Project Title: Not Again!

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Background

Agency for Integrated Care (AIC) is set up by the Ministry of Health (MOH) to oversee, coordinate and facilitate all efforts in care integration. AIC set up Aged Care TransitION Team (ACTION) in Restructured Hospitals (RHs) to:

- Ensure patient has a smooth transition from hospital to their home and community.
- Coordinate and facilitate the care of the patients to ensure that patients who are discharged receive the appropriate care and services for the patients and their caregivers at home (refer to Figure 1a and 1b).
- Older person to age in place and to live independently in the community for as long as possible.

Figure 1a.

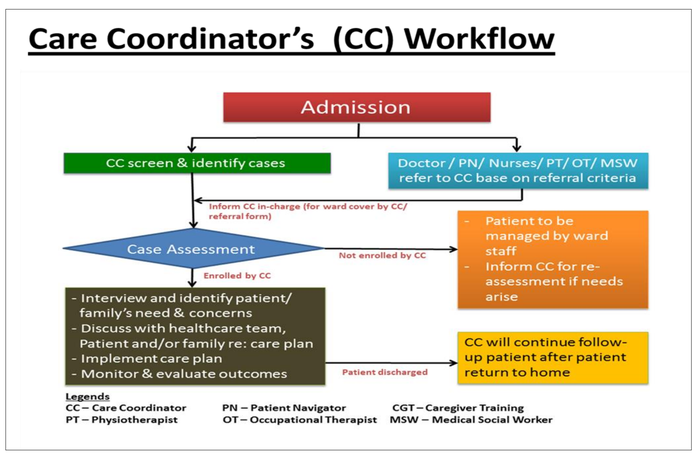
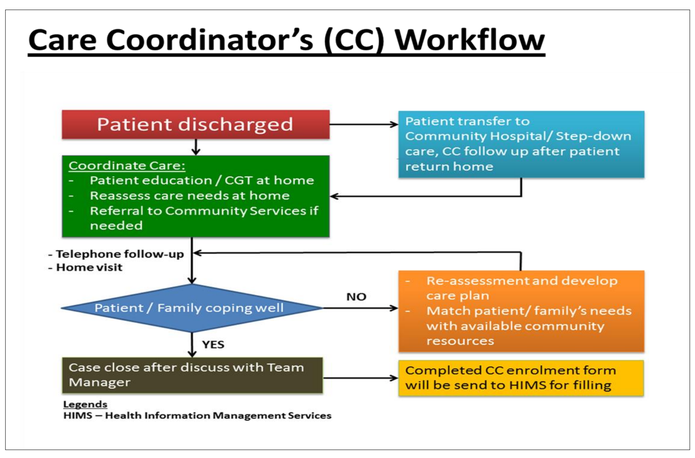


Figure 1b.



Aims / Objectives

- Based on AIC's Key Performance Indicators (KPIs) – aim to reduce readmission by 10% from baseline.
- Readmission is an indicator of patient's safety at home and by reducing it, we will be in line with SGH's Quality Priorities.

Mission Statement

- To achieve reduction of 10% readmission within 15 days for high risk patients enrolled by Care Coordinators.

Methodology (refer to Figure 2a, 2b and 2c)

Figure 2a.

Project Selection

Project Selection	Urgency of the problem	Impact on the organization	Patient's Safety	Cost Saving	Time Saving	Total Score	Rank
1. To increase nurses' knowledge on community services available	1	4	1	1	3	10	5
2. To achieve reduction of 10% readmission within 15 days for high risk patients enrolled by Care Coordinators	5	4	2	3	3	17	1
3. To increase patient's medication compliance in the community	5	4	4	2	1	16	2
4. To increase nurses' knowledge on discharge planning	3	3	3	1	1	11	4
5. To reduce patient's length of stay in acute hospital	4	4	2	3	2	15	3

Criterion	1 point	3 point	5 point
Urgency of the problem	Need to resolve within 6 months	Need to resolve within 3 months	Need to resolve as soon as possible
Impact on the organization	Patient and family will be unhappy with the organization	Affect organization's image	Patient and family does not trust organization
Patient's safety	Potential risk for compromising patient's safety	Compromise on patient's safety	High risk for compromising patient's safety
Cost Saving	Potential risk of incurring cost to patient and organization	Unnecessary expenditure incurred for patients and the organization	High risk of incurring cost to patient and organization
Time Saving	Time save for patient and organization less than 5 hours	Time save for patient and organization within 5 to 10 hours	Time save for patient and organization for more than 10 hours

Figure 2b.

Project Selection (Pre Data)

