QUALITY FESTIVAL 2025

Admission/Discharge Communications for Nursing/Welfare Homes

Problem

During an October 2024 meeting, Orange Valley Nursing Home (OVNH) highlighted difficulties in coordinating patient discharges from WH. The challenges included: (1) a lack of notifications from WH regarding resident discharge dates, (2) discharge summaries did not provide comprehensive information on treatment changes, and (3) a lack of memos in the discharge document regarding follow-up care instructions. This gap in handover practices resulted in care coordination issues and highlighted the need for a more structured admission and discharge process with community partners.

Aim Statement

In line with WH's strategic focus on fostering relevant and collaborative care with homes in our region, Continuing and Integrated Care (CIC) team piloted the Admission and Discharge Communications initiative with OVNH in January 2025. The pilot aims to (1) standardise the information provided for admissions and discharges, (2) improve communication efficiency with community partners through a CIC Point-Of-Contact/Hotline, (3) ensure safe transitions for patients into the community while maintaining continuity of care from hospital to community settings.

Team Members

Woodlands Health	Orange Valley Nursing Home	MWS Christalite Methodist Home
1. Ms Agnes Wong Siew Yong, Nurse Clinician (Co-Lead) 2. Ms Yeo Hui Quan, Asst Manager, CIC Ops (Co-Lead) 3. Dr Tan Hongyun, Asst Director of Nursing 4. Ms Lily Ng, Asst Director of Nursing 5. Ms Siah Cai Yun, Nurse Clinician 6. Ms Wong Suet Ying, Senior Staff Nurse 7. Ms Dolly Cheng, Deputy Director, CIC Ops 8. Ms Sheila Chua, Executive, CIC Ops	1. Ms Caymania Low, Director/Head of Nursing 2. Ms Siew Hwey Sean, Nurse Manager 3. Ms Jyacintha Rayapen, Nurse Manager	1. Mr Pacheco Alan Engelbert Respicio, Senior Staff Nurse 2. Ms Marie Lalhriatpuii, Nursing Aide

WH Collaboration With

The team would like to express our gratitude to the Inpatient Nursing and Inpatient Ops team for their support in making this initiative possible.

Current State

Within Woodlands planning area, there are 4 Nursing Homes (NHs), 1 Welfare Home and 1 Disability Home. Since WH opened, the 6 Homes' residents have been seeking care at our hospital for emergencies and outpatient appointments. Homes often do not know which hospital their residents end up at when they are sent in during medical emergencies and there is no shared patient tracking system in place. The absence of an integrated electronic medical record (EMR) system between hospitals and Homes poses gaps in handover communication. This leads to delays in Homes receiving crucial admission and discharge information of their residents. A tailored workflow need to be developed to address the specific requirements of Homes.

Root cause Analysis

5 Whys? – Why do nursing homes have difficulties coordinating patient discharges?

Multiple communication channels and varying information requirements between WH and nursing homes

↓ *Why are there multiple communication channels and varying information requirements?*

WH works with different nursing homes, each with their own unique admission criteria and documentation requirements

↓ *Why are there different requirements across nursing homes?*

No standardised point of contact or communication protocol between WH and nursing homes for discharge planning

↓ *Why is there no standardised point of contact and protocol?*

Different departments communicate independently with nursing homes, leading to fragmented information flow

↓ *Why is there fragmented information flow?*

Because there are no structured admission and discharge processes with nursing/welfare homes

Interventions

- The pilot began with weekly exchanges of patient information, where OVNH nurses provides a list of residents admitted to WH, and CIC nurses respond with treatment plans and care updates.
- The WH CIC team worked with the Inpatient team to develop a standardised discharge checklist.

NH/TCF/shelter home discharge checklist

Patient Name: *PDPA, Please don't use stick label*		Destination: _____ (institution/ ward) Transport booked by: Nursing Home ( ) Family( ) WH ( ) Transport date: _____ Time: _____ NH/ TCF/ SH informed of transport time? Yes ( ) No( ) Family informed of transport time? Yes ( ) No( ) NA ( )
Documents		
Hospital Medical Discharge Summary	Yes ( )	**Standard supplies for existing NH residents, unless special request by NH/TCF/SH :* • *supply 1 weeks worth of milk feeds* • *supply 2 week of wound care consumables* • *discharge medication sufficient until next TCU*
Nursing Discharge Summary (include description of wound condition, if any)	Yes ( ) NA ( )	
PT memo	Yes ( ) NA ( )	
OT memo	Yes ( ) NA ( )	Dressing materials/ other consumables Request for: _____ week/s
ST memo	Yes ( ) NA ( )	
Dietician memo	Yes ( ) NA ( )	Enteral feeds supply Request for: _____ week/s
Other memo:_____	Yes ( ) NA ( )	

- CIC nurses conduct follow-up calls with OVNH nurses within three working days post-discharge to check on patient wellbeing and escalate care if necessary. A CIC Hub hotline was also established for OVNH to address any issues.
- Following the pilot's success with OVNH, CIC Enterprise expanded the initiative to MWS Christalite Methodist Home (CMH) after a meeting in January 2025, where similar concerns were raised.

Results

	OVNH*	MWS*
No. of patients reviewed	41	59
No. of post-discharge calls made	51	66

*Analysis based on different observation periods - OVNH (7 months) and MWS (5 months)

Aims (1) and (2) were met with the weekly exchange of information. The open communication allowed for clarifications of care plans and meet Aim (3). OVNH care team feedback that they felt more supported with the established workflow and consistent communication.

"Our clinical team really appreciate Agnes and Team support in follow up post discharge as well as the POC for resident care matters. These allowed us to create an open channel of care communication" (Director of Nursing, OVNH, 2025).

Benefits

Improved patient safety and continuity of care	• Implementing a standardised checklist reduces errors and delays during admissions and discharges. • Structured information exchange keeps all parties informed, facilitating seamless transitions, • Post-discharge follow-up calls help identify complications and support recovery, leading to lower readmission rates.
Increased operational efficiency	• Clear staff responsibilities for discharge documentation streamlines communication between facilities. • Better preparation by Nursing Homes for residents' return improve resource allocation and operational readiness.
Built trust between WH and community partners	• Establishing CIC as the primary liaison between WH and community partners has strengthened community collaboration. This enhanced partnership improves care coordination and ensures comprehensive post-discharge support, ultimately benefiting both patients through better continuity of care and the healthcare system through more efficient service delivery.

Sustain & Spread

The structured protocols established for admission, discharge and post-discharge communications can be replicated across other Homes in the Woodlands catchment area. This strengthened partnership with Homes has led to other initiatives like Collaborative Outbreak Management, helping Homes manage outbreaks more effectively and minimise hospital transfers. The CIC team plans to leverage on digital platform to enable automated resident status updates and allow partners direct access to information, thus reducing manual processes.