BACHA KHAN MEDICAL COMPLEX / GAJJU KHAN MEDICAL COLLEGE Medical Teaching Institute, SWABI

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Policy on Patient Flow	
Patient Flow/POL/GKMC/BKMC-MTI/001	
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1.0 PURPOSE:

The purpose of this policy is to inform and provide guidelines to staff at BKMC-MTI, patients and visitors on the process of patient admission, discharge & transfer. The policy provides a framework for patient flow in the inpatient setting in accordance with their clinical needs. This includes admission to the hospital, transfer of care from one service to another including admission to specialized care units, transfer of care to another hospital as well as discharge from the hospital.

It also guides the healthcare team in evaluation, individualization and follow-up of a patient's discharge-related needs before, during, and after admission.

2.0 SCOPE:

This policy covers all medical and nursing staff, patients and their attendants at GKMC/BKMC-MTI & both constituent / affiliated THQ Hospitals i.e. Topi & Lahor.

3.0 POLICY STATEMENT:

3.1 **It** is the policy of GKMC/BKMC-MTI & both constituent / affiliated THQ Hospitals i.e. Topi & Lahor.

3.1.1 **To** provide continued care to the patients, including monitoring and / or admission to the appropriate units depending on their condition as well as the availability of beds,

3.1.2 **To** provide care in accordance with the patients' clinical needs whilst they wait for admission to the appropriate service within the hospital.

3.1.3 **To** ensure patients are housed in an appropriately equipped and staffed area whilst they wait for a bed to become available.

3.1.4 **To** assess the needs of all patients with regard to post-discharge care.

3.1.5 **To** develop a discharge plan that meets those needs, in a manner that is safe and efficient.

3.1.6 **To** provide guidelines for the transfer of care from one service to another within the hospital or from BKMC-MTI to another hospital, according to the patient's medical needs, if the required services are not available at the Hospital.

3.1.7 **Whenever** possible and practical, this will be to another hospital.

3.1.8 **Changes** in patient's flow can be done in response to any inevitable situation such as a pandemic, any disaster (internal/external) or any other, which can affect patient's routine functions.

4.0 PROCEDURE:

Admission Process.

4.0.1 **All** patients requiring inpatient admission must have an admission order generated in the HIS by an authorized physician. Patients are admitted under one of the following categories:

4.0.2 **Emergency** Admission: Patients admitted through the Emergency Assessment Room.

4.0.3 **Elective** Admission: Patients admitted for treatment, based on a planned protocol provided by their physician, including the recommended date of admission, treatment to be carried out, suggested after-care, etc.

4.0.4 **Day-Case** with Definite Admission: Patients admitted into the hospital after obtaining surgical treatment.

4.0.5 **The** Consultant of the admitting service or his designee generates an admission order citing the reason for admission.

4.0.6 **The** nursing staff in the clinical area sends the patient to admissions office for further processing of their inpatient admission.

4.0.7 **Every** admitting specialty has designated beds.

4.0.8 **From** 08 am to 02 pm daily these beds are allocated to admissions of the respective departments only.

4.0.9 **After** 02 pm all unutilized (Non-reserved) beds of all specialties will come in the pool system. Admission office will then categorize the admissions as below.

4.1 Category 1 (IMMEDIATE ADMISSION)

4.1.1 **Firearm** Injury.

4.1.2 **RTA**

4.1.3 **Foreign** body / Airway / Food Poisoning

4.1.4 **Fractures.**

4.1.5 **Emergency** Delivery cases.

4.1.6 **Superior** Vena Cava Obstruction (SVCO)

4.1.7 **Cord** Compression

4.1.8 **Life** threatening electrolyte imbalance e.g., severe hyperkaliemia, hypokalemia.

4.1.9 **Acute** Renal Failure.

4.1.10 **Febrile** Neutropenia/Sepsis.

4.1.11 **Life** threatening bleeding (Hematemesis, Melena).

4.1.12 **Life** threatening Cardiac emergencies (MI etc.).

4.2 Category 2 (URGENT ADMISSION)

4.2.1 **Hemoptysis**

4.2.2 **Virginal** Bleed / Melena

4.2.3 **IBPP** Admissions (All of the above should not be life threatening / Major)

4.3 Category 3 (Routine)

4.3.1 **Pleurodesis** / Chest tube insertion for symptom control

4.3.2 **Pain** control

4.3.3 **Palliation**/Supportive care

4.3A **Social** Circumstances such as distance traveling, Financial or domestic constraints etc. do not themselves, qualify a patient for admission,

4.4 EAR Admissions:

4.4.1 **Once** a decision to admit is made a bed is requested from the admission office.

