



Seamless Discharge Planning & Care Transition in SGH

Singapore Healthcare
Management 2022



Rachel Marie Towle, Mas Rizalynda Binte MR, Rose Bte Borhan, Manisah Binte Somadi, Siti Abidah Binte Muhamed, Nur Zarifah Binte Mustapha, N.Saratha Devi, Lim ES, Zunaitha Begum Binte MH & Sulastri Bte MS, Singapore General Hospital

Introduction

As Singapore's health care landscape evolves to cope with the rapidly ageing society, growing burden of chronic disease, rising health care cost and finite hospital resources, there is an impetus need for our team to review the hospital's discharge planning process, so as to facilitate timely discharge and safe care transition from hospital to community.

In SGH, the role of the Patient Navigator (PN) was first introduced in 2014 with the aim to facilitate care coordination, discharge planning and care transition from hospital to community (Mustapha et al., 2016). However, in order to meet the increasing demand and workload, there is a need to look into capability building and empowering all nurses on the essential skills to perform a comprehensive and timely discharge planning.

Nurses are with the patients 24 hrs, and they play a pivotal role in patient/caregiver's care needs assessment. Having the insight and knowledge will help them facilitate safe, smooth and timely discharge of patients from hospital to community. A pre-survey was done to understand the nurses' knowledge on discharge planning and care transition. 463 nurses responded to this survey. 56% of the nurses rated their knowledge on discharge planning as fair (4 to 7) from a Likert scale of 0 (no knowledge) to 10 (very knowledgeable) (9% rated as poor and 34% rated as good). Hence, this study aims to increase the nurses' knowledge on discharge planning and care coordination, from baseline 34% (good) to 54% (20% improvement) within 6 months.

Aim

To improve nurses' knowledge on discharge planning and care transition from baseline 34% to 54% (20% improvement) within 6 months.

Method

Literatures showed that the patient's discharge planning process is a critical point in care continuity but it is often complex and challenging, especially for the older patient (Bauer et al., 2008; Puvanendran, 2011). A successful discharge planning process involves the proactive identification and assessment of care needs, development of individualized care plan for patients leaving the hospital, patient-caregiver engagement and education, transitional care and proper handoffs to community services from a multidisciplinary team effort. The consequences of a poorly executed discharge plan are linked to serious adverse outcomes such as unscheduled hospital readmission, emergency department visits, compromised patient safety, patient/caregiver stress, poor health outcomes and prolonged hospital stay (Hesslink et al., 2014; Puvanendran, 2011; Shyu, 2000; Tan et al., 1998).

The team used the 5-whys root cause analysis to help us focus on finding the root cause/s to the problem (Diagram 5).

