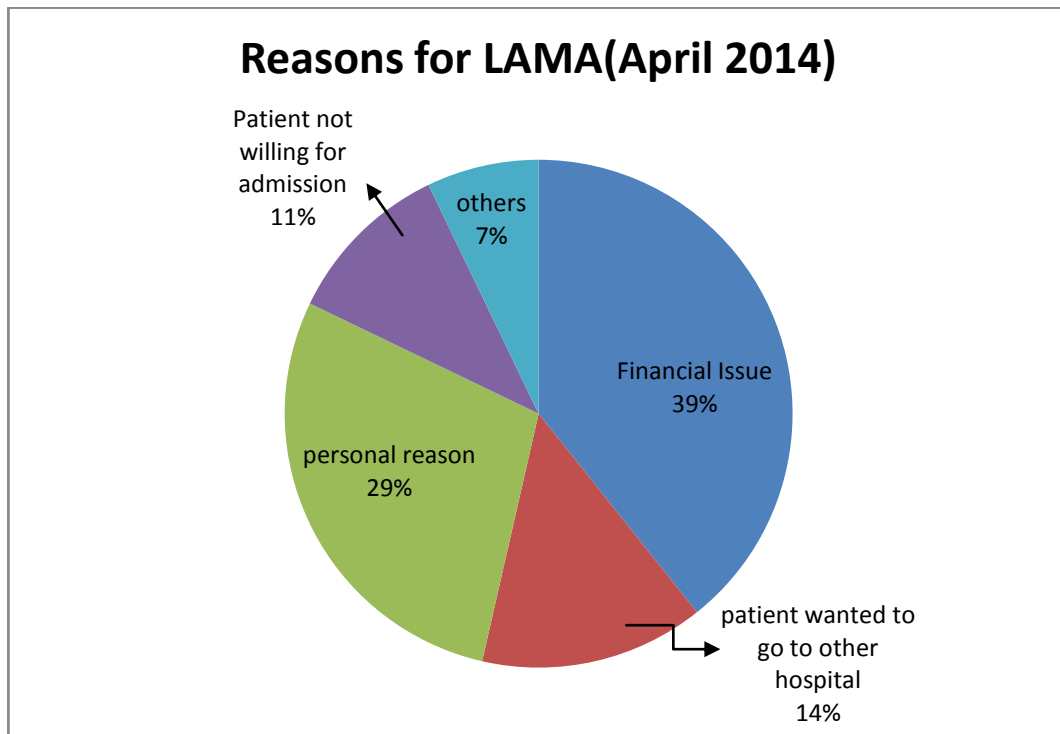
DATA ANALYSIS

A.



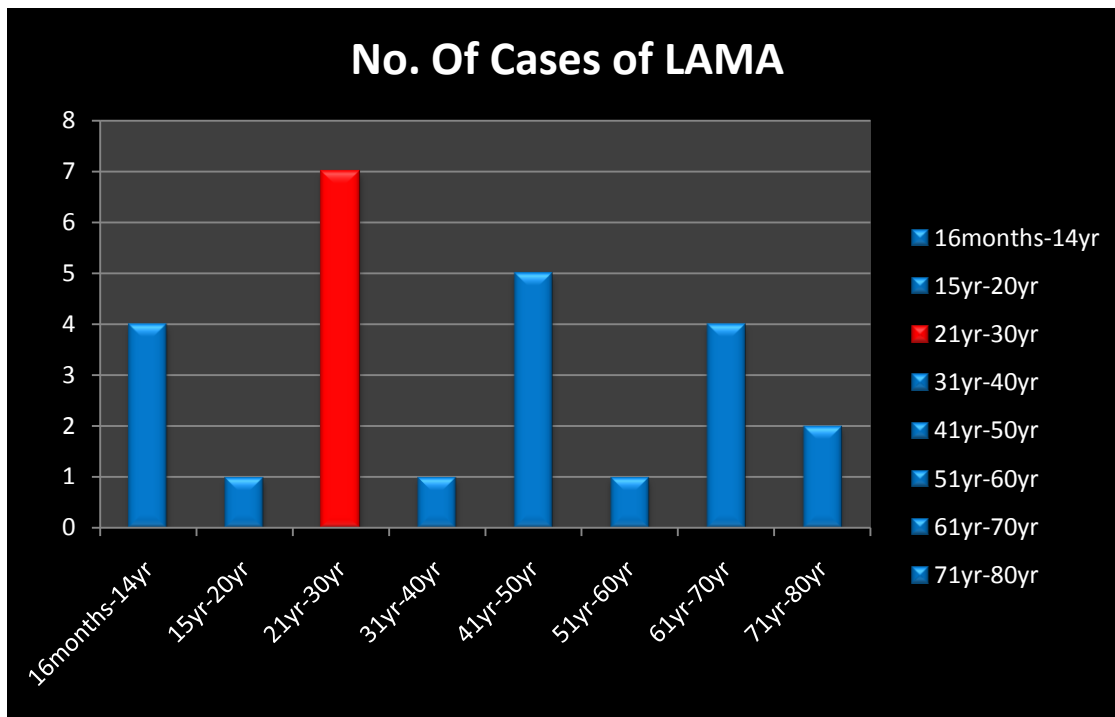
It is depicted from the graph above that there is a increase in Lama cases in april comparatively to march 2014. In march there were 26 Lama cases out of 233 cases admitted and in april there were 28 Lama cases out of 226 cases admitted. Number of patients admitted were less in april comparatively to march but Lama cases were high .

B.



It is depicted from this pie chart 39% patients leave (LAMA) ER department due to financial reasons. 29% had some personal issues, 14% cases preferred going other hospital for treatment , 11% were not willing for admission and 7% others. It shows that mainly patients leave against medical advice is due to financial reason as they cannot afford such costly treatment.

C.