4.4.2 **If** a bed is available for the admitting specialty, then the bed is allocated immediately.

4.4.3 **If** a bed is not available, the patient is transferred to the Admission Holding Bay (AHB), until a bed becomes available under the desired service.

4.4.4 **The** EAR team is responsible for continuing medical care and the clinical nurse manager ensures that appropriate nursing staff is assigned to provide care for patients in the AHB.

4.4.5 **The** holding bay (AHB) operates round the clock, but all efforts are made to transfer patients from the AHB to their assigned room as quickly as possible, once such a room becomes available.

4.4.6 **Patients** in the AHB will have first priority to be transferred to inpatient beds, as and when these become available through the course of the day.

4.4.7 **If** the AHB is full then patients will wait for a bed in the EAR or, after 02 pm, will be temporarily housed in the locally defined overspill area. In the latter situation, the Nursing Manager in EAR will assign a named nurse for these patients, ensuring that a ratio of one nurse to four patients is maintained

4.4.8 **It** is the responsibility of the EAR team to ensure regular reviews of all such patients

whilst they await a bed for formal admission.

4.4.9 **All** patients in AHB will be seen by the relevant admitting team at least once every 24 hours.

4.4.10 **Any** patient who has waited more than 8 hours in the EAR for a bed must be reviewed by the admitting team with a view to:

4.4.10.1 **Discharge** home with early follow up or

4.4.10.2 **Transfer** to another medical facility with a clear plan of treatment. In the event of transfer to another healthcare facility, the Hospital will not be responsible financially for any costs incurred by the patient.

4.4.11 **All** patients waiting for beds for admission are allocated beds after 02 pm in the pool system as per availability.

4.4.12 **In** the pool system, beds are allocated according to the category of admission on a first-come first-served basis.

4.4.13 **Where** the expected duration of admission is less than 24 hours, the patient should be admitted to SSU (for details refer to Policy on specialized care units).

4.5 Barrowing:

A consultant may barrow a bed from a consultant of a different specialty for an emergency admission.

4.6 ICU:

4.6.1 **ICU** admissions and discharges as per ICU admissions criteria. (Details in policy on specialized care units)

4.6.2 **For** an anticipated transfer out of ICU, the ICU team may reserve a bed on the floor up to 2 hours before the expected time of transfer.

4.6.3 **A** bed cannot be held on the ward for when a patient is in ICU.

4.7 Surgery:

4.7.1 **Where** there is a reasonable to high likelihood of a patient requiring an HDU or ICU bed following surgery, elective surgery must not commence until the availability of such bed has been confirmed and the bed reserved.

4.7.2 **In** the rare event that a bed has been reserved in the ICU or HDU but is not

available post operatively, then the patient will be kept in PACU until a bed becomes available in the HDU or ICU, or the patient becomes well enough to go to the ward.

4.7.3 **When** an elective surgical procedure is delayed for any reason, the patient will be informed of the reason for this and this will be documented in the patient's medical record. Each such patient will be given a new date for their procedure. Where such delay is greater than 4 weeks, the patient will be seen in the outpatient clinic by the consultant surgeon so that any possible implications on the treatment can be discussed.

4.8 Diagnostic & Treatment Procedure:

When a diagnostic or treatment procedure is delayed for any reason, the patient will be informed by the relevant team of the reasons for delay and this will be documented in the patient's medical record. Each such patient will be given a provisional new date for their procedure/ investigation.

4.9 Admission Process:

Upon admission, the inpatient department Unit Coordinator is informed of the patient's admission. The Unit Coordinator retrieves the patient's medical record and informs the assigned nurse So that a bed can be assigned, and admission preparations can begin.

The assigned nurse prepares the bed according to the patient's condition.

The patient is sent to the appropriate inpatient department where the Unit Coordinator informs the nurse assigned to the patient's room, of his or her arrival and issues an identification wristband to the patient.

The hospital will endeavor to ensure that patients are cohorted appropriate to their age and sex, and that staff in the receiving unit are appropriately trained to provide care according to patient category.

The assigned nurse accompanies the patient to his or her designated bed and assists him or her in changing into hospital clothing.

