



Tan Tock Seng  
HOSPITAL  
National Healthcare Group

# One Care Team

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## Background

The post pandemic demands have seen an exacerbation in the rates of healthcare manpower attrition, substantial financial implications, including concerns for quality and safe delivery. Clinical work rotations and changing schedules result in communication gaps, late or inappropriate referrals, overwhelmed teams and delayed care plans.

The importance of engaging and retaining experienced nurses to contribute to safer and cost-effective care is emphasised with the recent government-funded incentives for nurses. Despite this, there is a definitive requirement to nurture nurses, creating work flexibility and career advancement opportunities.

There are increased demands for partnered care

This necessitated a collaborative initiative towards fostering stronger team relationships through increased communication and by breaking down the barriers of direct communication to senior clinicians.

## Introduction

Nurses have been the backbone of healthcare systems, providing, supporting and coordinating care for patients. As healthcare environments become increasingly diverse, conventional team-based rounding and communication measures have become fragmented with the adoption of new technologies and conflicting pressures from the daily grind of routine clinical work.

The objective was to build shared governance team model that is facilitated by daily physical and virtual multidisciplinary connections led by Integrated Principal Nurses (IPNs). The work process involves nurse-led daily clinical huddles, physical/virtual multidisciplinary discussions with senior clinicians and other team members. Weekly virtual multidisciplinary rounds are conducted for complex cases, allowing the team to join from any geographical location. This enhances the practical development of timely and achievable care plans, contributing to early coordinated discharges and reduction in adverse events.

IPNs bridge care gaps by performing regular care plan updates, early family engagements, early review of discharge plans and nurse-led discharges.

Aligning with Healthier SG, One Care Team tailors care plans; communicating longitudinal plan of care to community partners (currently Kallang Polyclinic) with a referral system. Allowing for continued coordination of services and potential for early primary care interventions.

## Intervention

The project commenced 14<sup>th</sup> November 2023 and successfully continued to date (March 2024). One Care Team's service is provided to a group of General Medicine inpatients and their families.

### One Care Team

All members of the healthcare multidisciplinary team, within the ward, provide their services as One Care Team: doctors, nurses, allied health, social workers, pharmacists and patient service associates. Essentially, this is a shared governance model that is facilitated by daily physical and virtual connections. The work process is improved because it involves the **empowerment of nurses to co-lead** daily clinical huddles, physical/virtual multidisciplinary discussions that have been routinely medically led.

### Care Redesign

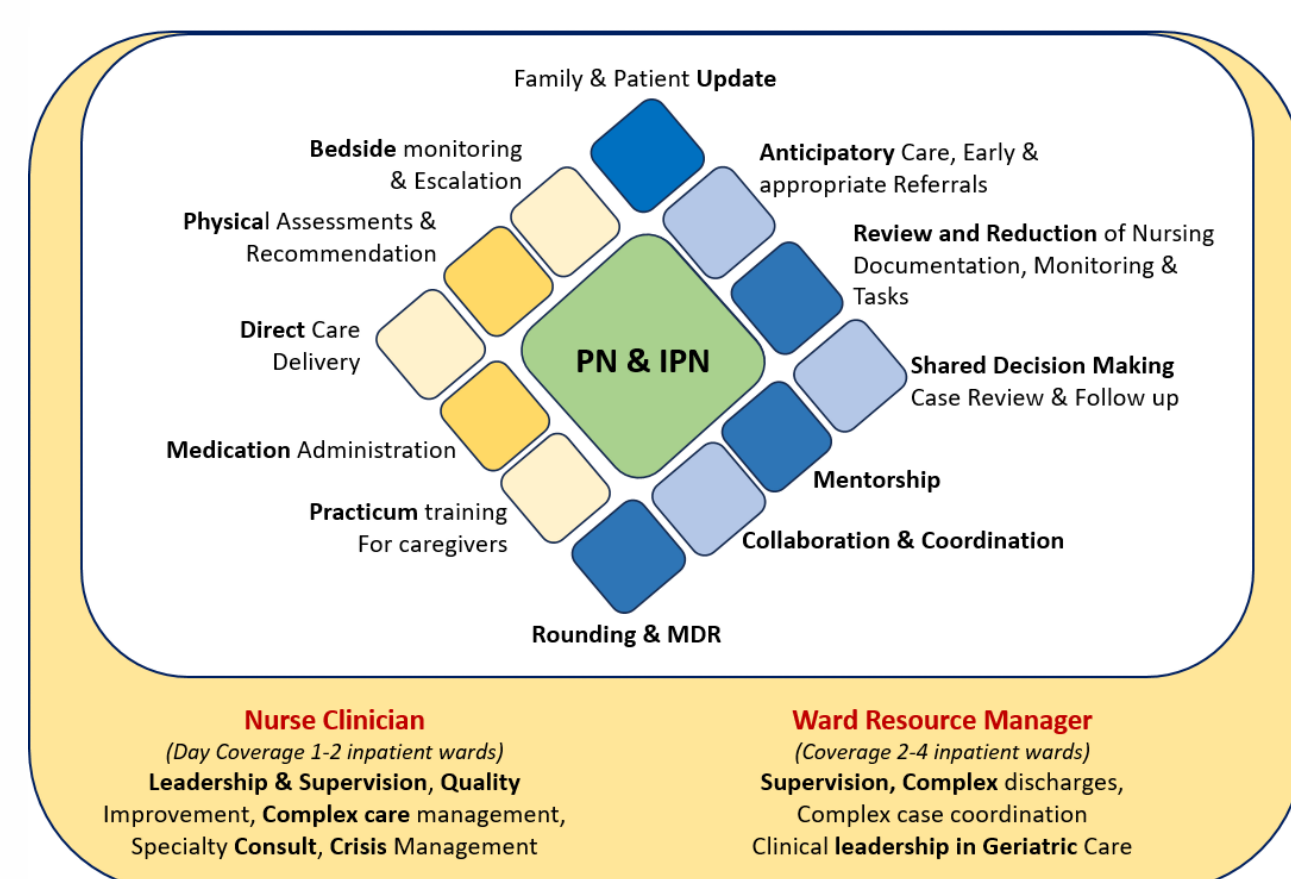
The main strategy of One Care Team was a strong emphasis on role re-design of experienced nurses to work closely with the primary clinicians and allied health. The experienced nurses (IPNs) worked primarily office hours as they were the main liaison person during the morning and early afternoons. Their core work involved case review, care coordination, communication and information management. Team members were able to use an Office Pod which provided instant quietness, privacy for meetings and ad-hoc discussions.