Diagram 1: 5-Whys Diagram

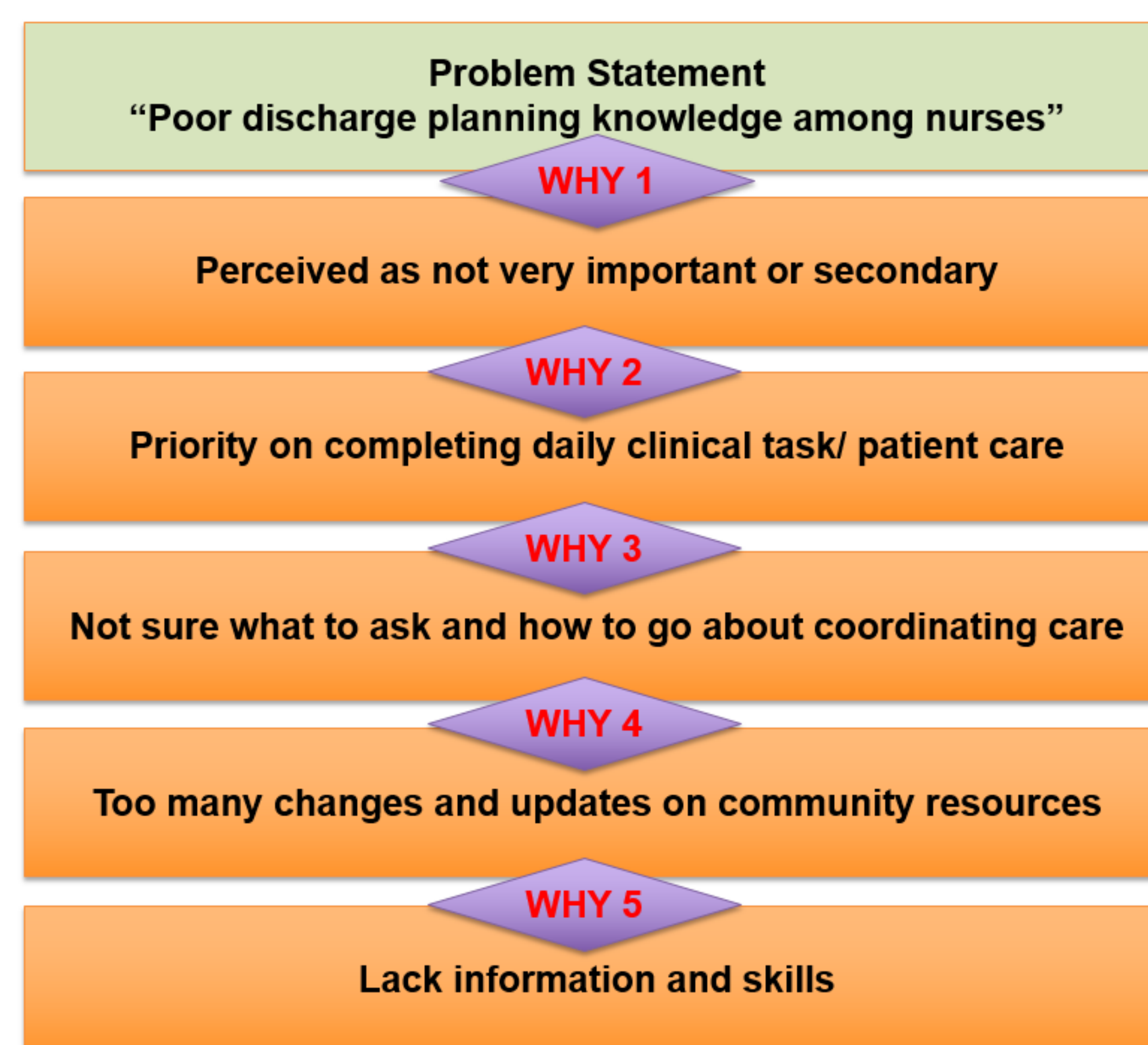
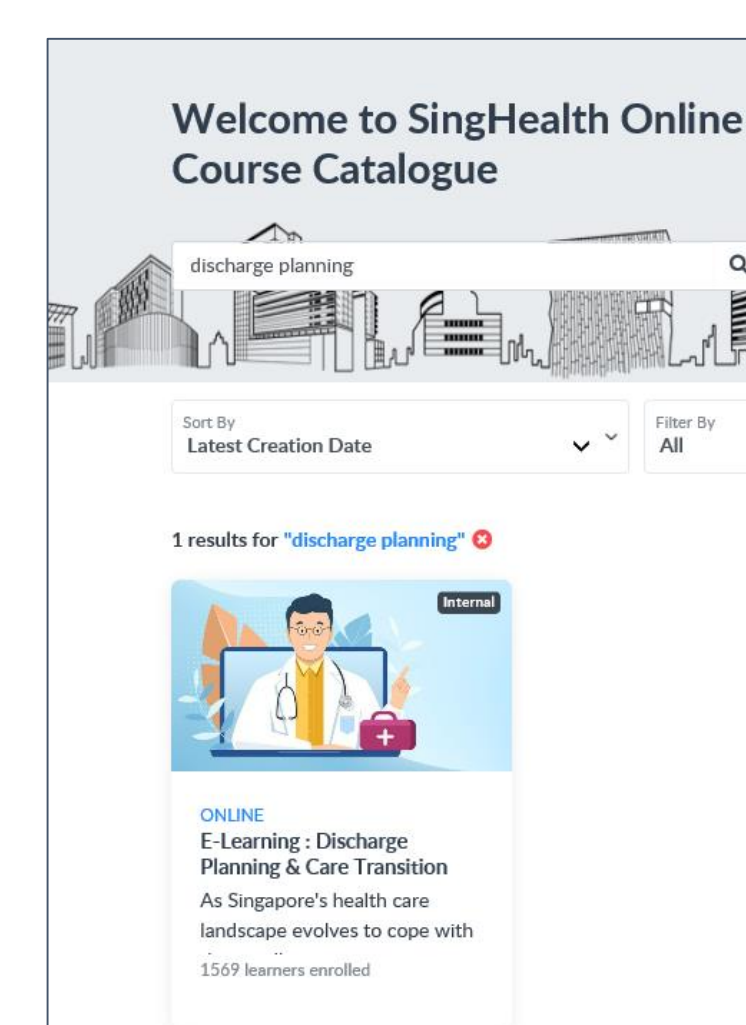


