**Service Priorities and Programmes**

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# Patient-centered discharge planning

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## Introduction

Discharge planning facilitates an early and safe patient transition from hospital to community. The current practice of performing pre-discharge planning within 72 hours upon admission causes delay in discharge coordination. The original discharge planning form was designed in 2002, which is also not comprehensive enough to identify nowadays complex discharge problems. This late and incomprehensive assessment has leaded to delay in implementation of appropriate patient care and prompt multidisciplinary referrals. These further result in prolonged patient hospitalization. To achieve an effective and efficient discharge planning, Department of Medicine & Geriatrics (M&G) has initiated a patient-centered and structured system for enhancing patient discharge process.

## Objectives

1.To cultivate a proactive and targeted nursing assessment for discharge planning.
2.To conduct a timely screening and management of risk factors of patient discharge.
3.To trigger an early referral of allied health care professionals for discharge support.
4.To promote patient-family engagement on discharge plan. 5 To facilitate a safe and appropriate patient discharge.

## Methodology

Literature review was done to identify the most current discharge problems for patients. Impairment in mobility and activities of daily living (ADLs), high fall risk, poor nutritional status, insufficient medication reconciliation, poor social and community support were recognized as principal barriers to patient discharge. A patient centered discharge care plan, was then re-designed for screening these potential risk factors, and was initiated within 24 hours upon admission. Designated ward discharge coordinators coached the staff in the care plan and monitored the pre-discharge preparation with patient and family. Allied health professionals and community care nurses were invited to introduce the community nursing service and referring system for early liaison. This newly discharge planning have implemented in 13 acute medical

wards with around 600 in-patient beds since mid-2016. Hospital statistic, staff survey and patient survey were used to evaluate the effectiveness of the newly

**Result**

1.The result was positive and encouraging. The average length of stay (ALOS) is reduced from 6.98 days in 2016 to 6.53 days in 2017 including general medical cases and sub-specialty cases. 2.There was 4.3% increase in referral made to allied health professional for discharge support. The screening time for referring allied healthcare professional was shortened by 68%. 3.The bed occupancy is relieved from 103.52% in 2016 to 98.76% in 2017 by speeding up the patient discharge process. 4.Staff satisfaction survey showed that 92% of nurses acknowledged the effectiveness of identifying discharge problems. 94% of nurses acknowledged that the program can facilitate early referral of allied health. 5.From the patient experience survey, 100% of patients appreciated nurses active communication, they were satisfied with the discharge arrangement with sufficient time for preparing discharge, 6.95% of patients reflected that they were being involved in the discharge planning and their need