5.0 Admission to Specialized Care Units:

Only ICU, SSU, AHB and OPAT services are available

5.1 Early Warning Scoring Systems:

Appropriate early warning scores, such as NEWS and PEWS for example, may be used to help identify patients requiring an enhanced level of care, including those likely to need transfer to the ICU. A rapid response team exists, to whom all patients with a high score are referred for rapid assessment, treatment and if needed, transfer to a higher level of care.

Further details on the applicable early warning scores, and on requesting review by the Rapid Response Team, are available in the HIS.

6.0 ICU (INTENSIVE CARE UNIT)

6.1 Criteria for Admission to ICU:

6.1.1 **Patients** requiring invasive mechanical ventilation and or invasive haemodynamic monitoring and all those on vasopressor medication.

6.1.2 **Post-operative** care after major surgery.

6.1.3 **Respiratory** instability or respiratory failure.

6.1.4 **Sepsis** with haemodynamic instability

6.1.5 **Gastrointestinal** bleeding or bleeding at other sites with haemodynamic instability

6.1.6 **Myocardial** infarction and unstable angina requiring cardiac monitoring

6.1.7 **Cardiac** arrhythmia affecting haemodynamics

6.1.8 **Post** successful resuscitation from cardiac arrest

6.1.9 **Significant** electrolyte disturbances that require cardiac or close monitoring.

6.1.10 **Druginfusions** that require cardiac monitoring.

	less than <	more than >
Systolic BP	1 1yr 60mmHg >1 yr 70mmHg + (age x2)	1 1yr 100mmHg > 1 yr 130 mmHg
Heart rate/min	1 1 yr 80 >1 *yr* 60	11yr 180-220 >1 yr 160-180
Resp. rate/min	0-8 yr 20 8-12 yr 15 > 12yr 10	
MAP	50 mm Hg	90 mmHg

However, this is meant as a guide only, and not as a replacement for clinical judgement.

Other patients, not falling within these guidelines, may be admitted at the discretion of the consultant physician in charge of or on-call for the ICU.

6.2 Prerequisites for Admission:

6.2.1 **When** a patient requiring ICU care is identified, the primary service resident / medical officer will discuss the case with the primary service consultant.

6.2.2 **An admission** request will then be made to the ICU consultant / resident /medical officer.

6.2.3 **The** ICU resident will immediately evaluate the patient in the room / bed & initiate necessary resuscitative support to stabilize the patient (endotracheal intubation, initiate vasopressors, sedation/ relaxation, etc). This evaluation will be performed regardless of whether an ICU bed is available or not.

6.2.4 **He** / she will report to the ICU Consultant, who will determine if the admission is appropriate.

6.2.5 **Once** the decision for admission is made, the ICU resident will inform the ICU nursing team leader.

6.2.6 **If** a bed is available, the ICU team leader will arrange the admission to the ICU.

6.2.7 **If** an ICU bed is not available, the ICU Consultant will assess all current ICU patients & determine if any patient can be shifted out from the ICU.

6.2.8 **If** such a patient is identified, the ICU team will inform the primary team of the identified patient and transfer the patient out.

6.2.9 **The** ICU nursing team leader will supervise the discharge and admission process.

6.2.10 **In** case an ICU bed cannot be made available, the ICU nursing team leader will inform the primary team. The attending Consultant of the patient on the floor would then be responsible for shifting patient out of the hospital to the ICU of another hospital.

6.2.11 **A** makeshift ICU on the floors will not be operated, but a bagging team is available around the clock for any intubated patient for whom a ventilator is not available.

6.2.12 **If** one ICU bed is available & there is a request for two patients, priority will be given to. Intubated patients, patients already admitted to the hospital versus patients in the Assessment room, or the recovery room.

6.2.13 **When** a patient is admitted to the ICU a new H&P template is filled out by the ICU resident.

6.2.14 **Normally** patients are not accepted directly for admission to ICU from another hospital. In exceptional circumstances this may be done with the approval of the Medical Director (MD).

6.3 Transfer of patient from the ICU for Investigations:

(Radiologic / endoscopic / other interventional procedures)

All patients admitted to ICU who need to be transferred elsewhere within the hospital for radiologic / endoscopic / other interventional procedures must be appropriately monitored throughout the process. This will include monitoring of oxygen saturation, blood pressure and heart rate.

