POLICY ON THERAPEUTIC PASS & DISCHARGE OF PATIENTS

1. PURPOSE

To ensure

- That all patients will be discharged based on their health status and need for continuing care services.
- That the discharge process of the patient takes place efficiently and with minimal delays and to prepare the patient in the transition to the next level of care.

2. DEFINITIONS AND ABBREVIATIONS

Discharge: Discharge means the patient who had complied with the fit to discharge criteria of the hospital and is going out of the hospital through a specific chain of activities.

Therapeutic Pass: A therapeutic pass (henceforth referred to as pass) refers to an authorized leave of absence of the patient from the hospital.

3. RESPONSIBILITY

1. Director – Clinical Services and Director – Administrative Services
2. Unit Heads
3. Consultants / Medical Officers
4. Nursing Superintendent / Assistant Chief Nursing Officer
5. Ward Nurse

4. SCOPE

IPD, Nursing, MO's and Consultants, Housekeeping, Kitchen, Accounts and Security

5. POLICY

Summary is given to the patient in the following events–

a. If the treating consultant/consultants decide that the treatment is complete and the patient has recovered. ***(Discharge Summary)***
b. In case of transfer of Emergency patients, or In case of the transfer of admitted patients ***(Transfer summary)***
c. In case of patients leaving against medical advice, a LAMA form has to be is filled (LAMA ***Summary)***
d. In case of the demise of the patient. ***(Death Summary)***

It is the policy at INDUS HOSPITAL that a framework for the appropriate and safe discharge of patients from the hospital to home or alternative Healthcare facilities be followed and that the patient's family is included in the discharge planning process.

The admitting consultant responsible for the care of the patient is required to use relevant criteria or indications to determine patient's readiness for discharge to ensure patient safety.

The hospital permit the patients to leave the hospital during planned course of treatment on an approved **Therapeutic pass** for a defined period of time; based on an evaluation of the patient by admitting consultant to determine safety of the patient and approval of such pass by the medical directors after discussions with the admitting consultant. (*ANNEXURE 3 – THERAPEUTIC PASS))*

6. PROCEDURE(S)

6.1 *Components of discharge planning*

- The early identification and assessment of the patient's needs and implementation of timely discharge plans result in continuity of care and efficient use of hospital and community resources.
- A ***provisional discharge date*** is decided at the time of admission in the PLAN of CARE. Based on the continuous reassessment of the patient, the treating consultant, in consultation with the patient and/or family, decides if the patient is stable and meets the parameters for discharge.
- The Nurse in charge as well as the Resident Doctor is responsible for coordinating the discharge with the other team members.
- Discharge planning should begin early during the stay of the patient and ***discharge plan should be documented at least 24 hours before the actual discharge process is initiated.***
- Clinical criteria for discharge must be documented and note of patients functional, medical and other systems status should be made.
- Assessment of the patient is to be made for **being 'medically stable' and fit for discharge**. This may include assessment of functional, medical, medication, psychological, and/or cultural needs.
- Discharge planning is a multidisciplinary, collaborative process involving the patient, patient's family, and concerned team members during a specific episode of illness.
- Discharge planning involves several activities:

✓ Development of a care plan for post discharge care.
✓ Arranging for the provision of services, including patient/family education and referrals.
✓ The Nurse in charge, Ward Officers as well as the Resident Doctor is responsible for coordinating the discharge with other team members.
✓ Routinely anticipated patient and family discharge needs are to be documented in the Patient **Discharge Summary**.

- Each Patient / Attendant will be provided with a discharge summary on the day of discharge.
- ***A COPY*** of the discharge summary will be kept in the medical record.
- In case of a death the death summary must contain the cause of death.
- For MLC cases, the discharge summary is given in the same manner as for other patients. However, the police is informed about the discharge and the same is documented in the POLICE INFORMATION REGISTER (Refer: IH.COP.002 – Policy on Medico Legal Case)

6.2 PROCEDURE FOR DISCHARGE

The complete and efficient discharge process requires coordination and timely information dissemination amongst various departments like Consultants, Resident Medical Officers, Nursing, Accounts and Billing, Housekeeping, Kitchen Staff, Pharmacy and Security.

