Singapore Healthcare Management 2018

Singapore General Hospital
SingHealth

To Improve Transfer Turnover to Community Hospitals within 3 Months

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Background of the problem

Patients who are deemed fit and require rehabilitation or sub-acute care are commonly referred to community hospitals. However, referrals to community hospitals may require the inputs of multiple stakeholders such as physiotherapists, occupational therapists, doctors and medical social workers, which may lead to delays in transfer due to incomplete referrals. Hence, there is a need to coordinate the referral process so as to shorten the time taken for patients to be discharged from SGH, so that they may continue with their next level of care in the appropriate setting.

Mission Statement

To increase the number of patients successfully discharged from all SGH inpatient wards to community hospitals by 30% within 3 months.

Analysis of problem

Currently the referrals that are activated are pending in the Integrated Referral Management System (IRMS) due to incompleteness. AIC is unable to process applications without pertinent information. Referrals take a longer time to be processed leading to a delay in the eventual transfer to the CH.

The following is the team's analysis of the current situation with a 5-Why method (refer to Fig.1).

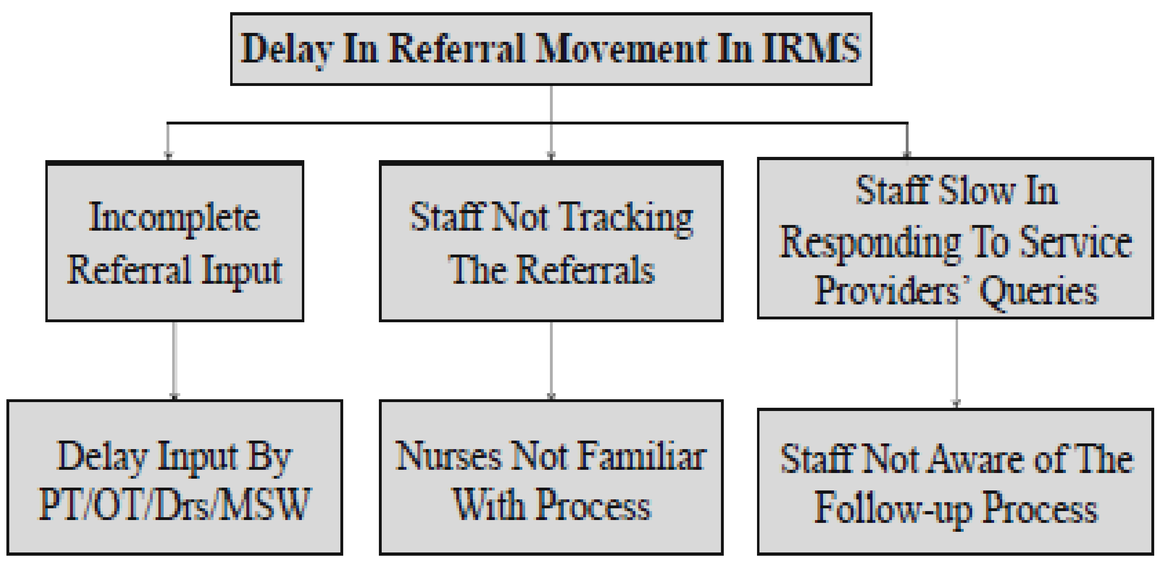

Figure 1: 5-Why analysis of reasons causing delays in referral movement in IRMS

Interventions / Initiatives

In order to keep track of the movement in the IRMS, a Fit For Transfer Team (FFT) has been set up to oversee and coordinate transfer turnover during the period of 1 July 2017 to 30 September 2017.

The OIC executive in charge emailed Patient Navigator team the daily list of Fit For Transfer (FFT) and IRMS to PN for close tracking of the referral status.

The PN team followed up on each referral input updates on a daily basis to ensure smooth transition. The team members communicated directly with other multi-disciplinary teams on the pertinent information that required for follow through in the IRMS).

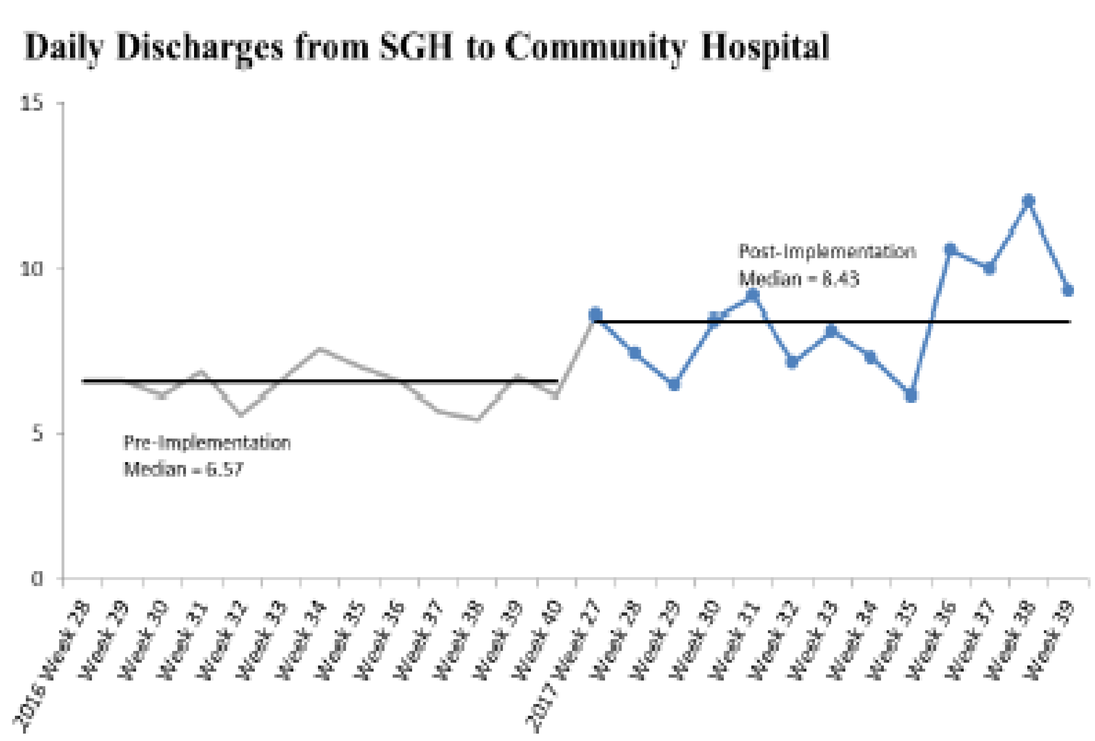

Figure 2: Run Chart

Results

Comparing with the corresponding period, the turnover rate in 2017 has increased by 28.3%, translating to an additional 2 patients being discharged to Community Hospitals than before, freeing up hospital beds for more acute patients.

Sustainability Plans

The Team has plans to continue the implementation of this project that will facilitate prompt transfer of patients suitable and fit for transfer to community hospital. The outcome of the improved workflow will be monitored continuously for better seamless care transfer and bed utilization.