In addition, especially for ventilated/comatose patients, special care will be taken to ensure that the airway is protected. This will be by ensuring that the patient is accompanied by a trained nurse and a respiratory therapist.

6.4 Procedure for Discharge:

The decision to transfer would be made, by the ICU physician when the patient does not need ICU level of care. This would be documented in the progress notes. Patient will only be transferred once their clinical and nursing needs can be met in the ward where they are being transferred.

6.4.1 Criteria for discharge from the ICU

6.4.1.1 **Successful** discontinuation of mechanical ventilation.

6.4.1.2 **The** patient's physiologic status has stabilized, and ICU care and monitoring is no longer needed.

6.4.1.3 **The** ICU care of the patient has been deemed as futile by the ICU Consultants in which case care is withdrawn in consultation with the family and the patient may be transferred to another level of care.

6.5 Prerequisites for Discharge

6.5.1 **Once** a decision for discharge from the ICU has been made, a physician will document that criteria for discharge have been met, after which the order for transfer out will be completed.

6.5.2 **The** ICU service will inform the primary service about the transfer out of the patient from ICU to the floor. The ICU team will write a transfer out note, and the primary team will write a receiving note.

6.5.3 **The** ICU nursing team leader will be responsible for arranging the required bed.

6.5.4 **Discharges** will be made as soon as a bed is available and to the service deemed most appropriate by the ICU consultant.

6.5.5 **If** no bed is available, a booking will be made for the first available, acceptable bed.

7.0 HDU (High Dependence Unit)

7.1 Admission to HDU.

7.1.1 **Post**-operative care after major surgery.

7.1.2 **Respiratory** instability or respiratory failure requiring non-invasive ventilation.

7.1.3 **Sepsis** with haemodynamic instability

7.1.4 **Gastrointestinal** bleeding or bleeding at other sites with haemodynamic instability

7.1.5 **Myocardial** infarction and unstable angina requiring cardiac monitoring.

7.1.6 **Cardiac** arrhythmia with haemodynamic instability.

7.1.7 **Significant** electrolyte disturbances that require cardiac or close monitoring.

7.1.8 **Drug** infusions that require cardiac monitoring.

7.1.9 **Acute** neurological events that require intensive monitoring.

7.1.10 **Hemodynamic** instability, in adults, is defined as a systolic blood pressure of less than 90, or greater than 200 mm Hg, or a heart rate of <55 or

>140. However, this is meant as a guide only, and not as a replacement for clinical judgement.

7.2 Discharge from HDU:

7.2.1. **The** patient's medical/nursing needs can be met on a general ward.

7.2.2. **The** criteria for discharge from ICU will be followed.

8.0 SECU (SURGICAL EXTENDED CARE UNIT)

8.1 Admission Criteria for SECU:

All patients who have had major surgery but do not need HDU/ICU care, can be transferred to SECU for post op care and two hourly monitoring.

8.2 Discharge from SECU:

Patients will be transferred out of SECU, once two hourly monitoring is no longer required. This will be documented in the medical record by a physician prior to transfer out.

8.3 Business Rules for SECU:

8.3.1 **SECU** will maintain a patient to nursing ratio of 1:4 at all times.

8.3.2 **SECU** will follow ICU/HDU timings for visitors.

Please also review the SOP for SECU.

9.0 SSU (SHORT STAY UNIT)

9.1 Admission Criteria:

9.1.1 **Patients** needing prolonged observation following an emergency or elective procedure for a period of no more than 24 hours.

9.1.2 **Patients** needing inpatient medical care for a short duration deemed to be less than 24 hours.

9.1.3 **Patients** may be admitted from the OPD or from the EAR.

9.2 Discharge /Transfer-Out Criteria:

9.2.1 **If** stay in the hospital has exceeded 24 hours but the patient is not ready for discharge, (s) he must be transferred out to the other unit most appropriate to the clinical situation, a process which the admissions office will complete as a matter of priority. However, in case the bed is not available, patient's need will be met through the provision of required medical & nursing care in SSU.

9.2.2 **If** a patient's clinical needs have been met within 24 hours of admission and it is felt that admission is no longer necessary, the patient may be discharged home from the SSU.

Please also refer to the SOP for SSU.

10.0 OPAT (OUTPATIENT PARENTERAL ANTIBIOTIC THERAPY BAY)

The OPAT Bay is designed to administer all parenteral non-chemotherapy drugs, as well as blood products, with an infusion time not exceeding 4 hours. This includes

10.1 **All** antibiotics, anti-fungal.