6.3 TYPES OF DISCHARGES

Discharges can be of two kinds:

6.3.1. PLANNED DISCHARGE

- When the treating Consultant feels the patients is stable and, in a condition, to be discharged the next day, procedure for planned discharge is followed.
- Once the treating Consultant plans that patient is to be discharged the next day **after review**, a tentative discharge summary is prepared in the software by the RMO on duty.
- The CMO prepares a list of the '***tentative' planned discharges*** by checking from RMO on duty and Nurses in charge.
- List is handed over to RMO on night duty. He calls for the files of patients and the types the discharge summary.
- The Consultant reviews the patient the next day. Changes if any are made in the discharge summary in the file.
- The medical officer makes the desired changes/ additions and prints the summary
- The summary is printed and signed by Consultant. One copy is handed over to the patient. A photocopy is kept in the patient file
- Mean while Clearance is obtained from Canteen, Pharmacy, Housekeeping, Reception - Billing and finally from Nursing

6.3.2. UNPLANNED DISCHARGE

- During the rounds, the Consultant decides the patient needs to be discharges
- The RMO prepares a Discharge Summary immediately, prints and the same is signed
- Clearance from various departments is obtained as specified above
- One copy is handed to the patient and one is put in the patient file

6.4 *DISCHARGE PROCEDURE*

6.4.1 Each Patient will be provided with a Discharge Summary on the day of discharge as far as practicable. If not, then it will be posted within 24 hours.

A copy of the Discharge Summary will be kept in the patient file.

6.4.2 The admitting doctor after reviewing the patient and getting convinced by the stabilization of the patient decides to discharge the patient and give written orders for discharge.

6.4.3 Resident doctor/Registrar of respective specialty timely updates the progress notes and completes required discharge records and documents.

6.4.4 Nurse initiates the Clearance protocol.

6.4.5 FLOW PROCESS FOR DISCHARGE PROCEDURE

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Planned Discharge is conveyed by the Consultant a day before by 6 pm. List is ready and mailed by the Discharge Coordinator (IPD) by 6pm, so that summaries can be prepared in night.

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Planned discharge summaries are made by the MOs in the night except Stat Discharges. By 0900 hours all discharges made and it is the responsibility of the Medical Officers to get it finalized and signed by the Consultant. This entire process should be complete by 1000 hours

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By 1000 hours all Discharge Summaries will be complete and signed by Consultant after a FINAL REVIEW OF THE PATIENT

(Discharge process for TAT monitoring will start from here)

And assigned nurse/nursing in charge will initiate the discharge process by Initiating CLEARANCE PROCESS in the Software

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FIRST clearance - CANTEEN (Check all dues, enters pending dues if any)

CLICKS OK

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SECOND Clearance - PHARMACY (Nursing will return medicines physically and indent discharge medicines)

Checks RETURN Medicine, prepares packets of discharge medicine and sends to respective Nursing Stations
CLICKS OK

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THIRD clearance - HOUSEKEEPING (checks for no dues for room amenities, dresses and linen, enters pending dues if any)

CLICKS OK

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FOURTH clearance- <u>RECEPTION</u> (final bill to be collected and verified for respective category from billing department)

Financial Clearance

CLICKS OK

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FIFTH and final clearance- NURSING STATION (as per checklist)

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Once all clearances are complete and discharge medicine reached Nursing Station, then Nurse will take a print of Clearance Card.

Area nurse will explain discharge medicines, remove Cannula, and Patient is handed over the Clearance card.

Nurse hands over complete Discharge Bag to patient which include following:

- Discharge summary signed by the patient or relative; one copy of the original is kept in the patient file
- all the investigation reports, films,
- also Inform patient regarding any pending reports and intimate regarding the time and date of report collection and hand over a pending reports
- Medicines will be given and explained
- Cannula will be removed
- Special Instructions if any given
- Emergency Contact Numbers explained in case of URGENT CARE.

