The Effectiveness of Point-of- Contact in Improving Communication Between Acute Care Hospital and Nursing Home

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Project Background

Nursing home residents often face higher risks of multiple hospital admissions associated with their underlying frailty, multiple comorbidities, and polypharmacy. Several nursing homes request for updates on their residents during their hospital stay. Research has shown that hospital readmission is associated with an increased risk of adverse health outcomes, including heightened patient stress and higher healthcare costs.

We reviewed the characteristics of admissions from 5 NHs in 2022, with the aim to improve the communication between NHs and hospital healthcare providers, and to develop targeted interventions to reduce the likelihood of readmission.

Aim

The aim is to introduce a work process to improve communication with engaged Nursing Homes to ensure continuity of care for their residents. This improvement will enhance the exchange of vital information and facilitate seamless transitions between the Nursing Home and other healthcare settings. By achieving this goal, the quality of care and patient outcomes can be enhanced.

Methods

The Patient Navigator - Nursing Home (PN-NH) team will be notified via email by the nursing home regarding admissions to Changi General Hospital. To ensure continuity of care, the patient navigator will assess the patients in the ward before providing updates to the nursing home. For urgent matters, the nursing home nurse manager can directly contact the PN-NH nurse clinician. The team will keep the nursing home updated on the patients' current diagnosis and treatment. Access to this information is secured through a password-protected Excel sheet within the department.

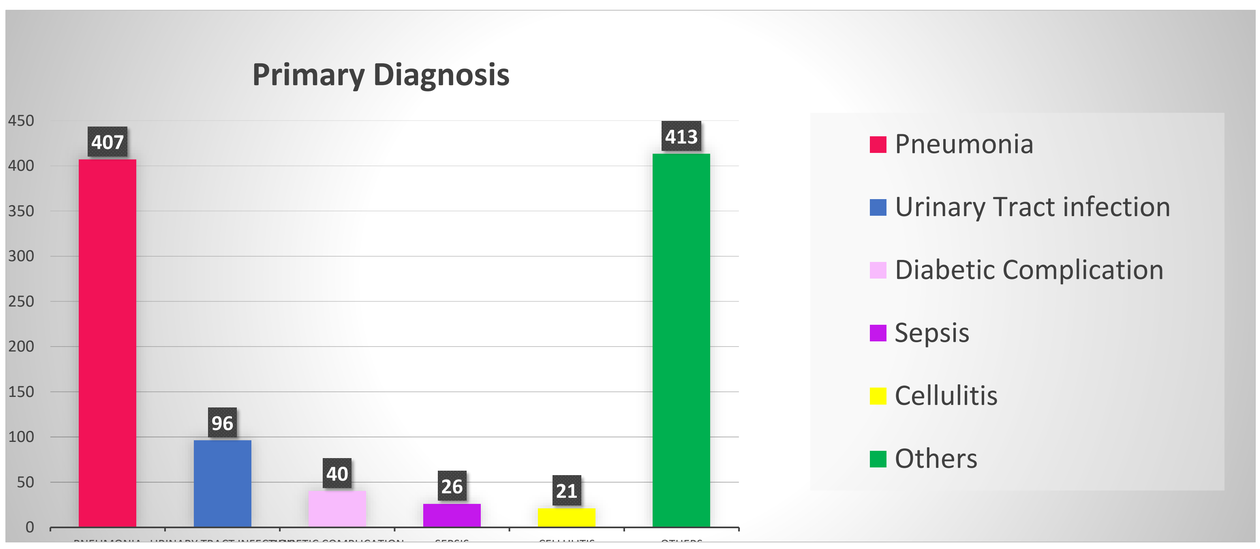
A retrospective study of 5 nursing home with 1003 admissions admitted from January 2022 to December 2022 was conducted. Complex cases were highlighted to a Geriatric senior consultant for review as required.

Data were extracted through collaboration with performance management to retrieve diagnosis at discharge, nursing home and readmission- rates. The primary and secondary diagnosis at discharge, by the international classification of disease version 10 was retrieved through hospital-based patient's record and the top 5 diagnosis was extracted from the database.
Readmission rates were calculated based on readmissions in the one-year review period.

Enhanced workflow Process	
Before	Nursing Home staff will contact the ward for update for every admission on alternate days. Sometimes, they face difficulty contacting the ward. Ward staff will have to spend 10 minutes per patient to update Nursing Home Staff. Nursing Home staff verbalized that they do not know who to contact in the hospital when issues arises.
After	Nursing Home team will send their resident's list to CGH via a password lock excel sheet twice a week. Patient Navigator Nursing Home Team will review patient and update the nursing home through the list. In case of urgent matters, the nursing home nurse manager can directly contact the PN-NH nurse clinician. Half yearly zoom meetings are held between NH Nursing team and CGH PNs to discuss concerns and support required to improve communication and patient care

Measures (Results , Outcomes and Figures)

Nursing Homes were updated of their resident admission to Changi General hospital from January 2022 to December 2022. Nursing home residents were aged between 28 to 103 years old with an average age of 80. 62% were male and 38% participants were female.
457 patients accounted for 1008 number of admissions with an average of 2.2 admissions (range between 1-17 admissions) per resident in the period reviewed Over all 89% (893) has more than 1 admission and 41% (366) has more than 3 admissions in a year. 2.5% (22) patients has 10-17 admission in one year.



Feedbacks were obtained from the nursing home nurse managers and the following benefits of collaboration were summarized

Resolved issues to reduce A & E Visit:
1) **Protocol for re-insertion of male catheterization in Specialist Clinic**
2) **Arrangement for dislodged Percutaneous Transhepatic Cholangiogram (PTC) Tubes**

Bridge in communication between multi-disciplinary team and nursing home nurse managers with a 24hrs urgent support phone number

Complex discharges - Direct communication with nursing home nurse manager to resolve concerns and rely fear of taking patient back to nursing home

4. **Identify reasons for frequent re-admission and provide support to address them at ad hoc basis**

Conclusion

The enhanced work process has enhanced communication between the nursing home in the east and Changi General Hospital. This improved process plays a crucial role in maintaining seamless care and expediting discharges, thereby reducing the bed occupancy rate. Additionally, it cultivates a closer working relationship that yields various other advantages, as highlighted in the benefits of collaborations above. Research has shown that hospital readmission is associated with an increased risk of adverse health outcomes, including heightened patient stress and higher healthcare costs.

Future Recommendation

By Identifying a patient's medical profile , healthcare providers can develop targeted interventions to reduce the likelihood of readmission. Admissions for infections (pneumonia, urinary tract infection, sepsis and cellulitis) accounted for more than 50% of admissions. With the top admitting diagnosis as pneumonia, the team is looking into collaboration with CGH respiratory departments to look into how we can reduce readmission for the following population.