10.2 **GCSF.**

10.3 **Parenteral** anti-coagulants, such as enoxaparin.

10.4 **Venofer.**

10.5 **Blood** Transfusions on available slots.

Please also refer to the SOP for OPAT.

11.0 AHB (ADMISSION HOLDING BAY)

11.1 **Patients** in the EAR needing inpatient admission will be considered for transfer to AHB if a bed on the appropriate ward is not immediately available.

11.2 **Patients** requiring HDU/ICU care, or the equivalent thereof, or those requiring isolation, will not be transferred to the AHB.

Please also refer to the SOP for AHB, which is available in the office of the relevant Managers.

12.0 PACU (POST ANAESTHESIA CARE UNIT)

12.1 PACU Admission Criteria:

Patients eligible for admission to the PACU may include but are not limited to:

12.1.1 **Patients** recovering from Monitored Anesthesia Care (MAC), general, or regional anesthetic.

12.1.2 **Patients** requiring mechanical ventilation and/or airway protection.

12.1.3 **Patients** requiring invasive hemodynamic monitoring including pulmonary artery catheters and arterial catheters.

12.1.4 **Patients** receiving medication and/ or treatments requiring continuous hemodynamic monitoring (e.g. elective cardioversion, central line placement, epidural placement, etc.).

12.1.5 **Patients** with a documented etiology for potential instability.

12.1.6 **Patients** requiring noninvasive ventilation post anesthesia.

12.1.7 **Patients** requiring critical care admission can be admitted to PACU for monitoring and management in the absence of critical care beds till the time bed is created or arrangements made to transfer the patient to an outside facility.

12.2 Discharge / Transfer Criteria from PACU:

A minimum score of 9/10 of Modified Aldreth Scoring System (and/or return to

pre-operative status) is achieved prior to transferring the patient to an inpatient unit or to the chair recovery prior to discharge to home.

A minimum score of 9/10 of Post Anesthesia Discharge Scoring System (and/or return to pre-operative status) is achieved prior to discharging the patient home from the chair recovery.

For further details, please refer to PACU Monitoring Guideline for Nurses.

13.0 INTERFACILITY REFERRAL / TRANSFER OF A REGISTERED INPATIENT:

13.1 Transfer of Care within the Hospital:

13.1.1 **The** attending physician may request another consultant to take over the care of the patient. This can be done either by following the hospital consult policy requesting a transfer of service or by speaking to the receiving consultant on the phone and getting his/her consent. In all such cases it is the responsibility of the referring physician to ensure that the patient / responsible family member has been told that such a request has been made and the rationale underlying this has been clarified before the patient is seen by the receiving consultant. The transfer note is entered in the HIS by the transferring team and a fresh handover template is completed prior to transfer.

Since all care provided is documented in HIS thus the receiving service can access all other details through the electronic medical record.

13.1.2 **When** patients require services that are not available at the hospital, they will be considered for transfer, depending on their clinical situation. In the first instance, this will normally be to another hospital. If the **patient's** condition does not allow for such a transfer, the patient may be transferred to a local tertiary care hospital in accordance with the procedure detailed below. Where a formal arrangement exists with another institution within the same city, for specific diagnostic or therapeutic procedures, and when the clinical situation requires that the

patient be treated locally, rather than being transferred to another hospital of the SKM Trust, then the patient may be sent to such a local facility. This sort of transfer usually requires prior approval of the MD/Associate MD, other than in an emergent situation, when approval will be sought *OSt facto.*

13.1.3 **+** a consultant is away, on leave or sick their HOD must ensure that their all-clinical tasks including admitted patients in their queue are transferred to another consultant.

13.2 **Transfer /Referral of Care to an Outside Facility:**

13.2.1 **The** Attending physician is responsible for determining whether the patient is stable for transfer and the need for special equipment or personnel during the transfer. This would be documented in the patient's medical records and/or transfer form.

It will be ensured that the Patient/relatives/attendants give their consent for a referral and/or transfer out from BKMC-MTI, Swabi.

13.2.2 **The** transferring physician and other team members will comply with the Hospital policy to ensure safe and appropriate referrals/transfers.

13.2.3 **Before** initiating the process of transferring the patient to another facility, the attending physician shall advise the patient, or person authorized to consent on behalf of the incompetent patient, of the need, risks and benefits of the transfer.