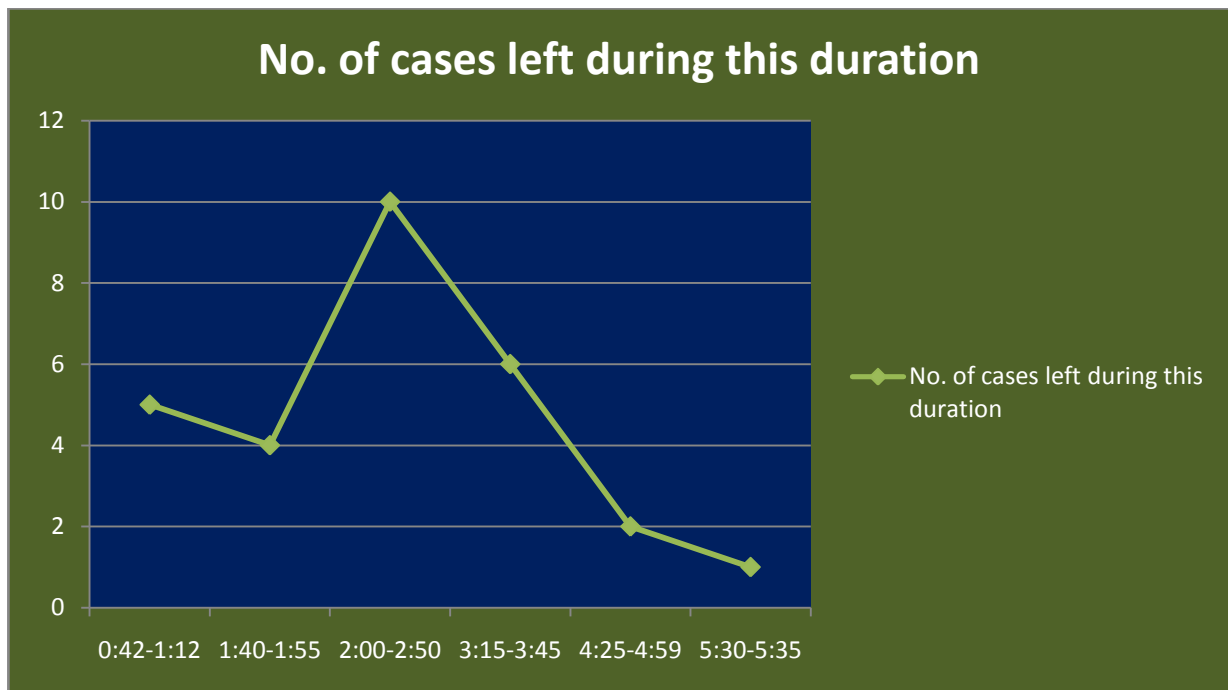


This graph depicts number of cases of LAMA were more in age group of 21yrs to 30 yrs i.e. 7 cases out of 28 were of young age group. This age group is less bothered about health issues and cannot take decision properly.

Key issues :

- Young age group
- No insurance
- RTA/ alcohol abuse cases

D.



This graph depicts Turn around time for LAMA patients. As u can see maximum leave ER department in 2:15 to 2:50 hrs duration and very less stay for long duration i.e. more than 5 hrs.

Out of 28 cases , 10 cases left in 2:15 to 2:50 hr duration, 6 left in 3:15 to 3:45 hr duration, 4 left

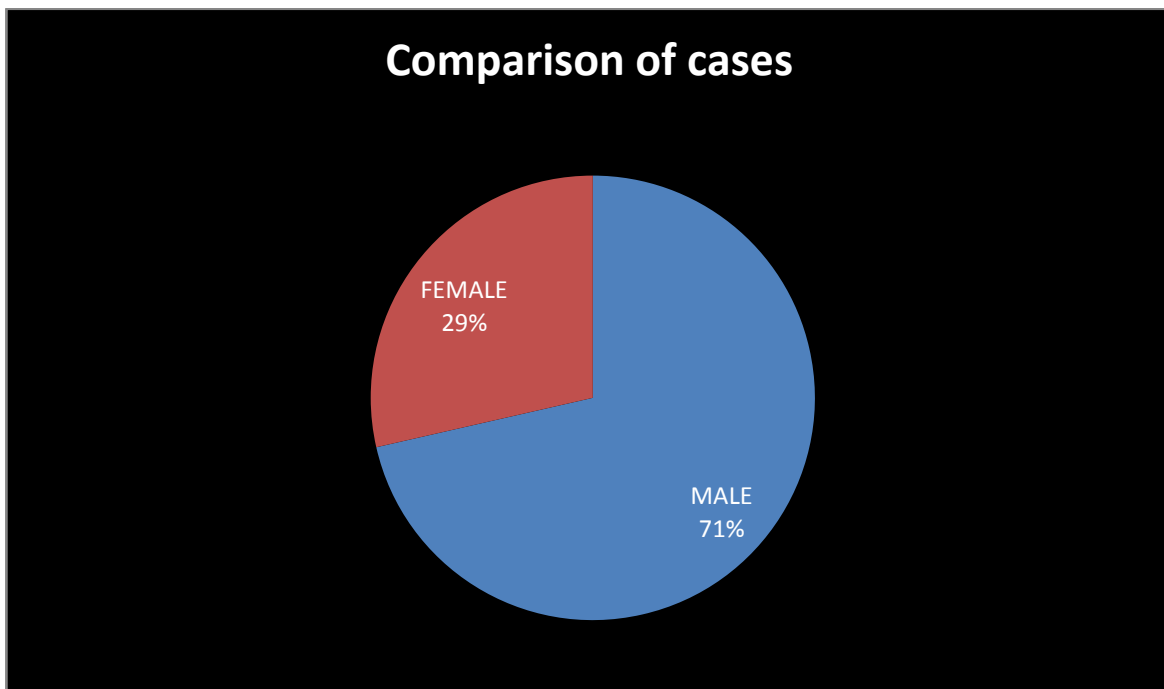
in 1:40 to 1:55 hr duration. And very few i.e. 1 patient stayed for 5:30 hr duration.

TAT(turn around time) is calculated by : The time patient enters ER department and the time patient leaves ER against medical advice . So the time duration is calculated and an estimation is made.