Diagram 2: Survey on learning needs

Demographic Data	
1. Age	As is / As was
2. Gender	Male / Female
3. Location	Emergency ward / Outpatient / Community
4. Work experience in SGH	0-2 yrs / 3-4 yrs / 5+ yrs
5. Designation	Registered Nurse / Nurse Practitioner / Advanced Nurse Practitioner / Other
Learning Needs	
6. On a scale of 0 to 10 (0=No knowledge, 10=Very knowledgeable), how would you rate your current knowledge on discharge planning and care transition?	Score: _____
7. List the top 3 discharge planning challenges that you face (most common first).	1. _____ 2. _____ 3. _____
8. Which topics would you like to learn most about? (List all that apply)	Principles of discharge planning & care transition How to assess for prolonged hospital stay Care needs assessment Discharge planning & care transition services in SGH Community services Emergency hospital readmission
9. What other topics would you like to learn?	1. _____ 2. _____ 3. _____
10. What is your preferred learning method? (multiple options)	Online learning/resources Workshop In training Other: _____
11. Do you have any suggestions or requests?	_____

Diagram 3: Wizlearn



Intervention

From the 5-Why diagram, the final root cause identified was “nurses lack the information and skills” to initiate a comprehensive discharge planning. The team then conducted a survey to gather the nurses (stakeholder) feedback on what areas/topics they would like to learn (Diagram 2). From the survey results, the team then brainstormed on the delivery mode. Due to the Covid-19 restrictions, the team opted for online e-learning via Wizlearn (Diagram 3). The e-learning invitation was then emailed to all Registered Nurses (RNs) in SGH to complete and their feedback was gathered for continued improvement.

Results

Post e-learning, the nurses would rate their knowledge gained using a Likert Scale of 0 to 10 (with 0 being no knowledge gained). As of 16 Dec 2021, 504 nurses completed the wizlearn and post-survey. Below are the results:

- Score 0: Nil (0%)
- Score 1-3: 4 nurses (0.8%)
- Score 4-7: 193 nurses (38.2%)
- Score 8-10: 307 nurses (61%)

Pre-survey Results (n=463)

Score 0 (no knowledge): Nil
Score 1-3 (poor): 9%
Score 4-7 (fair): 56%
Score 8-10 (good): 34%

From the pre-post results, there was an increase in ‘Good’ by 27%. P value was statistically significant for “Fair” and “Good” outcomes, $p=0.011117$. Intangible results include the good feedback received from the nurses in wizlearn stating their appreciation for the information (staff satisfaction).

Sustainability

The e-learning module is incorporated into the Singhealth e-learning portal and is made available to all staff. New nurses are encouraged to register for this course. The next phase of the project's sustainability plans include measuring how the knowledge translates to actual clinical outcome, such as patient's discharge care plan are documented in SCM timely as part of the nurses assessment.

