Research Article

In Patient Department Services at a Private Super Specialty Hospital of a Metrocity

Aditi Veda[1], Amreen Khan[2], Soumitra Sethia[3], Veena Melwani[4], Yachana Choundhary[5], Manju Dubey[6]

Abstract

Introduction: A patient's episode of care should be planned before his/her admission and should take account of the entire "journey" up to and after discharge from hospital. Patients and their care-giver should be partners in this planning. Pre-admission assessment should be a standard requirement for all elective admissions. The anticipated length of stay for elective admissions should be indicated as early as possible to facilitate scheduling. Discharge plans agreed between the hospital and a key worker in primary care, discharge planning that commences on day of admission.

Objectives

- To study the admission process.
- To study the discharge process.

Methodology: A cross-sectional study was conducted in a private super specialty hospital of a metrocity. A check list was prepared for various desks of the hospital such as admission desk, discharge desk, cash desk, billing desk, etc. Also, descriptive data was collected from various departments.

Observation andResults: The various sources of admission to hospital were: direct admission, general OPD, emergency department and consultants' clinic. Registers maintained at the Admission desk: Handover Book, Admitted Patient Register, Bed management Register, Announcement Register, OT Register, Briefing Register, Counselling Register. Discharge Process: On being advised discharge, the billing prepares the patient bill in two copies. Process of discharge is initiated after administration/ consultant advice. A detailed discharge summary covering investigation reports, treatments given and advice on discharge will be provided by the attending doctor and it will be given to the patient at the time of discharge. Charges for the full day on the day of admission are applicable irrespective of time of check in. Patient is discharged after the payment of the bill.

Recommendations: There should be a hanging bold-written signage for insured patients, strict adherence to the visiting hour timings. More number of staff needs to be deployed in the billing department as because of staff crunch the billing gets delayed. Discharges must be pre-decided so that the nurses get sufficient time to prepare the patient file.

Keywords: In Patient, Admission, Discharge

[1]Assistant Professor, Hospital Management, SIAM&S, Indore.
[2] Post Graduate Student, Gandhi Medical College, Bhopal.
[4]1st Year PG Student, [3,5,6]2nd Year PG Student.

Correspondence: Ms. Amreen Khan, Gandhi Medical College, Bhopal.

E-mail Id: doc.amreen.khan@gmail.com

Orcid Id: https://orcid.org/0000-0001-6378-1754

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Introduction

A patient's episode of care should be planned before his/her admission and should take account of the entire "journey" up to and after discharge from hospital. Patients and their care-giver should be partners in this planning. Bed management should be overseen by a hospital bed manager (HBM) who has the authority to implement the bed management policy and to coordinate the bed management team. Part of their role would include continuous analysis and the provision of reports and forecasts. The function of allocating beds to patients should be centralized and the hospital bed manager should have authority over the access to all hospital beds. There should be an awareness of bed designation ratio as set out by the Department of Health and Children. The hospital bed manager should work within the notional allocation of beds to each specialty to ensure that patients are accommodated in the most appropriate bed available at the time of their admission, and to ensure that patients are cared for by staff with appropriate expertise. The following key requirements have been identified to facilitate effective elective admission practices such as centralized waiting list management and agreement on the parameters for scheduling theater lists with clinicians. Pre-admission assessment should be a standard requirement for all elective admissions to ensure appropriate planning of the entire patient journey. The anticipated length of stay (this should be indicated as early as possible to facilitate scheduling) for elective admissions should be indicated as early as possible to facilitate scheduling. Increased day surgery can also be supported by admission assessment to ensure appropriate scheduling and to minimize transfer to inpatient beds. Discharge lounges may be used to facilitate early discharge as well as accommodation for *day of surgery* arrivals and timely commencement of theater list.

