



Singapore Healthcare Management 2017

Decongesting Inpatient Flow with the Discharge Lounge Experience

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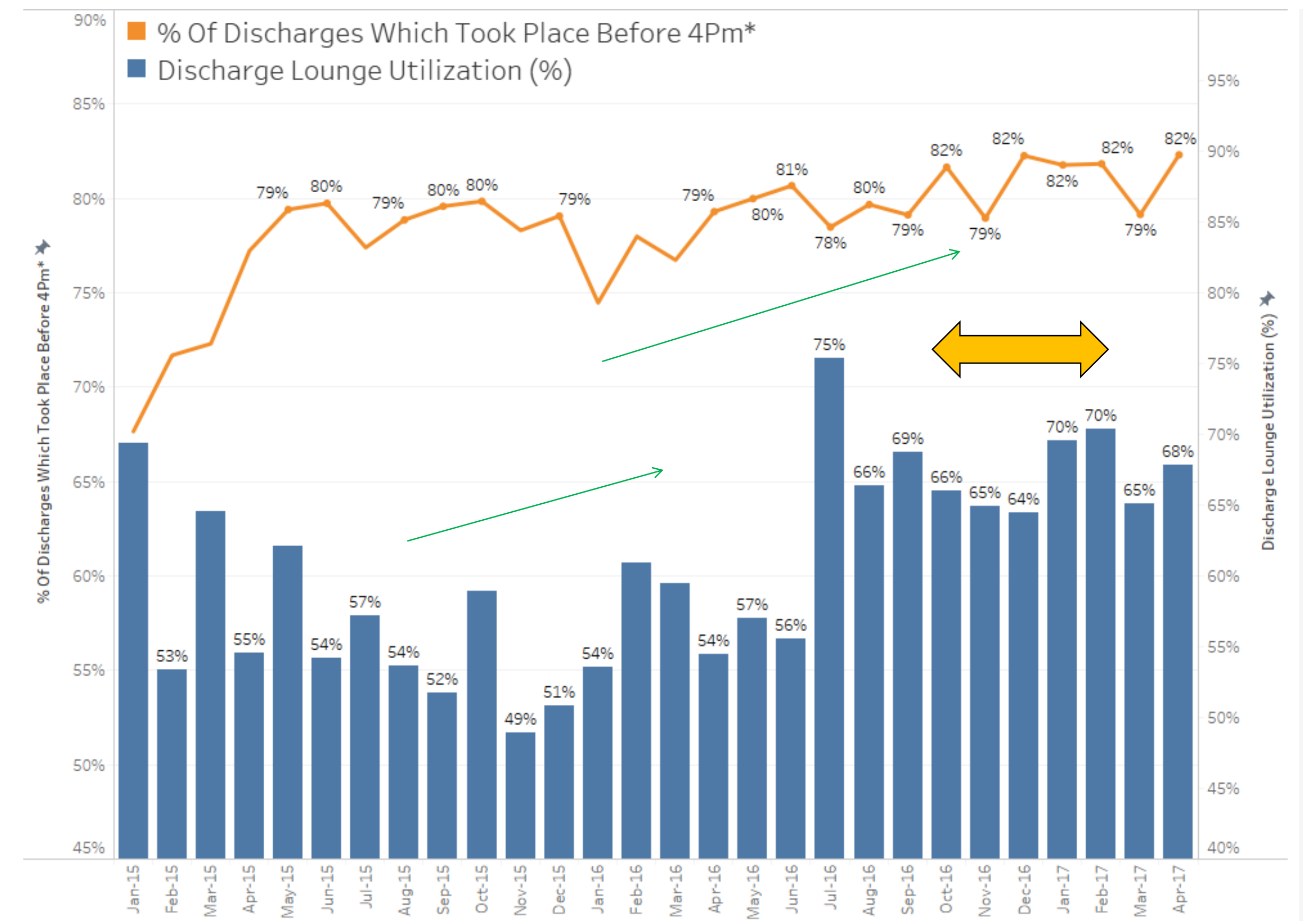
AIMS

Improve patient flow from Emergency to Inpatient wards by streamlining inpatient discharges via the Discharge Lounge (DL) to align with the acute admission demand profiles. Improving percentage of inpatient discharges before noon and 4 pm.