❖ On average: 84% of readmission within 15 days

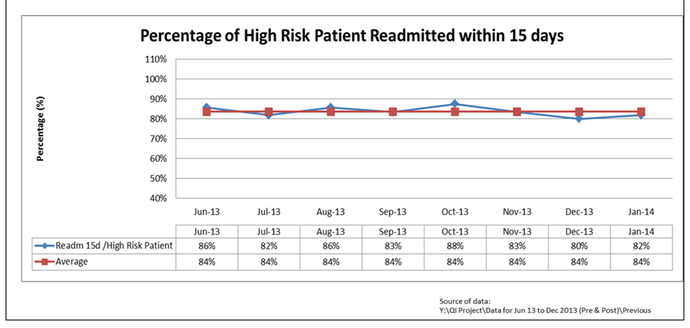
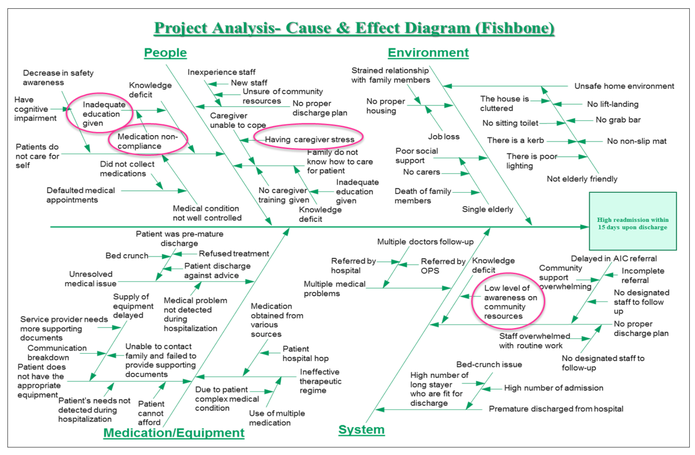


Figure 2c.



Description of the intervention (refer to Figure 3a and 3b)

Figure 3a.

Project Analysis

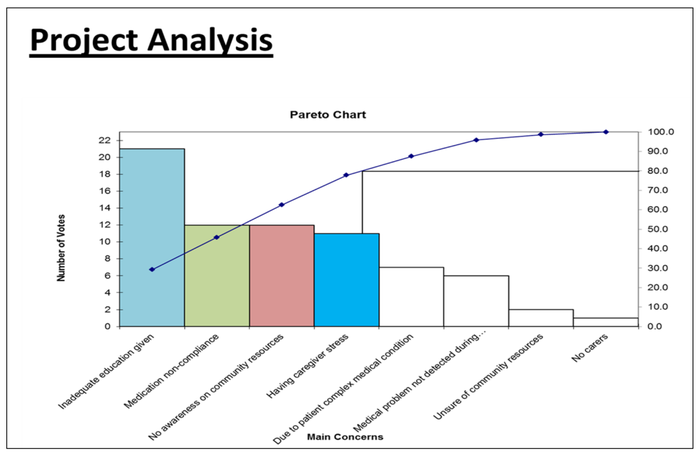
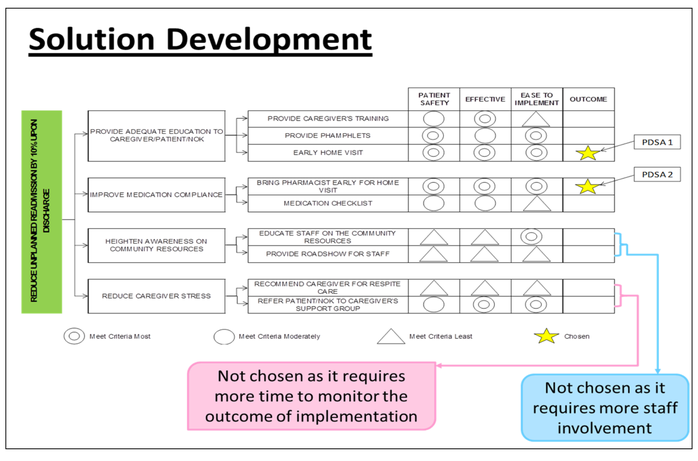


Figure 3b.

Solution Development



Results / Before and after implementation (refer to Figure 4a, 4b and 4c)

Figure 4a.

Solution Implementation – PDSA 1

❖ Early home visit to review medical condition, home safety and medication adherence as compared to previous home visit which is done within 1 month.

Figure 4b.

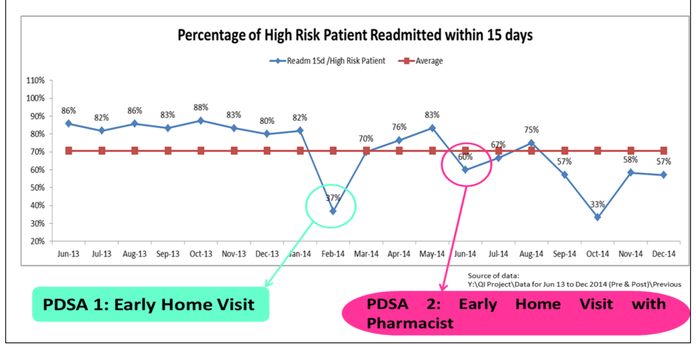
Solution Implementation – PDSA 2

❖ Early home visit with pharmacist if there are medication issues.

Figure 4c.

Project Achievement (Post Data)

❖ On average: 71% of readmission within 15 days



- **Benefits**
  - Project team members – better knowledge of QI tools, increase staff cooperation and staff morale, improved job satisfaction of care coordinators.
  - Patients – increase satisfaction, better quality of life and receive higher quality of care.
  - Next-of-kin – reduce caregiver stress, increase satisfaction and improve social life.
  - Healthcare workers – lower workload and increase productivity.
  - Organization – reduce bed crunch and save costs.
- **Sustainability**
  - Orientate new staff – include this new initiative during orientation for new staff who join the department.
  - Designate one team member to be in-charge of orientation for new staff.
  - Create an audit system to ensure that care coordinators continue to conduct early home visit – within 15 days after discharge.
  - Review results during monthly department meetings.

Conclusion

- Implementation of early home visit within 15 days post discharge resulted in 13% reduction in readmission.
- With a reduction of readmission rate of 13%, our team shared this result with ACTION teams in other RHs during AIC Manager's meeting.