Key issues:

- Financial issues
- Personal reasons
- Want to get treated from other hospitals
- Don't want to get admitted

E.



It is depicted from this chart that males are more comparatively to females leaving against medical advice in ER department. Males are 71% where as females are 29%.

Mostly young males were there. Many of them don't have insurance coverage so they Cannot afford treatments and in few cases they prefer second opinion from their known doctors.

There has also been a common belief amongst patients that visits with AMA dispositions would not be paid for by insurance companies.

Multiple reasons including

- financial burden,
- family emergencies,
- other personal agendas, and
- even dissatisfaction with treatment, putting patient autonomy often at odds with physician beneficence.

RESULT

Overall , Out of 226 ER cases 28 ER patients left against medical advice, of which 11 (39%) reported leaving because of financial reasons. 8(29%) patients had some personal problems, 4(14%) wanted to get treated from other . 3(11%) not willing for admission. Males (20/28) were more likely to leave against medical advice compared to females (8/28). Among females who signed out AMA, the decision was never made by the female herself.

RECOMMENDATIONS:

Before a patient leaves AMA, the treating physician / SBU Heads of the concerned department should take the following steps:

1. Assess the patient's decision-making ability:
 - Assess the decision-making ability
 - Document the capacity in the chart
 - Document the discussion held with the patient

2. Attend to follow-up arrangements:

- Discuss possible treatment scenarios
- Arrange for phone, home, or outpatient follow-up
- Provide needed prescriptions
- Document efforts in the chart

3. Communicate:

- Provide the patient with a summary of diagnosis and treatments and follow-up plans
- Communicate with the patient's primary care physician if possible
- Communicate with next of kin (with the patient's permission)

Document communication efforts in the chart

CONCLUSION

The number of people leaving the ED LAMA in FMRI is relatively high, with most leaving for financial reasons. In most cases, women did not decide to leave the ED LAMA for themselves, whereas males did. This survey suggests that steps are needed to ensure that the inability to pay does not prevent emergent care from being provided.

Keywords: Against medical advice(LAMA); Discharge; Emergency department(ED),medical advice.

SECTION C

PROJECT II

A Study to probe in the reason for delay in all type of patient discharges

INTRODUCTION

Discharge is defined as, “a release of a hospitalized patient from the hospital by the admitting physician after providing necessary medical care for a period deemed necessary¹”.

It is also 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 as well as his relatives is eager to resume their routine life immediately and any undue delay in the discharge process leads to patient dissatisfaction and takes a toll on image of the hospital, even after a successful and satisfactory treatment.

The process comprises of clinical, financial, legal and administrative and recordkeeping aspects starts right from writing of discharge orders to settlements of all kinds of hospital bills is a time consuming process; but if executed in an organized way with assistance from trained medical, para-medical and administrative staff, can be completed as per global standards or those prescribed by hospital accreditation boards like NABH at national level.

The time study measures the time required to perform a given task in accordance with a specified method and is valid only so long as the method is continued. Once a new work method is developed, the time study must be changed to agree with the new method.

Time study is a direct and continuous observation of a task, using a stopwatch, video camera etc, to record the time taken to accomplish a task

Time motion study is often used when.

- ☐ there are repetitive work cycles of short to long duration,
- ☐ wide variety of dissimilar work is performed, or
- ☐ process control elements constitute a part of the cycle

RATIONALE

FMRI has a monthly discharge of 278 patients in month of may'14. It has been observed there are more cash(198) patients than TPA(80) and no. of planned discharges are more than unplanned. This study aims for finding out the reasons in delay in dischrge cases and to make recommendations for it.

AIM- To analyze the reason for delay in discharges and to make recommendations for reducing their number .

OBJECTIVES

- (1) Identify the major bottlenecks and their root causes for delay.
- (2) To give the recommendations for it.

REVIEW OF LITERATURE

A comparative time motion study of all types of patient discharges in a hospital

Swapnil Tak^{1}, Sheetal Kulkarni², Rahul More³*

ABSTRACT

Introduction Discharge is a release of a hospitalized patient from the hospital by the admitting physician after providing necessary medical care for a period deemed necessary. Any hospital needs to work on finer aspects of the discharge process, to make it more patient friendly and less time consuming as it directly connects to patient satisfaction.

Methodology This observational study was carried out in a tertiary care 350 bedded hospital in Pune city on 354 discharged patients of all types of discharges, comprising of Insurance patients (104), self-payment patients (227) & discharges against medical advice (DAMA)(23).

Results and Discussion The results indicate that there is a delay in all types of discharges in this hospital in all the steps except for the time needed to return unused medicines to the pharmacy. Time and tedious discharge procedure, also contributes to patient dissatisfaction.

METHODS

This observational study was carried out in a tertiary care 350 bedded hospital in Pune city, selected randomly by throwing chits with hospital names written on them. The time taken for discharge from physician writing orders on the case sheet to completion of billing process in all the departments was observed and measured using a stop watch by staff nurse present in each department of the hospital. The data was collected for all the patients discharged from 4th June, 2012 to 10th June, 2012.

Total 354 discharged patients of all types of discharges were included during this period comprising of Insurance patients (104), self-payment patients (227) & discharges against medical advice (DAMA)(23) were included in the study and separate record was maintained for each type of discharge .

A semi structured interview was administered on the discharged patients about the discharge process and the time taken for its completion.

A survey of the internal layout of the hospital was also done to assess the transit time for discharge procedures according to locations of concerned departments.

The data thus collected was analyzed using percentages and were presented in a tabular format.