Summary of Decongestion Initiatives for Patient Flow

Pre-Admission	Increasing Holding Capacity • ATA Expansion • SSU Expansion	Reducing Demand • GP First • General Practitioner Empowerment Programme (GPEP)
Inflight	Increasing Capacity • Transformation of Demand Beds • Opening of Integrated Building	Improving Bed Management • Enhancing Right Siting Algorithm
Discharge	Internal Process Enhancement • Discharge Coordinators & Discharge Coordinating Tower • Community Referral Team (AIC/CGH Collaboration) • Official Discharge Timing to 1130 Hrs	Collaboration with External Agency • SACH Sub Acute Ward 66 • OVNH L6 • Grace Corner • Homecare Enterprise - home care beds Interim Discharge Location • Setting of Discharge Lounge @ L1 and L8
Post-Discharge	Standardisation of Outpatient Care • Defined End to End Care Pathway • Multi-Disciplinary Approach • Improving lead time through resource optimisation for timely outpatient care	Enabling Community Collaboration • Shared referral protocols • Empowering GPs/Polys/FMCs on follow up care

Source: Decongestion Workgroup



METHODOLOGY

Patient flow from ED to wards is affected by multiple factors including hourly discharge profile and downstream flow. Inpatient discharge hourly profile when not in alignment with the admissions profile causes preventable delays resulting in higher waiting time for admissions. One of the initiatives implemented by the Decongestion Committee, was to get inpatient beds ready for occupancy a few hours earlier. To enable inpatients ready for discharge to vacate their beds earlier, a discharge lounge facility was established. Operations and Nursing teams worked closely with clinical teams to identify patients fit for discharge who met the criteria for DL utilisation. The time saved would be the difference between the time when a patient occupied the DL and the actual time when the patient left the hospital. It was also necessary to maintain a high right siting % for admissions to these beds.

DL Patients By Specialty

Overall CGH Right Siting% = 85%

Bed Discipline	Admitting Specialty																	Grand Total
	Cardiology	Dermatology	Endocrinology	Gastroenterology	General Medicine	General Medicine	Respiratory Medicine	Otolaryngology	Eye	General Medicine	Neurology	Oral & Maxillofacial Surgery	Orthopaedic Surgery	General Surgery	Urology	Grand Total		
Cardiology	226	1	6		41	11	3			2	2		12	14	3	321		
Dermatology	1	1			5	2							3	4	1	17		
Endocrinology	2	2	4		21	8				2			5	5	2	51		
Gastroenterology	10	1	10		46	20	1			5	1		28	24	2	140		
Geriatric Medicine					1											1		
General Medicine	42	9	32	1	232	89	2	1	18	4			68	61	5	542		
Respiratory Medicine	18	4	4		85	14	1			5			12	13	1	157		
Infectious Disease					1											1		
Renal Medicine	2		2		18	5				1			5	4		37		
Rehabilitation Medicine															1	1		
Otolaryngology	1				10	4	2			1			11	18	2	49		
Eye					4	1	1						8	9		23		
General Med/Geriatric Med					1								1		1	3		
Neurosurgery	1				1	1							4	9	2	22		
Dental/Maxillofacial					1								1			2		
Orthopaedic Surgery	4	2	19		70	16	2	1	4	12			165	141	23	459		
General Surgery	13	4	27		99	27	9	5	7	6			186	259	31	673		
Urology	3		2		16	3	1			3	1		27	38	3	97		
Grand Total	323	23	107	2	654	180	22	7	44	30	1	695	602	77	2607			

Assigned to Right Bed : 75% (1951)

Assigned to a Different Specialty Bed : 25% (656)