13.2.4 **If** the patient/authorized person refuses to consent to the transfer, the refusal shall be documented in the progress notes of the patient's medical record.

13.2.4.1 **In** case the patient/family refuses transfer or where the patient's clinical condition does not allow transfer, the hospital will provide the best possible care with available resources as per patient's clinical needs, including by temporarily credentialing outside physicians.

13.2.5 **After** the Physician has written an order for transfer ensuring the above is met,

his/her team and the floor/area nurse manager/team leader would coordinate for the transfer and/ or receiving back the in-patient in case of a temporary referral.

13.2.6 **The** medical team identifies suitable vacant beds in other institutions in the city and speaks directly to the doctor at the receiving hospital to provide the following details.

13.2.6.1 **Details** of the patient (full name and age)

13.2.6.2 **A** brief history and physical

13.2.6.3 **Diagnosis** and treatment

13.2.6.4 **Reasons** for transfer

13.2.7 **The** Physician's team and the nurse manager/team leader would coordinate the time and details of the transfer with the patient, relatives/attendants, and the receiving facility. They would review the order and confirm:

13.2.7.1 **Order** for transfer

13.2.7.2 **Mode** of transfer

13.2.7.3 **Any** special equipment/ staff needed for a safe transfer

13.2.7.4 **Patient**/patient representative has given the consent for transfer. If the patient is not in a stable state, then the patient may only be transferred if the attending physician determines that the risks of the transfer outweigh the medical benefits. If the patient is incapable of consenting because he/she is a minor, unconscious, or otherwise incompetent, the patient's parent, guardian or next of kin should give consent.

13.2.8 **Transfer** information will be documented in the patient's medical records on the appropriate template (Annexure A).

13.2.9 **The** Nurse manager/team leader together with the concerned physician assesses the care needs of the patient during transportation.

In all direct transfers, the attending physician will decide whether a doctor (MO/Resident), nursing staff (RN), or other suitable paramedic is required to

accompany the patient.

13.2.10 **Patients** must have their vital signs checked and documented within 30 minutes of transfer. Following that, vitals should be repeated as per NEWS protocol or at least once during the transfer and once at the time of handing the patient over.

13.2.11 **Medical** / Nursing staff accompanying the patient must take appropriate resuscitation equipment and medication, if needed, with them in the ambulance.

13.2.12 **The** cost of transfer and any other costs related to the investigation / procedure / dialysis will be paid by the patient/relatives/attendants. For supported patients, the matter will be referred to the Medical Director for decision on case to case basis. The specified staff members will coordinate this before transfer.

13.2.13 **When** the transfer letter is completed in the HIS, 2 copies are printed out. One copy is handed over to the physician receiving the patient whilst the other copy is made part of the individual patient's medical record. It contains details of monitoring during the transfer and if possible, the signature of the receiving physician or at least the name of the physician to whom the patient was handed over.

13.3 Referral to an outside facility (OPD patients)

When a stable patient needs an outpatient referral to get an opinion from a specialty not available within SKMCH&RC, he may be referred to a specialist outside. In all such cases, a referral letter may be provided to the patient, a copy of which will be held in the patient's medical record. The referring physician will be responsible for documenting the referral outcome in the patient's medical notes when possible.

14.0 DISCHARGE PROCESS:

14.1 **Discharge** planning is initiated at time of admission & the plan is updated regularly and communicated to the patient and family throughout their stay in the hospital.

14.1.1 **Physicians** conduct daily rounds and decide to discharge patients, based on their medical condition. As far as possible, the decision to discharge the patient should be made before noon. The patient and the Assigned Nurse are both informed of the patient's discharge.

14.2 **Discharge** planning needs of the patient are assessed based on some or all of the following criteria:

14.2.1 **The** level at which the patient and/or family understands the patient's medical condition and reason for hospitalization.

14.2.2 **Tasks** the patient can/cannot accomplish as a result of current health problems.

14.2.3 **Socio-cultural** and religious practices and beliefs.

14.2.4 **Age-related** issues.

14.2.5 **Language** barriers that affect the understanding of the treatment plan.

14.2.6 **Physical** and/or cognitive limitations.

14.2.7 **Emotional** and mental status.

14.2.8 **Level** of post-hospital care needs (acute, intermediate, chronic, etc.)

14.2.9 **Availability** of adequate financial resources to assist in the discharge process.