RESULTS AND DISCUSSION

Table 1 Comparison of Average Time Taken According to

Type of Discharges and NABH Prescribed Standards (n=354) Sr.No		Steps in Discharge Procedure	Average Time Taken According to Type of Discharge (In minutes-rounded off)		
Self Payment (n=227)	Health Insurance (n=104)	Against Medical Advice (n=23)	NABH Standard		
1	Preparation of Discharge Summary	49 minutes	51 minutes	63 minute	30 minutes
2	Return of Unused Medicines to Pharmacy	28 minutes	33 minutes	31 minutes	30 minutes
3	Clearance from all departments	78 minutes	74 minutes	75 minutes	60 minutes
4	Preparation of Bill	67 minutes	66 minutes	71 minutes	30 minutes
5	Bill Settlement/A pproval	56 minutes	113 minutes	62 minutes	30 minutes
Total Mean Time inMinutes	278 minutes	337 minutes	302 minutes	180 minutes	

METHODOLOGY

A . STUDY AREA:

Fortis Memorial Research Institute, Gurgaon

B. STUDY POPULATION:

Discharge patients on 4th floor

C. SAMPLE SIZE :

278 Cases

D. STUDY METHOD:

A prospective study was carried out in FMRI on 4th floor to determine the reasons for delay in discharges.

E. STUDY TOOLS:

Tools used were trackcare, and audit checklist The analysis was done with the help of Microsoft Excel .

F SAMPLING METHOD:

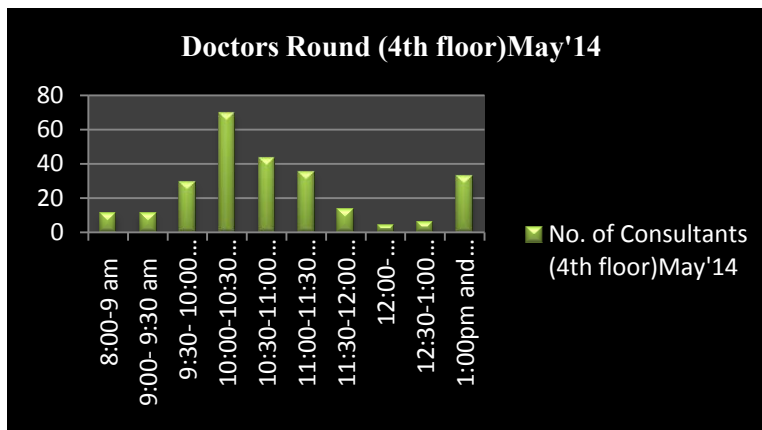
Non probability sampling

G: STUDY TYPE:

Convenient

DATA ANALYSIS

GRAPH 1



This graph depicts that maximum no. of doctors round takes place around 10:00 to 10:30am(69).

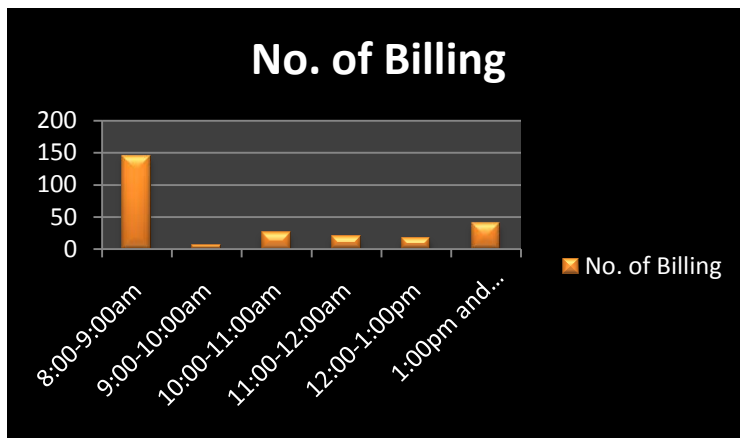
And after that 10:30 to 11:00am (43) , 11:00 to 11:30am (35) and others after 1:00 pm (33). This shows that doctors round not happening on time .

KEY ISSUES

- Proper timings are not followed by doctors.

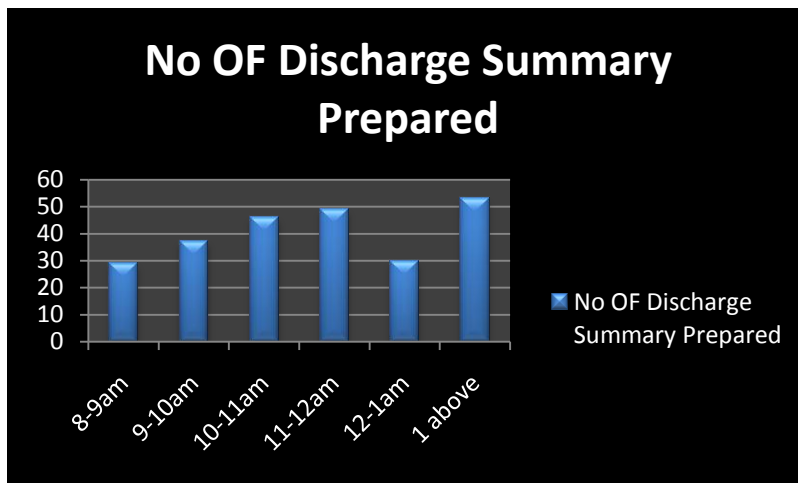
- Time not mentioned on some of discharge files.

GRAPH 2:



This graph depicts that maximum no. of billing activity happens around 8:00 to 9:00am and in few cases after 1:00 above. This shows that billing activity are happening on time

GRAPH 3:

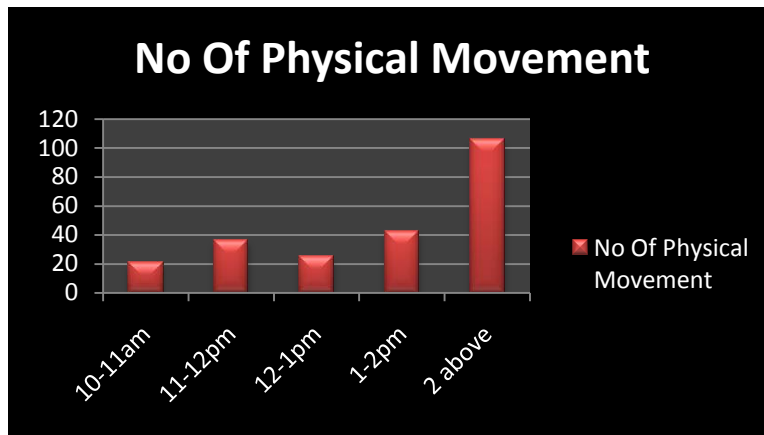


This graph depicts that maximum no of discharge summary are prepared around 10 to 11 am and after 1 pm. This shows that discharge summaries are not prepared on time. There are many reasons for it:

KEY ISSUES:

- Doctors not coming on time
- Interdepartmental issues
- Lack of coordination between staff.

