	Quality Management Systems Procedure	
	Title: Discharge of Patient Policy	
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POLICY:

1. Discharge planning is to be initiated on the basis of the patient's condition by the Treating Doctor at least 24 hours before actual discharge.
2. Assessment of the patient is to be made for being 'medically stable' and fit for discharge. This may include assessment of functional, medical, psychological, and/or cultural needs.
3. Discharge planning is a multidisciplinary, collaborative process involving the patient, patient's family, and concerned team members during a specific episode of illness.
4. If it's a medico legal case police is informed about the recovery of the patient and need to wait for further instructions from them.
5. Two copies of discharge summary shall be prepared in hospital, of which one is provided to the patient, one is included in the patient's record.

DISCHARGE PLANNING INVOLVES SEVERAL ACTIVITIES:

1. Development of a care plan for post discharge care (Medical).
2. Arranging for the provision of services, including patient/family education and referrals (Medical, Nursing).
3. The Nurse in charge, the Duty Medical Officers are responsible for coordinating the discharge with other team members.
4. Medication to continue and follow up visit details to be included with date specified.
5. For regular visit patients, the medical record needs to be arranged.

DISCHARGE DECISION:

- Decision regarding discharging the patients rest with the Treating Doctor of the patient who make such decision during his/her rounds on the previous day prior to the discharge of patient and the same is communicated to the patient, relatives ,the concerned ward nursing staff and the duty medical officer. However, the final decision regarding discharge is made on the basis of the condition of the patient by Treating Doctor on the scheduled day of discharge.

TIME FRAME FOR DISCHARGE AS FOLLOWES:

- Time taken for patients is 2-3 hrs
- Time taken for Aarogya shri patients 3-4 hrs

CONTENT OF DISCHARGE SUMMARY:

- As per the instructions of the Treating Doctor of the patient, the Medical Officer on duty write the discharge summary according to the care provided to patient by basing Medical records:
- History Record
- Physical Examination
- Progress record
- Investigation Record
- During the morning rounds of the Treating Doctor on the scheduled day of discharge of the patient, reassessment of the patient is done to confirm whether the patient is fit to be discharged. After being confirmed about the fitness of the patient to get discharged the consultant informs the same to the ward nurse. Treating consultant shall sign the discharge summary.
- Referral doctor advice to be added.

DISCHARGE SUMMARY CONTAINS THE FOLLOWING INFORMATION:

a. Patient's name, UHID & Date of Discharge

b. Reasons for Admission

c. Investigations performed and summarized information about the results of the investigations

d. Diagnosis made

e. Record of any procedures (operation, etc) performed

f. Condition of the patient at the time of discharge

g. Medication instructions

h. Follow up Advice

- As per the instructions of the Treating Doctor in the Discharge Summary, the discharge medicines are indented by the ward nurse and handed over to the patient/patient relatives with proper instructions as to when to take the medication as per the doctor's orders.
- Diet advice is added when there is a need for therapeutic diet continuation at home.

PATIENT COUNSELING:

Prior to final discharge of patient from the hospital the ward nurse counsels the patient regarding the medications , follow up procedure etc as mentioned in the discharge summary. Patient follow up visit dates are clearly informed.

LEFT AGAINST MEDICAL ADVICE (L.A.M.A):

- Under the scope of patient rights, no patients can be kept in hospital against their will.

- The nursing staff and the doctor concerned should try to persuade the patient to stay and at the same time try to find out why the patient wishes to leave, if possible the problem should be resolved.
- It is the responsibility of the doctor to explain to the patient that if the patient leaves the hospital against medical advice the hospital ceases to be responsible for his/her care.
- Despite this if, the patient still wishes to take his/ her own discharge all possible steps should be taken to ensure the patient/authorized attendant signs a form to this effect before leaving the hospital.
- In the event that the patient refuses to sign the form, this should be documented clearly in the Medical Records.
- Without signature patient cannot be sent out by Duty Medical Officer and Nurse.
- All discussions and risks explained should be recorded in the patient's Medical Records.
- A discharge summary is given to all patients leaving Against Medical Advice. In case of patients leaving against Medical Advice from the ER a brief discharge note is given.

MEDICO LEGAL CASES (MLC):

- Medico legal form is filled by Casualty Medical Officer and details of the MLC is documented
- Police intimation will be given immediately by Causality Medical Officer.
- All investigation reports and evidential materials shall be preserved by staff nurse on duty.
- MLC on admission / LAMA / death will be documented & police intimated.
- In case of death of MLC body is handed over to police.

Non MLC

In case of Non MLC, normal discharge will be followed

PATIENT EXPIRY:

- In-case of expiry of the patient, treating doctor/medical officer informs the patient relatives. Patients relatives are allowed time with the deceased patient.
- Ward nurse makes necessary preparation for cleaning the deceased. Body is cleaned by Mortuary department staff and wrapped in clean sheet. The on duty medical officer prepares two copies of the Death Certificate and the Death Summary. Death summary includes cause of death. The Death Certificate and Death Summary is stamped. Body handed over to the patient relatives or kept in the mortuary within an hour of death. Body handed over to the relatives along with one copy of Death Summary and Death Certificate and the other copy is attached to the patient Medical record.
- In case of medico legal cases, postmortem shall be conducted by Medical Officer on-duty and reason for death is documented, the one copy for forensic report is handed over to the local police station and another copy to patient attendants. Finally the body is handed over to the police.
- In case the patient is brought dead, death certificate is given by the hospital not the death report.