### Empowerment and training

The secondary strategies were to equip IPNs with a skill mix: clinical assessment skills, case review, care coordination and patient safety reviews. Training and curriculum were designed and supported Advanced Practice Nurses, Nurse Educators and Ward Nursing Officers. IPNs were much involved with the team rounds and case coordination work which resulted in a reduction of non-IPN nurses' mental workload allowing them to focus on providing general nursing services. IPNs actively screened through care plans, expediting referrals, reducing and deferring non-essential services.

### Nurse-led discharges and community initiatives

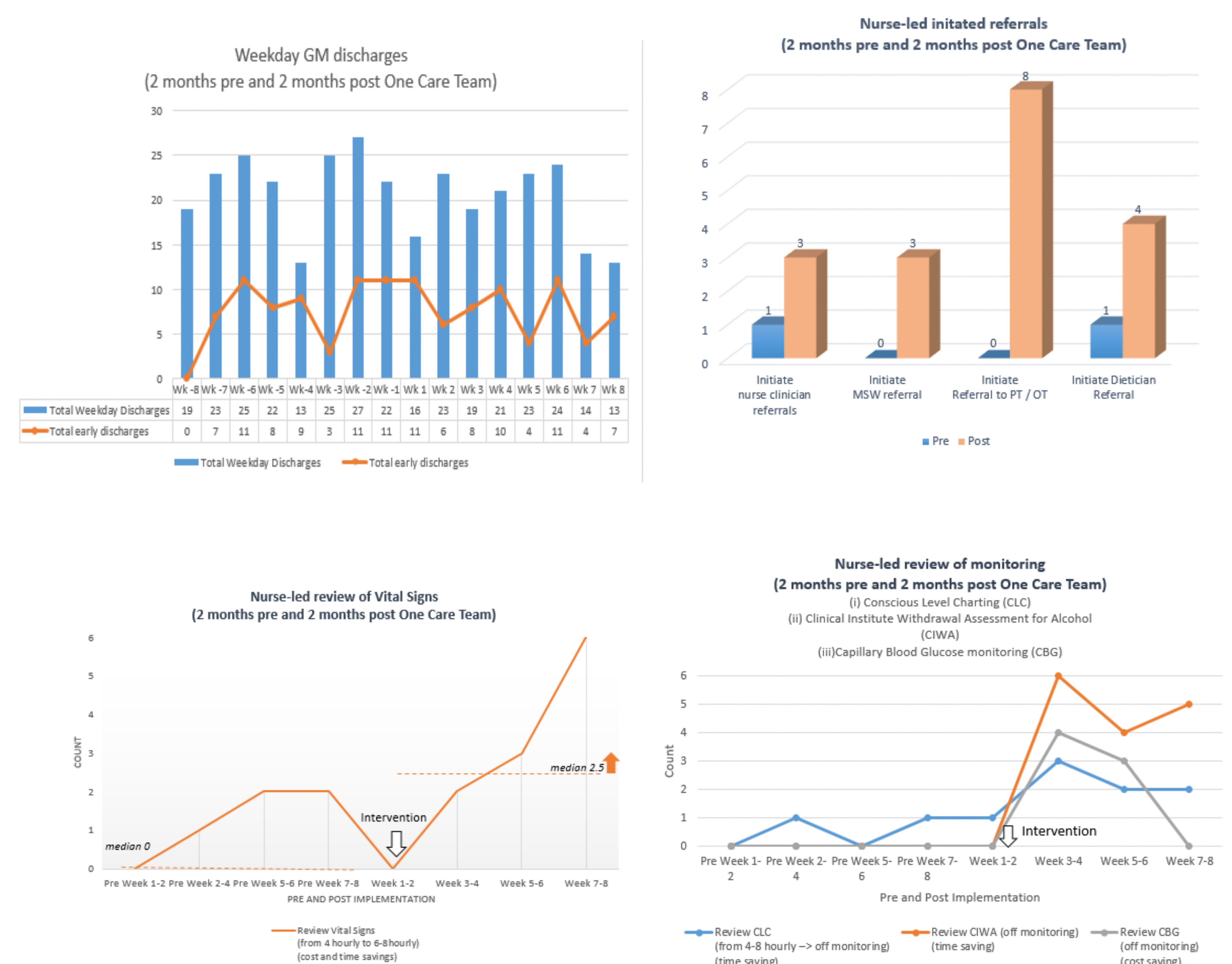
There was active screening of cases for nurse-led discharge. This is a criteria-based workflow, where patients are pre-identified a day prior and decision to discharge is made by ward nurses. These patient do not require a physical review by a Senior Clinician on the day of discharge. Thereafter, partnerships with community sectors are built through referrals made within the EPIC system. The team connects with community care providers by ensuring succinct, essential clinical information is communicated and followed through.