GRAPH 4:

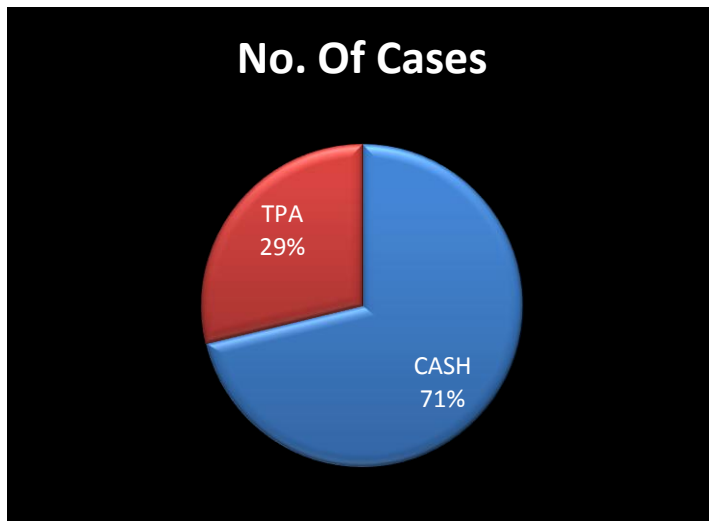


This graph depicts that maximum no of physical movement is happening after 2 pm, irrespective of the things that maximum no of discharges are planned.

Key issues:

- Lack of coordination between staff.
- Doctors not coming on time
- Doctors give verbal orders for discharge leads to delay in documentation.
- Documents not completed.
- TPA issues

GRAPH 5

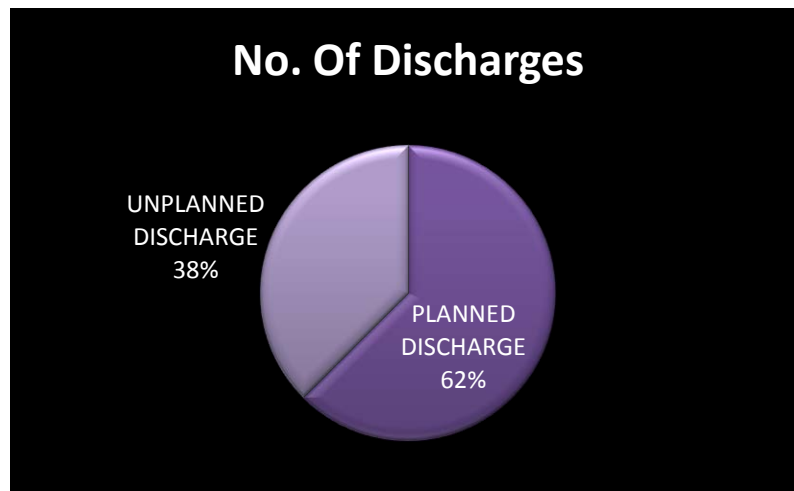


This graph depicts that maximum no of cases are of cash i.e. 71% and rest are TPA i.e. 29%. It shows that irrespective of cash patients delay in discharge is happening.

KEY ISSUES:

- Doctors not coming on time
- Documentation not complete
- Medication return delay.

GRAPH 6:



This graph depicts that no of planned discharges i.e. 62% are more than unplanned i.e.39% In spite of large no. of planned discharges there is a delay in discharge process.

KEY ISSUES:

- Doctors rounds not on time.
- Lack of coordination between DO and Nurses.
- Doctors not mentioning time on reports.
- Nurses are unaware about the verbal orders given by doctors to patients.
- Reports kept on hold due to doctors.

RESULT

As shown in graph

There are no. of reasons computed for delay in discharges either planned or unplanned.

Out of 278 discharges 198 are cash patients and 80 are TPA patients. Many a times delay in discharge is considered due to TPA but here as depicted by graphs there are very less ratio of TPA patients in comparison to cash patients. 99 are unplanned discharges where as 165 are planned and it's a huge amount . After 10:30 there is a half day room rent for patient but as shown in graph maximum doctors visit during 10 to 11am.

During observation on floor:

- Lack of coordination between nurse and DO.
- Last minute changes in discharge files
- Late completion of discharge summary.
- Resident doctors are making rounds in morning while senior consultants are coming late
- Patient not aware about delay in discharge and has to pay half day room rent
- Discharge summary kept on hold as doctor needs to change some medications.
- Lot of chaos on nursing station at the time of discharge
- Language problem dealing with international patient
- Shortage of nurses that leads to stress among nurses and decreases there working efficiency.(8patient: 1 nurse ratio sometimes)
- Shortage of GDA leads to delay in reporting sending or billing activity to concerned departments.
- Lack of coordination among nurses.
- Security guards not making entry of physical movement of patient leads to difficulty in tracking the delay.

Bottleneck and Root cause

- Delay in start of discharge process

Care plans with the expected length of stay and discharge date were not created at time of admission. The discharge process began unpredictably only when the consultant determined the patient to be ready during rounds.

- Delay in completion of discharge card

Cards are handwritten and activity begins after consultant signoff on the day of discharge

- Delay in completion of final case file

Case file not checked each day to update services ordered with services and reports received

- Delay in preparation of final bill Wards waited for a stack of billing files to accumulate before

sending them to the billing counter for processing

- Delay in financial clearance Attendants were not immediately informed that the final bill

was ready.

