



# ST. ANDREW'S COMMUNITY HOSPITAL

## Smooth Transitions: Enhancing Nursing Home Referrals

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### Problem Statement

- St. Andrew's Community Hospital (SACH) is a service under the St. Andrew's Mission Hospital group. In addition to inpatient rehabilitation, subacute and palliative care, SACH also operates home care and home palliative care; centre-based day and rehabilitative care; and outpatient and migrant worker clinics.
- The referral process for patients from SACH to Nursing Homes (NHs) involves multiple stakeholders with varying practices, differing requirements, and frequent reworks and delays. These issues lead to longer Length of Stay (LOS), which affects both the hospital's bed occupancy and the timely access of patients to the appropriate care they need.
- In 2023, an average of 11 patients per month were referred from SACH to NHs. The LOS for these patients ranged from **52 days (at the 50th percentile)** to **103 days (at the 95th percentile)**, indicating a significant variation in the processes.

### Project Aim

- To streamline the NH referral process (Figure 1) and reduce the LOS for patients discharged to NHs by approximately 20% from **52 days to 42 days at the 50th percentile** and from **103 days to 83 days at the 95th percentile**.

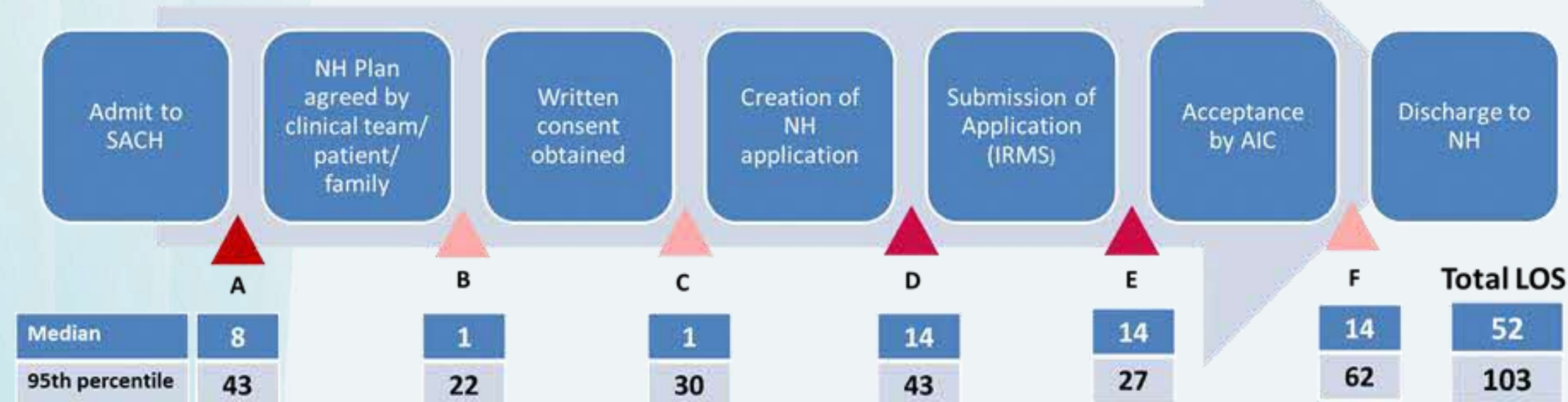


Figure 1

### Risk & Complexity

- Patients are usually referred to SACH for rehabilitation before considering NHs. The team has to balance efficiency with allowing families time to make informed decisions as NH referral should be a last resort.
- Multiple stakeholders contribute to the referral reports, leading to overlapping information, making consensus on key details like mobility status difficult at times.
- The multidisciplinary team's collaboration has broadened the role of Medical Social Workers (MSWs) to ensure coherence in reports before submission to AIC.
- Achieving zero rework between SACH and AIC remains challenging. Inviting AIC to join the project team could have improved clarity on report requirements.

### Solutions

The project team implemented several interventions (Figure 2) to improve the referral process from SACH to NHs.