14.2.10 **Access** to transportation.

14.2.11 **Readiness**/availability of family to assist with care needs of the patient at home.

14.2.12 **Need** for special equipment, monitoring agents, supplies, or medication.

14.3 **Upon** conducting his or her rounds, the physician fills out the online 'Discharge

Summary Form' as well as the 'Discharge Medicine'. This information is saved on the patient's online medical record. Every admitted patient will have discharge planning.

The patient's discharge summary is reflective of the patient's status at the point of discharge, i.e. patient's needs, problems, capabilities, limitations.

14.3.1 **The** discharge summary must not contain any abbreviations.

14.3.2 **At** a minimum the discharge summary will contain the following:

14.3.2.1 **Reason** for admission, diagnoses, and comorbidities

14.3.2.2 **Significant** physical and other findings

14.3.2.3 **Diagnostic** and therapeutic procedures performed

14.3.2.4 **Medications** administered during hospitalization with the potential for residual effects after the medication has been discontinued and all medications to be taken at home

14.3.2.5 **The patient's** condition/status at the time of discharge (examples include "condition improved" "condition unchanged" and the like)

14.3.2.6 Follow-up instructions.

14.4 **The** Unit Coordinator is informed of the completion of the 'Discharge Medicine' and sends it to the Pharmacy. Upon collecting the patient's medication, a Pharmacy staff member delivers the medication(s) to the patient's room in the In-patient department. Pharmacy is responsible for educating the patient on his/her discharge medications.

14.5 **Nursing** staff assists the patient in getting dressed and commences preparations for discharge. The Assigned Nurse contacts the patient's family, checks and records the patient's vital signs, provides discharge instructions as per hospital policy and as requested by the physician, and records other relevant discharge information in the 'Nurses' Discharge Notes'. The nurse also ensures that all relevant education at discharge is completed. This may include, but is not limited to, education on care provided during the inpatient stay, care and precautions at home, appropriate follow up both for medical as well as any other issues and phone numbers to call if there are any queries once home.

14.6 **A** The patient's physician is notified of any decline in the patient's medical condition that would require amends to be made in the patient's discharge plan, e.g. Abnormal blood pressure levels, extreme body temperatures, abnormal test results after discharge orders have been written and prior to the patient leaving the facility, etc.

14.7 **The** Unit Coordinator then informs the Admission & Discharge Office of the physician's orders to discharge the patient.

14.8 **Upon** arrival of the patient's family, they are sent to the Admission & Discharge Office.

14.9 **Vulnerable** patients must be discharged to an appropriate family member or guardian.

14.10 **The** Admission & Discharge Officer reviews the patient's medical record and identifies all procedures, medications and services provided during the current admission period, and accordingly creates the bill (for paying patients).

14.11 **All** outstanding payments are made to the cashier in the Out-patient department or the cashier in the Pathology department, and a receipt is issued to the patient.

14.12 **The** patient and his or her family are sent with the receipt to the Unit Coordinator in the In-patient department, where the patient is provided with a copy of the physician's 'Discharge Summary', and any required follow-up appointments are scheduled. It is at this point that the patient is officially considered to be discharged.

14.12.1 **A** copy of the discharge summary is held in the patient's medical record as well.

14.12.2 **Ambulatory** patients who are deemed safe will be sent to discharge lounge (where applicable).

14.13 **Upon** exiting the SKMCH & RC facility, an officer of the Security department asks for the patient's receipt in order to ensure whether the patient has in fact been discharged from SKMCH & RC.

14.14 Patients Proceeding on Short Leave of Up to 10 Hours.

14.14.1 **Resident** doctor will ensure and document that it is safe for the patient to leave the hospital. This includes an assessment of required medications during this time or any medical/nursing interventions.

14.14.2 **If** the patient is to have any oral medication during his/her time away, those will be prescribed and provided as *once-only* doses.

14.14.3 **The** resident doctor will discuss with and obtain approval from the admitting / on-call consultant.

14.14.4 **The** patient will be asked to provide a phone number on which he/she can be contacted.

14.14.5 **The** unit coordinator will record the time when the patient leaves in the HIS and will document that he has explained the rules regarding short leave to the patient/responsible family member.

14.14.6 **In** the event the patient does not return at the appointed time, the unit coordinator will contact him/her on the number provided, and the admitting team will be informed.