Late entry of charges led to a substantial hike between the interim and final bill that was often questioned during settlement.

RECOMMENDATIONS

Recommendation:1

- Discharge planning begins at admission -
Create a care plan for all elective patients
within 24 hrs of admission.

Impact:

The patient, family and care team are all informed of the discharge date. The discharge process can then begin predictably 24 hrs prior to the discharge day.

Recommendation 2:

- Update the discharge card daily.

Impact:

Complete the discharge summary quickly within 10-15minutes of discharge orders.

Recommendation 3:

- Update the patient's case file daily.

Impact:

The case file is ready when the discharge orders are given - only services provided on the morning of discharge are pending.

Recommendation4:

- Return discontinued medications daily in the wards.

Impact:

Eliminate the pharmacy from the discharge process Altogether.

Recommendation 5:

- Enter charges at the time and point of Consumption.

Impact:

Generate up-to-date interim bills and minimize billing Errors.

Recommendation 6:

- Send an automatic SMS to patients and families when the bill is generated.

Impact:

Enable quicker bill settlement.

Other Recommendation:

- Number of nursing staff should be increased
- Some rule should be made mandatory for doctors round

- Proper training regarding discharge process should be given to staff

CONCLUSION

The delay in discharges are due to number of reasons linked together as mentioned above.

This survey suggests that steps are needed to ensure that a strict action/rules , training should be given to staff so as to prevent delay in discharge process.

SECTION D
PROJECT III
Training Need Analysis

INTRODUCTION

One of the primary concerns in the healthcare sector revolves around the issues of patient/customer satisfaction. In today's market, due to the varying options, quality and service stand out as two essential elements that influence the selection process. A healthcare organization's reputation for its commitment to quality and patient-centred customer service stands as the main criteria for individuals in choosing a healthcare service provider. Therefore, measurement of patient satisfaction and incorporating results to create a culture where service is of deemed importance and should be a strategic goal for all healthcare organizations.

PROBLEM STATEMENT

Health care organizations are operating in an extremely competitive environment and patient satisfaction has become key to gain and maintain market share. Nurses , GDA , Housekeeping staff are critical Areas who are related to patient satisfaction since they are the point of contact with the patients . Hence , it is necessary to Analyze need of training among contractual staff.

RATIONALE

The purpose of this study is to gauge the behaviour of staff with patients and with each other , so that supreme quality customer service can be provided to the patient . As Training improves employee skills and allows organization to gain competitive advantage.

REVIEW OF LITERATURE

- **NABH** has defined three fold benefits for its stake holder's . According to NABH “patients are the biggest beneficiary. Patient satisfaction should be regularly evaluated[2].
- A Study by **Brent J. Morris, MD; Alex A. Jahangir, MD; and Manish K. Sethi, MD** Patient satisfaction is a key determinant of quality of care and an important component of pay-for-performance metrics
- Study assessing patient satisfaction in a tertiary care hospital in India: the changing healthcare scenario by **Aggarwal A , Garg S & Pareek U** The healthcare service scenario in India is expected to evolve into a more developed stage. More emphasis has been given on patient satisfaction as this is an important consideration for the assessment of the hospital services.

OBJECTIVE

To study and analyze need of training for contractual staff by performance analysis through floor manager feedback (form and verbal) and floor inspection.

To determine the reason of poor performance.

To recommend appropriate training interventions.

To Identify loop holes in service.

Study area	FMRI, Gurgaon
Type of study	Cross sectional
Sampling method	Non-probability convenience sampling
Sample population	In-patients & outpatients
Sample size	163 (IPD) & 201(OPD)
Data collection tools and technique	Secondary data (Feedbacks) was collected from GRO's)

RESEARCH METHODOLOGY

The attributes covered in feedback form:

- ☐ IPD- Front office, Medical and Nursing process, Accommodation, Facilities for attendants/patients and Discharge process
- ☐ OPD- Registration, Facilities for attendants/patients , Medical and Nursing process

Under these attributes there were different parameters based on which services were analysed quantitatively.

verbatim & written complaints were analysed under following parameters:

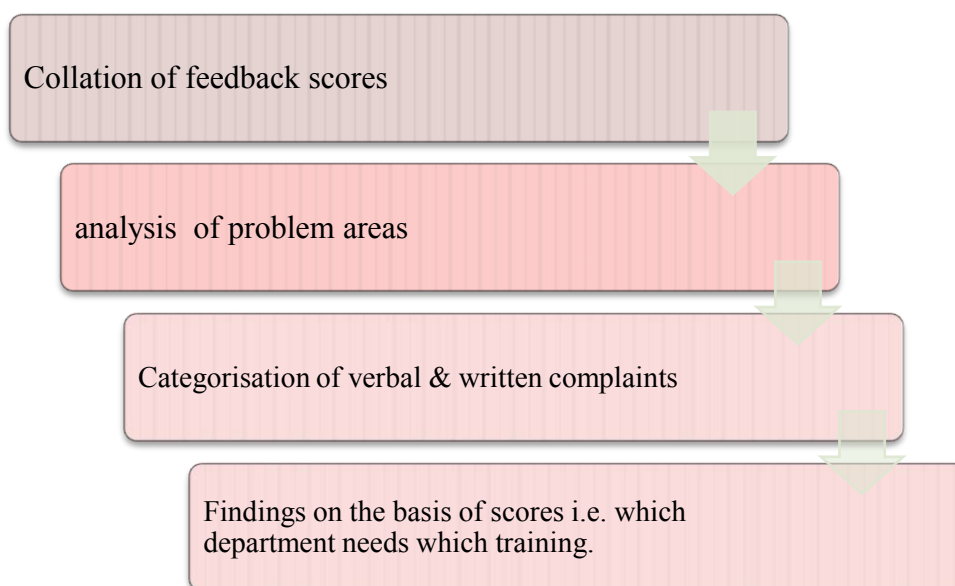
- Response time
- Customer service orientation
- Interdepartmental coordination