The Acute Hospital Service should cooperate with other service providers in primary, community and continuing care. A description of the range and detail of the services provided in each care setting should be available to all users and providers. The route of access to each service is made explicit in appropriate formats to providers and users. A range of tools to support effective service delivery, including referral guidelines and protocols for consultant care and diagnostic services. Discharge plans agreed between the hospital and a key worker in primary care, discharge planning that commences on day of admission, efficient communication from acute care service providers, e.g., discharge letter accompany patient or/and e-mailed to GPs and key worker on or before the day of discharge, Integrated care pathways facilitated by key workers, individual care plans appropriate to the needs of the patient and their care-givers are developed by the multidisciplinary team and in collaboration with them, e.g., chronic disease management, shared care arrangements between patient/GP/consultant for specific health conditions. The care/case management in the health services should be further developed. The provision of medical prescriptions, aids and appliances along with transport issues should be identified and addressed to meet the needs of patients/clients, families and communities

Discharge planning should commence with pre-admission. On admission, the patient's pre-morbid and functional status information are documented in order to inform discharge planning and to identify patients at risk on returning home. In this way, referrals to inter-hospital and community services are initiated in a timely manner. The core principles for effective discharge planning are: a patient's use of a hospital bed and their discharge should be planned before their admission; the estimated date of discharge should be documented and communicated to the patient and relevant personnel within 24 hours of admission; discharge should be "streamlined" (e.g. prescriptions and letter should be completed in a timely manner, transport booked and test results made available promptly); complex discharges should be discussed at a regular multidisciplinary forum to ensure discharge is expedited. Multidisciplinary teamwork is the key to success with discharge planning. A patient's discharge plan is coordinated by a nominated member of the multidisciplinary team. General practitioners, primary care teams and community providers are involved in the discharge process

Objectives

- To study the admission process.
- To study the discharge process.

Methodology

A cross-sectional study was conducted in a private super specialty hospital of a metrocity over the period of two months (September and October 2016) after seeking the permission from authorities of the hospital. A check list was prepared for various desks of the hospital such as admission desk, discharge desk, cash desk, billing desk, etc. Also, descriptive data was collected from various departments to gain the respective admissions and requirement of beds by them. Data collected included details of sources of admissions, admission process, calculation of estimated bill, types of beds, wards and private rooms available, sections of ward such as ICU, SNCU, etc.

Observation and Results

The various sources of admission to hospital were: direct admission, general OPD, emergency department and consultants' clinic. The process of admission includes: 1. Admission request form, available with all the consultants and at the front office. The consultant recommending admission makes a 'provisional estimate' on the proforma

printed on the forum and authenticates the same with his signature. 2. Having received the provisional estimate from the attending consultant, next step would for the patient/authorized attendant to get the 'Admission Sheet' filled up at the 'Admission Desk' and consent will be obtained from the patient for any investigation/diagnosis/treatment/procedure/surgery and also on admission request form, general consent form and declaration for admission form. There are many other documents in the file which need to be filled in by the nursing staff. 3. The front office shall feed the data from the Admission Request Form and allot room, bed to the patient according to the desired bed category. Printout of the patient's admission form mentioning the details like room number, address, phone number, etc., and declaration form is taken out and is attached in the patient's file. 4. The patient is given two passes – one is a visitor pass and the other is attendant pass – and is asked to pay cash at the cash counter. 5. The patient admission file is sent to the nursing station through the ward boy and the patient is asked to proceed to his/her room. The patients are priory informed about the room charges when they come for admission.

Apart from wards, patients can get admitted in critical care areas like ICU/CCU/PICU and NICU. For these patients, one extra pass is given named critical care attendant pass without which the patient's relatives do not have access to the critical area to meet the patient. Bed category includes suite, deluxe, single, double room, economy A/C, daycare, ICU/SICU/NSICU/CCU, PICU/NICU, level-1, 2 and 3.

