POSTER ABSTRACT

Seamless Discharge Planning and Care Transition in a Tertiary Hospital

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Background: As Singapore's health care landscape evolves to cope with the rapidly ageing society, growing burden of chronic disease and rising health care cost, there is an impetus need 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) is to facilitate care coordination, discharge planning and care transition from hospital to community. 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 discharge planning. Nurses 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. Patient's discharge planning process is a critical point in care continuity, but it is often complex and challenging. A successful discharge planning involves the proactive identification of care needs and development of individualized care plans.

Methods: 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.

The team used various Quality Improvement tools and techniques, such as the 5-Why diagram to identify the root cause/s to the problem. The final root cause identified was "nurses lack the information and skills" to initiate a comprehensive discharge planning.

Intervention: The team then conducted a survey to gather the nurses (stakeholder) feedback on what areas/topics they would like to learn. 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. 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. 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 plans: 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 includes measuring how the knowledge translates to actual clinical outcome, such as patient's discharge care plan are documented timely as part of the nurse's assessment.