- Job skills
- Resources/instruments
- Query resolution

LIMITATIONS

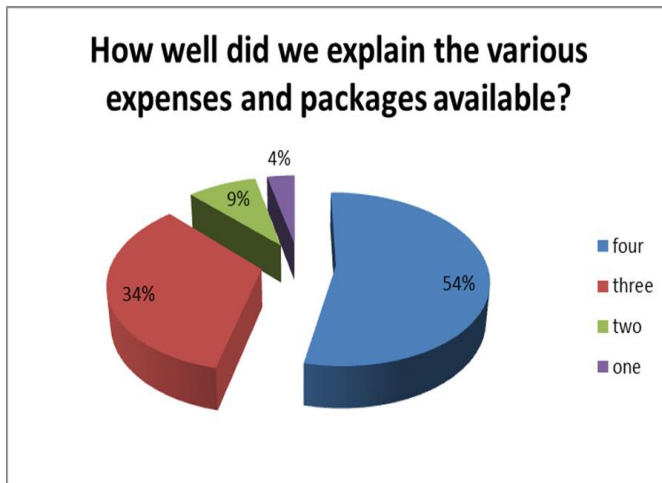
- The study is subjected to the understanding, bias and prejudices of the respondent.
- OPD feedback covered approximately 5% of total population; hence the data is very less to reach any conclusion.
- It is very difficult to seek response from patient because patients are reluctant and annoyed to respond.

Process of analysis

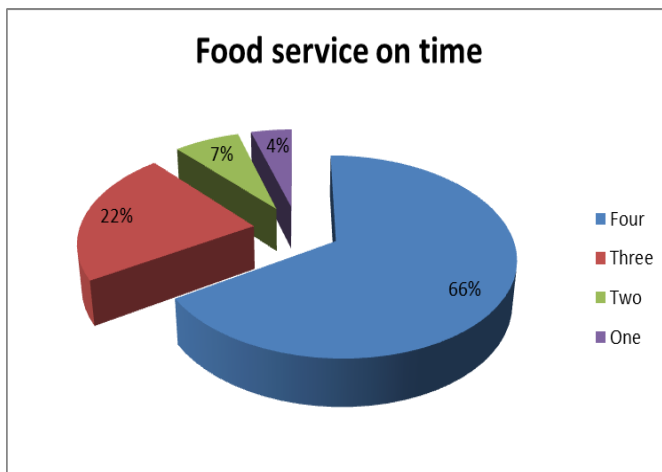


IPD FINDINGS

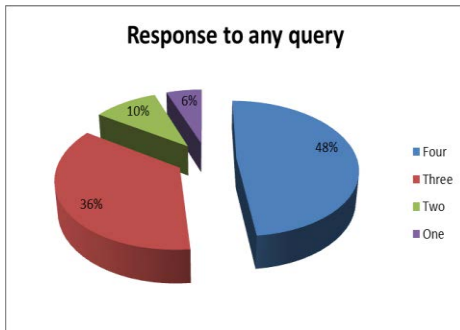
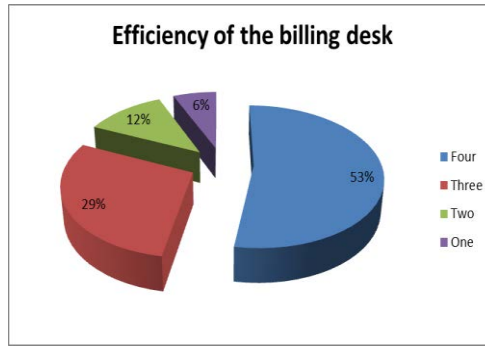
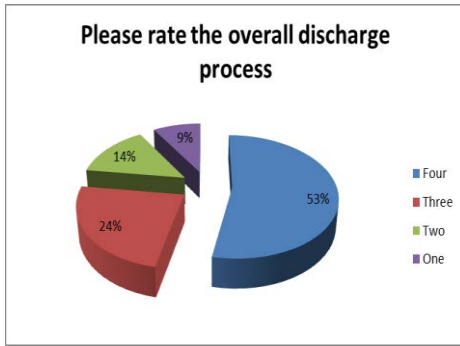
Front Office



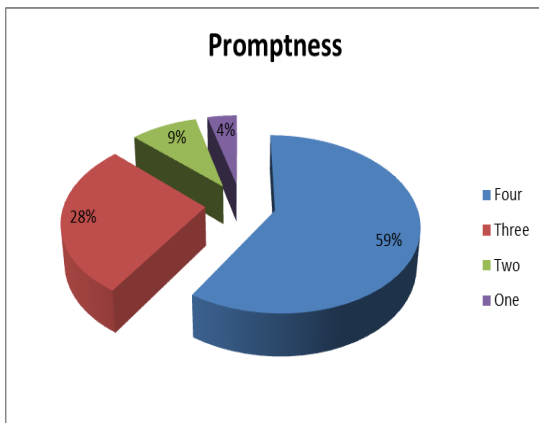
Food Beverages



BILLING



Medical and Nursing processes



INFERENCES

As the minimum decided percentage for each department is 90 percent. So the department who have less then 90 percent are matter of concern for us.

Front office parameter that is how well they people explain packages 88 percent people think that they are able to do it well rest are not satisfied.