Advance money to be deposited at the time of admission: The deposit amount varies depending on the type of treatment and room category opted. Deposit can be made in cash or by credit card. The hospital accepts guarantee letters issued by companies that have credit facilities with the hospital. If the guarantee letter is not presented at the time of admission, the patient is required to pay a deposit which is refundable at discharge, if accompanied with a valid guarantee letter. The letter of guarantee must be presented within 24 hours of admission. Otherwise the patient will be required to settle the bills by cash or credit card. The patient whose surgery is to be done must deposit their full estimated amount before surgery. International patients are charged 25% extra on every billing parameter.

Consumables and drug charges: Wherever applicable, cost of consumable material and drugs will be charged separately. If in any of the above-mentioned cases, the patient/attendant is unable to deposit the full given amount then a minimum of half the value is to be deposited, nothing less than that can happen for admission (if not deposited an undertaking is taken for the remaining amount of money).

Bed transfer guidelines: In case a patient is shifted from a lower to higher category the charges for the consultant visits, investigations, critical care and surgery from the DOA will be according to the higher category. In case of credit patients, the request for transfer to a higher category will require approval from authorized signatory of the respective company/TPA/insurance. In case approval is not provided, the patient will have to pay the balance amount (other than entitlement) at the time of discharge.

Basis for computing bed charges: For the purpose of billing, a day is calculated from 12 noon to 12 noon. Full room/bed charges apply even for part of the day. When a patient is shifted from one patient area to another, bed charges for the accommodation occupied for the maximum number of hours during the day will be charged.

Registers maintained at the Admission desk: *Handover Book* **–** whenever handover is given following details are written in the register – vacant rooms, blocked rooms, rooms blocked for maintenance and any other specific note which is to be informed to the coming personnel for the night shift. *Admitted Patient Register* – The admission number, patient's name, doctor's name, room number, room category, cash or corporate and initial deposited amount of new admissions are entered in this register. *Bed management Register, Announcement Register, OT Register, Briefing Register, Counselling Register*

Discharge Process: 1. On being advised discharge, the billing prepares the patient bill in two copies – original for the patient and duplicate copy for hospital records. 2. Bills are prepared after proper verification and the patient/attendants are informed about the payment formalities. 3. Process of discharge is initiated after administration/consultant advice. 4. On completion of hospitalization, a detailed discharge summary covering investigation reports, treatments given and advice on discharge will be provided by the attending doctor and it will be given to the patient at the time of discharge. He will also be explained by the nursing staff about the post discharge medication/care to be observed by the patient. 5. In insurance/cashless/medico-legal cases, all records are kept with the hospital; however, a photocopy of these documents and duplicates of radiological investigations can be provided on cash payment. 6. Charges for the full day on the day of admission are applicable irrespective of time of check in. For up to six hours of stay as an in-patient, charges of half day would be levied. However, the stay of six hours and above up to 24 hours is counted as one day. 7. It would take approximately three hours to process a patient's discharge. This includes the preparation of discharge summary, return of unused medicines and consumables, compilation of reports and preparation of bills. Patient is discharged after the payment of the bill.

Recommendations

There should be a hanging bold-written signage for insured

patients. 2. There should be strict adherence to the visiting hour timings so that the patients do not get disturbed and get sufficient time to rest, and proper peace is maintained on the floors. 3. More number of staff needs to be deployed in the billing department as because of staff crunch the billing gets delayed and this becomes the biggest reason for patient dissatisfaction. 4. Communication gap should be eliminated amongst the staff nurses, PCCs and between both of them so that the work is completed hand to hand, and they have on-tip information of necessary details about the patients avoiding inconvenience to the patients and for that they should be properly trained. 5. Discharges must be pre-decided so that the nurses get sufficient time to prepare the patient file, avoiding confusion and miscommunication in the morning hours, when giving patient care is most important.

Conflict of Interest: None

References

1. Admissions and Discharge Guidelines Health Strategy Implementation Project 2003.
2. Admissions and Discharge Guidelines Nurse Practitioner Utilisation Toolkit.

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