## Results

Baseline data was collected from 18<sup>th</sup> September 2023 to 10<sup>th</sup> November 2023 (8 weeks). The project was implemented on 14<sup>th</sup> November 2023. 8 weeks of post implementation data was collected until 5<sup>th</sup> January 2024. Weekends and public holidays were excluded

- There were no significant changes in weekday early discharges before and after implementation.
- For anticipatory care referrals there was a significant increase in referrals post implementation. There was near missed identified.
- Nurse-led discharges: Prior to One Care Team, there were no known workflows for nurse-led discharge in the inpatient wards. One Care Team has successfully achieved 3 nurse-led discharges over 2 months, contributing to reduced length of stay and cost savings.
- There was overall reduction in nursing documentation and monitoring activities. Nurses team satisfaction scores increased from 52% to 74%.
- Staff satisfaction score increased by approximately 20%.



## Estimated Cost Savings and Manpower Savings

| Off monitoring or reduction in frequency      | Estimated Time Required   | Frequency | Total Nursing Time saved per patient/day | *Predictive: If continued for 3 days more based on the average LOS |
|---|---------------------------|-----------|--|--|
| Vital Signs reduced from 4 hourly to 6 hourly | 3min                      | 2x/day    | 6min                                     | 18min  |
| Postural BP off monitoring                    | 7min                      | 2x/day    | 14min                                    | 42min  |
| Conscious Level Chart off monitoring          | 5min                      | 3x/day    | 15min                                    | 45min  |
| CIWA-Ar off monitoring                        | 5min                      | 4x/day    | 20min                                    | 60min  |
| Capillary Blood Glucose (CBG) off monitoring  | 1min                      | 3x/day    | 3min                                     | 9min   |
|   | (\$7/test before subsidy) |           | (\$21/day/patient)                       | (\$63 per patient)   |

\*Estimated length of days before the monitoring is reduced by Clinicians or when patient is discharged.

## Conclusion

- Enhanced care coordination; alignment of care goals; multidisciplinary discussions for patients with complex care needs led by Integrated Principal Nurses.
- Improved clinical outcomes; early review of care plans and identification of care gaps, matching clinical needs with appropriate and timely referrals.
- Improve efficiency in resource allocation by reduction of non-indicative allied health referrals and nursing tasks.
- Role-design and increased empowerment of nurses through nurse-led discharges.
- Enhanced healthcare staff, patient and caregiver experiences with increased communication and liaison
- Active bridging of tertiary-primary care information gaps with succinct primary care referrals, wherein important care plans are summarised and communicated.

**References:**  
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