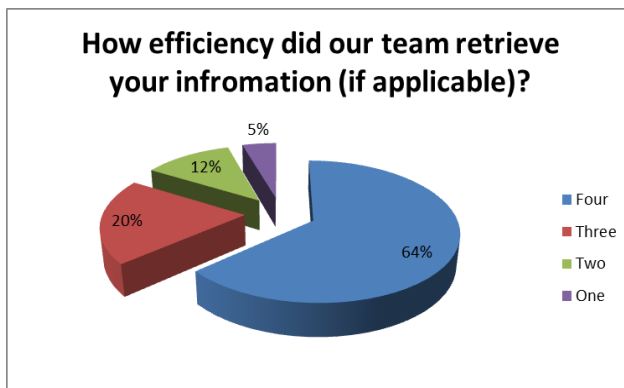
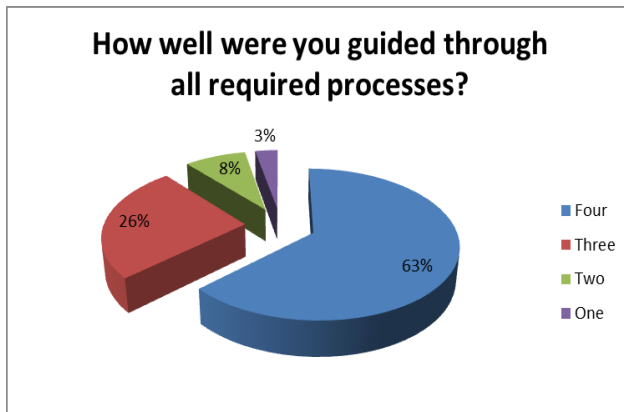
Food and beverages department is lacking in service on time 88 percent people think that they are doing well but rest are not satisfied with food service on time.

Billing and discharge process are the one who are not up to mark 84 percent people think that discharge process is good rest think that it was not so smooth, 87 percent people think the billing team is efficient others think that it is not, 86 percent people think that billing people respond to their queries rest do not think so.

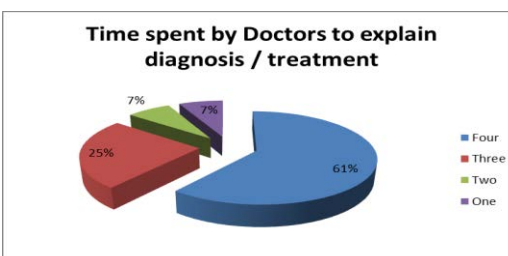
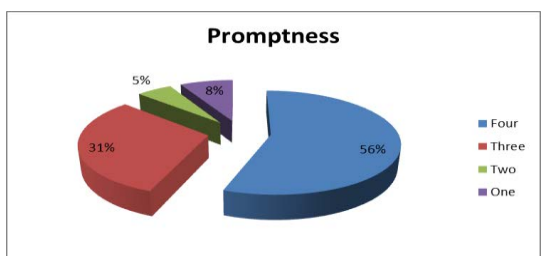
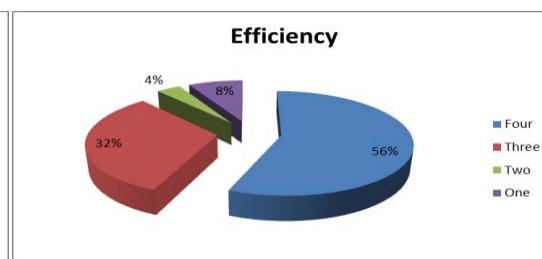
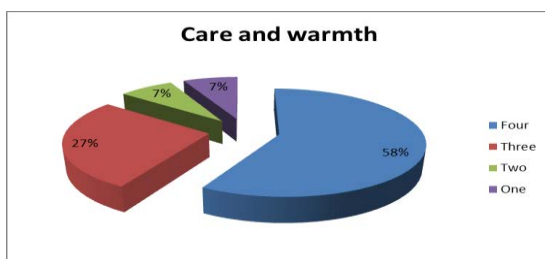
For medical & nursing process 87 percent of people think that their promptness is well others are not satisfied

OPD FINDINGS

Front Office



Medical and Nursing processes





INFERENCES

For **front office opd** 89 percent people think that it is good others are not satisfied with their guidance & information given to them.

For **medical & nursing process** 77 percent people think that attention from doctors is good rest are not satisfied, 85 percent people think that doctors spend ample time with them rest are not satisfied, 80 percent of people think that medical support staff is attentive towards them and others think it is not and processes are not explained them correctly.

Around 80 percent of people think that **quality of medical & nursing processes** that is efficiency , care and promptness is good others are not agreed with this statement.

Department	Verbatim comments	Trainings suggested
Billing	uncourteous & turns conversation.	Communications skills & costumer service
Food and beverages	Not punctual	Costumer service & Time management
Nursing	Lack of sensitivity	Emotional quotient
security	Rude behavior & got angry	Costumer service &

		Emotional quotient
PCS	Bad service not on time.	Costumer service & service excellence

DISCUSSION

- Billing has large no. of complaints like lack of efficiency and unresponsive to patient attendants verbal written complaints also shows this.
- Most of the complaints are being raised because of lack of customer service orientation, slow response time for the service and lack of interdepartmental coordination.
- Collation of data from bar graphs and pie chart helped in identifying top four departments which needs training to improve its services. These departments are PCS, Billing, Food & Beverage, and Nursing.
- Communication Skills, Soft Skills, Team Work came out as common training need for PCS , F&B, Billing dept .
- Security team was also not up to mark they also need to learn communication skills with patients and attendants as shown in verbal written complaints.
- F&B is closely Followed by Nursing & Billing department, it has Third highest percentage of complaints.
- Out of five types of attributes in IPD feedback forms, Discharge Process has highest percentage of complaints.
- The parameter response to any query has the lowest percentage of satisfaction in comparison to others in discharge process.

RECOMMENDATIONS

- To excel in **Customer Service soft skills** (empathy, listening skills, body language and tone) and service with sensitivity for the right attitude should be conducted
- To inculcate feeling of ownership and responsibility **Value workshops** through various methods and role-plays should be carried out, it will also help in building trust and confidence among the participants
- **Service standards training** for contractual staff. Also, they should be made to understand importance of satisfied customer and their contribution
- For interdepartmental coordination **training for team work** should be conducted within and between two departments

SUMMARY

Patient satisfaction depends upon many factors such as: Quality of clinical and non clinical services provided, facilities given, behaviour of doctors and other hospital staff, hospital infrastructure, physical comfort, emotional support, and respect for patient preferences. Mismatch between patient expectation and the service received is related to decreased satisfaction. Analysing patient perspective through their feedbacks :

- Give them voice
- Helps in gap analysis
- Identification of training needs
- Make hospital services patient centric.

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