- Standardized Guidelines**
  - Created guidelines with an FAQ to address common inquiries from AIC and reduce waste and rework
- Gatekeeper Role**
  - MSWs ensure completed reports are in order before submission to minimize rework
- Expedited Psychogeriatrician Assessments**
  - Introduced the "Blue Letter" to speed up assessments, replacing the monthly visit with a more immediate process
- Timely Guidelines for NH Applications**
  - Set clear timelines for each step of the NH application process to reduce delays
- Visual Guide**
  - Provided a visual tool to help patients and families make informed decisions on discharge options and associated costs
- E-Consent Option**
  - Enabled busy family members to sign consent forms remotely for NH placement
- Network Building with NHs**
  - MSWs developed a network and rapport with NHs in eastern Singapore for smoother placements

Figure 2

### Outcome & Impact

- The post-implementation results are shown in the following table (Figure 3) and detailed dashboard (Figure 4): -.

| LOS             | Baseline (days)          | Target (days) | Post-RIE (days)          | % Changed |
|-----------------|--------------------------|---------------|--------------------------|-----------|
|                 | Jan – Dec 23 (126 cases) |               | Jul to Dec 24 (47 cases) |           |
| Median          | 52                       | 42            | 38                       | 27%       |
| 95th percentile | 103                      | 83            | 72                       | 30%       |

Figure 3

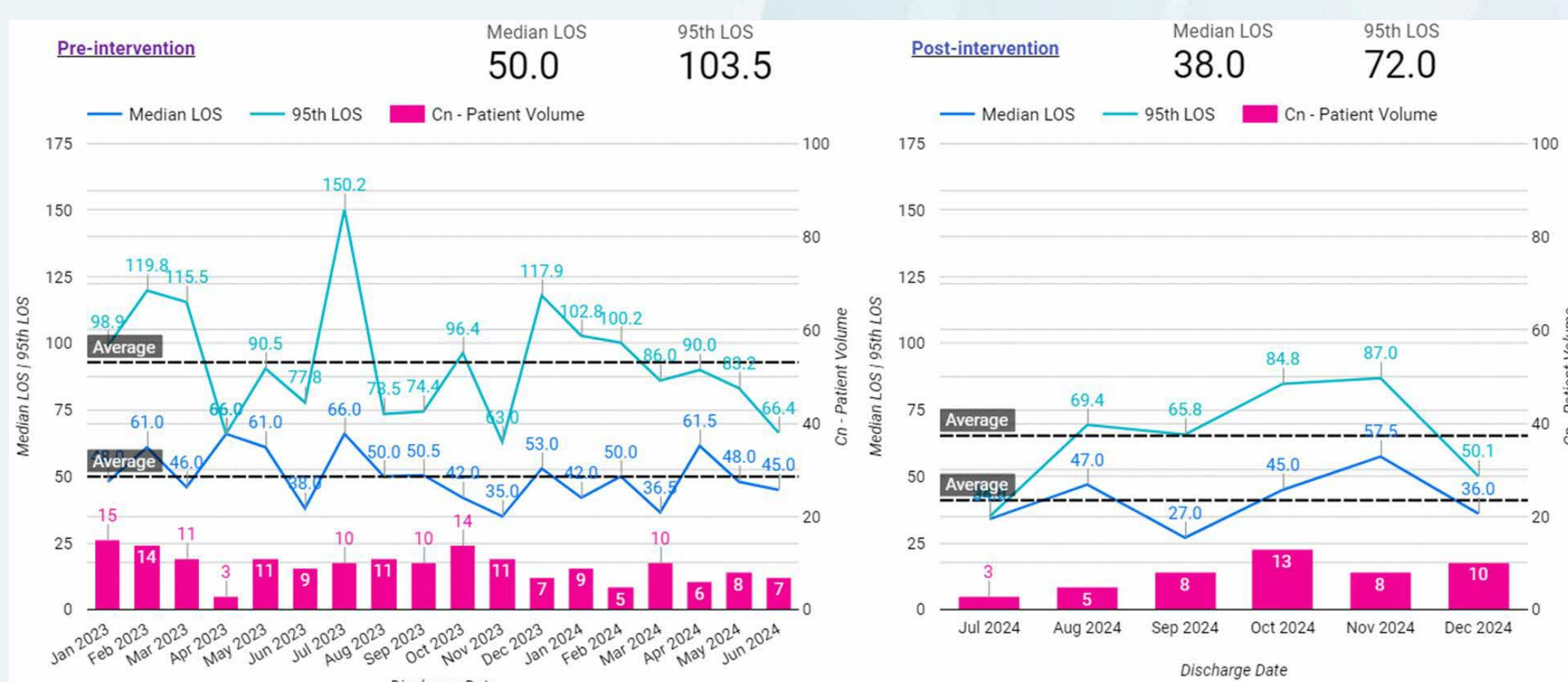


Figure 4

- Average bed days saved per patient are 9 days with ALOS reduced from 50 days to 41 days, leading to **cost avoidance of S\$238K per annum**.