14.14.7 **If** the patient fails to return within 16 hours of leaving the hospital, the admission will be cancelled, and the patient will be assumed to have absconded. The resident doctor will formally discharge the patient to release the bed.

14.14.8 **If** the patient reappears after the lapse of this period, (s)he will have to follow normal procedures for admission.

14.15 LAMA (Left against medical advice)

14.15.1 **Patients** who take the decision to leave the hospital against the advice of their physicians are entitled to supportive, non-judgmental care until the moment of departure from the unit.

14.15.2 **The** patient must receive complete information from the health care team regarding his/her disease/condition and the risks involved in leaving the hospital, alternative treatment options if available, and steps to be taken to safeguard his/her health including scheduling a follow up at SKMCH&RC with the appropriate medical team.

14.15.3 **The** assigned nurse / Team Leader must try to ascertain from the patient his

reason(s) for wanting to leave the hospital prematurely. They must inform the CNM/ CNM on call about the patient's intention to leave.

14.15.4 **The** patient's Consultant/Medical Officer/Resident must be informed by the nurse of the patient's desire to leave, so that he/she may visit the patient to reassure him/her, or otherwise try to persuade him/her to remain under care. The patient must be explained in detail the risks of leaving the hospital prematurely.

14.15.5 **If** despite above patient wants to leave, then the assigned nurse and Resident/Medical Officer must get the LAMA form completed and signed by the patient or relative. This should be witnessed by the assigned nurse, team leader, or resident/medical officer. This form then becomes part of the patient's medical record.

14.15.6 **The** patient should follow normal discharge procedure. In particular, the patient must be offered an outpatient appointment with their primary physician and must be offered copies of all relevant investigations.

14.15.7 **If** the patient has left the hospital without notifying the hospital staff, every effort will be made to contact the patient or his family by the concerned nursing staff and entry into the patient medical record will be made. The nursing staff will inform the primary physician and fill a quality improvement opportunity.

14.15.8 **When** applicable, the hospital reports cases of infectious disease and provides information regarding patients who may harm others to local and national health authorities as required.

15.0 RESPONSIBILITY FOR ADMISSION AND DISCHARGE PROCESS:

15.1 Admission & Discharge Office:

The Admission Office is responsible for assisting the patient in the admission process by making arrangements for a bed for the patient, updating the patient on any outstanding payments, as well as any other related information.

It is also responsible for providing clearance to the patient once all outstanding payments and bills have been paid.

15.2 Patient's Physician:

Each physician recommending patient admission must fill out an Admission Request Form (ARF) appropriate to the patient.

The physician should initiate discharge planning as part of the initial medical assessment.

15.2.1 **The** physician is responsible for updating the discharge plan as the patient's clinical needs change and documenting these changes on the prescribed discharge planning template in the HIS.

15.2.2 **The** physician should discuss discharge plan of care with appropriate health care team as well as the patient's family.

15.2.3 **Create** the 'Discharge Summary' for the patient, which includes Diagnosis During This Admission, Reason for Admission, Significant Physical Findings on Admission, Management During Admission, Diagnostic & Therapeutic Procedures Performed, Condition at Discharge, Follow-up Instructions, Significant Tests/Problems to Address on Follow-up, Medications to Take at Home, Appointment(s) & Instructions (if applicable).

15.3 Nursing Staff:

Nursing staff are responsible for receiving the patient in an appropriately prepared and equipped area. Nursing staff are responsible for orienting the patient to the hospital's environment as well as policies and procedures pertaining to patients.

15.3.1 **Ensure** that all necessary patient teaching has occurred, and that the patient/family is familiar with discharge instructions.

15.3.2 **Ensure** that all patient belongings, valuables and medications have been taken by the patient or his or her family.

15.3.3 **Document** patient's condition/status at the time of discharge in the 'Nurses' Discharge Notes'.

The Nurse manager/team leader will ensure that all required documentation is complete, in writing, before a patient is moved out.

15.4 Unit Coordinators:

Confirm arrangements for any medical supplies or equipment to be provided in the home.

Establish transportation home by the most appropriate means if the family is unable to provide transportation.

Responsible for updating the patient's medical record as being 'discharged' once clearance has been provided by the Admission & Discharge Office.

15.5 Pharmacist:

Pharmacist will provide patient/family with discharge medications, as recommended by the physician, as well as any other information related to the use of this medication.

15.5.1 **Pharmacist** will document all such encounters in HIS.