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The Discharge Summary os handed over to the patient / attendant and a copy is retained on the Patient file

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The Nurse will tear of the slip attached at the end of the Clearance Card for submission at security and give it to the patient. This will be submitted at the security gate with identification band.

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The Security hands over the clearance card to the IPD.

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The IPD staff then discharges the patient from the computer system/software.

6.5 TAT FOR DISCHARGE IS CALCULATED FROM SOFTWARE

Turnaround time for Discharge is calculated by difference between time of discharge put by MO/Consultant and the time of discharge reflected in the software. The endeavor at Indus Hospital is that the **Turnaround Time** for discharge should not be more than **4 hours.**

6.6 COMPONENTS OF A DISCHARGE SUMMARY

The following information is accurately and legibly displayed in the PATIENT DISCHARGE CARD by the IPD staff and MEDICAL OFFICERS in consultation with the treating doctor/Consultant.

- Name , Unique identification number, date of admission and date of discharge
- Reasons for admission, significant findings and diagnosis
- Condition of patient at the time of admission and discharge.
- Principal Diagnosis: The condition established after study that is chiefly responsible for necessitating the admission.
- Secondary Diagnosis: All conditions that coexist at the time of admission, that develop subsequently, or that affect patient care, or that require clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of stay, or increased nursing care and/or monitoring.
- All examinations conducted and all positive and negative findings are documented in an objective manner.
- Principal Procedure: The one performed for definitive treatment rather than diagnostic or exploratory purpose or to treat a complication; the one most clearly related to the principal diagnosis.
- Secondary Procedures: All other operative or invasive procedures.
- Includes a careful record of investigations, so that the results can be reviewed by the consultant at a later date or by another consultant if necessary.
- Includes procedures performed, medications administered and other treatment given
- Record of further follow up advice, medication and drugs dosage is prescribed.
- Summarizes the information given to the patient regarding his/ her condition, including appropriate precautions and information about the side effects/ risks/ benefits of proposed treatment is mentioned
- It clearly contains the detail of the persons to be contacted in case of emergency and incorporates instructions on how and when to obtain urgent care
- All this is documented and explained in a language understood by the patient.
- In case of demise of the patient during treatment, it contains a copy of death certificate indicating the cause, date and time of death.
- No abbreviations are to be used in the Discharge summary.
- In case of death of the patient, a Death Summary is given and the cause of Death is also given. However, cause of death can never be given as Cardio Respiratory Arrest.
- Discharge summary should be filed in patient file within 24 hours of patient discharge.

6.7 MODIFICATIONOF DISCHARGE SUMMARY

After discharge, a discharge summary can be modified only under following circumstances:

6.7.1 If the patient name, age, address and sex is wrongly mentioned in the summary. The modification can be done only on production of one of the following:

- Voters ID
- Passport
- Driving license
- Birth certificate/Pan card

6.7.2 If a disease term is mis-spelt.

6.8 MEDICATION AT DISCHARGE

- Discharge medications are written in the discharge summary by the treating physicians at the time of discharge
- The concerned nurse returns the medications that have not been used (***PHARMACY RETURN)*** and those written in the discharge summary are procured by the patient.
- Doctor preparing the discharge slip clearly writes the instructions for the use of drugs and date for follow up
- Pharmacy dispenses the medications as full strips or bottle showing:
  - Name of the drug
  - Expiry date
  - Batch number
- The doctor or nurse makes the patient/attendant clearly understand the dosing schedule and manner of drug intake in a language understood by them.
- For outdoor patients, the dispensing pharmacist in the Outsourced pharmacy clearly states the manner of drug intake or administration in local language. This can be further confirmed by the treating consultant

7. IMPLEMENTATION

1. Consultants
2. Medical Officers
3. Nursing
4. Operations Management - IPD, Housekeeping, Kitchen, Accounts and Security

8. POLICY CROSSLINKAGES

Nil