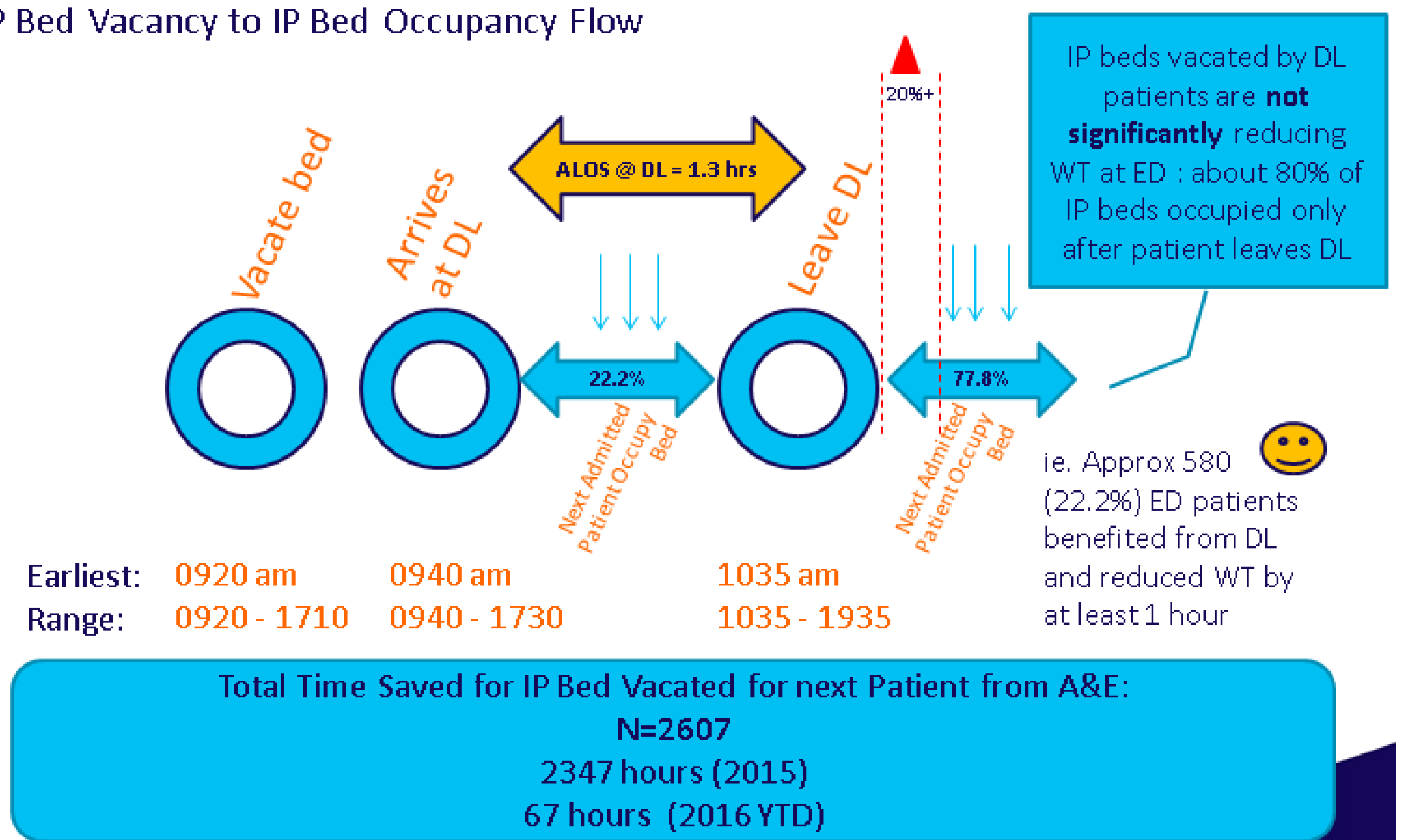


RESULT / OUTCOMES

With the introduction of the DL and the continuous refinement of the methodology in identifying appropriate patients, we were able to improve our discharge profile to align with the admissions demand. With a consistent 65% utilisation in the first 2 years, this initiative has resulted in an average **1.3 hours** of time saved per DL patient. 20% of ED admitted patients have benefitted from DL with at least 1 hour reduction in their waiting times. Inpatient discharges before 4 pm improved from 68% (Jan15) to 82% (Apr17). Patient feedback and staff satisfaction have been very positive and the CGH Discharge Lounge success was also appreciated by external JCIA Survey team.

Effectiveness of Discharge Lounge in Reducing WT@ED IP Bed Vacancy to IP Bed Occupancy Flow

Jan 2015-Jun 2016



CONCLUSION

By streamlining inpatient discharges via a discharge lounge facility to meet the admissions hourly demand, we were able to lower wait times for one-fifth of daily admitted patients and improve daily discharges before 4 pm. Expansion of the Discharge Lounge capacity will enable further improvements and greater impact on patients waiting for acute beds.