Project Title

Scheduling Heart Failure Appointment prior to Patients Discharge: A Quality Improvement Project to Improve Service Provision and Patient's Experience

Project Lead and Members

Project lead: Toh Lay Cheng

Project members: Lee Ying Ming, Yang Li Jia, Dr Chan Po Fun, Dr Elaine Boey Chen Chen, Dr Loh Puay Huan, Elainena Than Jia Hui

Organisation(s) Involved

Ng Teng Fong General Hospital

Healthcare Family Group Involved in this Project

Medical, Nursing, Ancillary

Applicable Specialty or Discipline

Cardiology

Project Period

Start date: Apr 2021

Completed date: Apr 2022

Aims

To reduce the % of patients who got wrong or no appointment from 13.5% to 0% by August 2022.

Background

See poster attached

Methods

See poster attached

Results

See poster attached

Lessons Learnt

See poster attached

Additional Information

This project is related to a 2019 project titled: Closing the Care Gap – A nurse-led heart failure clinic to timely clinic review and reduce unplanned 30 days readmission

Project Category

Care & Process Redesign

Quality Improvement, Workflow Redesign

Keywords

Heart Failure Appointment, Scheduling, Prior to discharge

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SCHEDULING HEART FAILURE APPOINTMENT PRIOR TO PATIENTS DISCHARGE : A QUALITY IMPROVEMENT PROJECT TO IMPROVE SERVICE PROVISION AND PATIENT'S EXPERIENCE

✓ SAFETY ❑ PRODUCTIVITY
✓ QUALITY ❑ COST
✓ PATIENT EXPERIENCE

MEMBERS:

TOH LAY CHENG, LEE YING MING, YANG LI JIA, CHAN PO FUN,
ELAINE BOEY CHEN CHEN, LOH PUAY HUAN, ELAINENA THAN JIA HUI

Define Problem, Set Aim

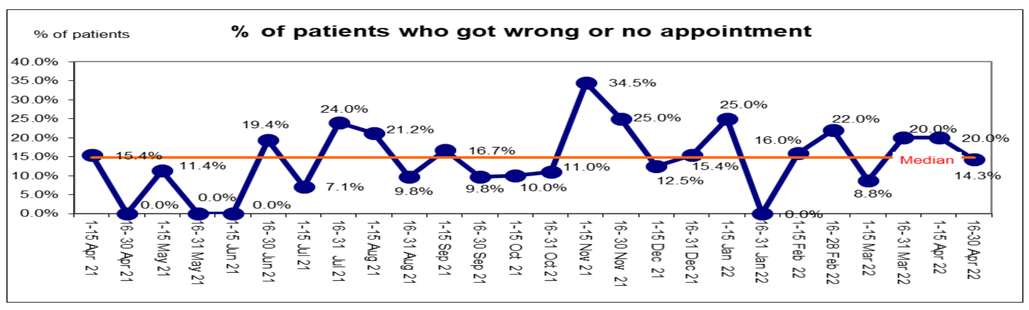
Part of the services we provide to heart failure (HF) patients include post discharge telephone calls.

Among other purposes, we want to ensure HF follow up appointment are scheduled in a timely order and to the right HFMDC Clinic, usually within 2-3 weeks from discharge. Initial visit is particularly important to monitor if any adverse effects from initiation of HF medications and if treatment is adequate to improve symptoms.

From April 2021 to April 2022 we have conducted 755 calls. Amongst these patients, 89 did not received appointments and 13 were given wrong appointments. 13.5% (102) of the patient could have potential slipped through the net without a follow up review and this could resulted in worsening symptoms and readmissions.

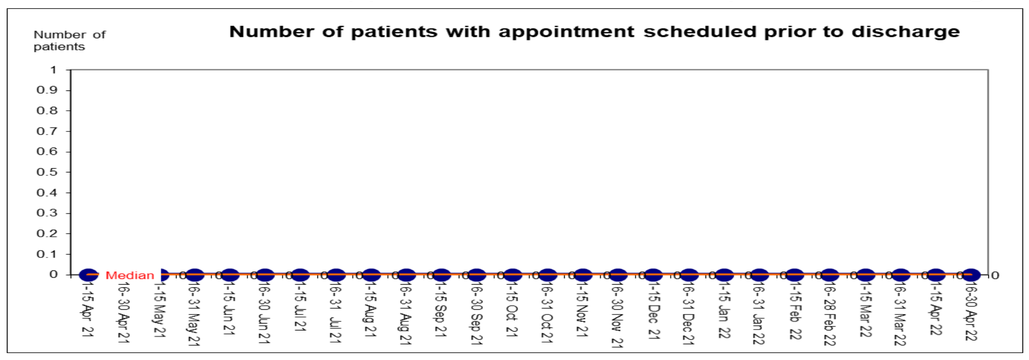
Establish Measures

Outcome Measure: % of patients who got wrong or no appointment



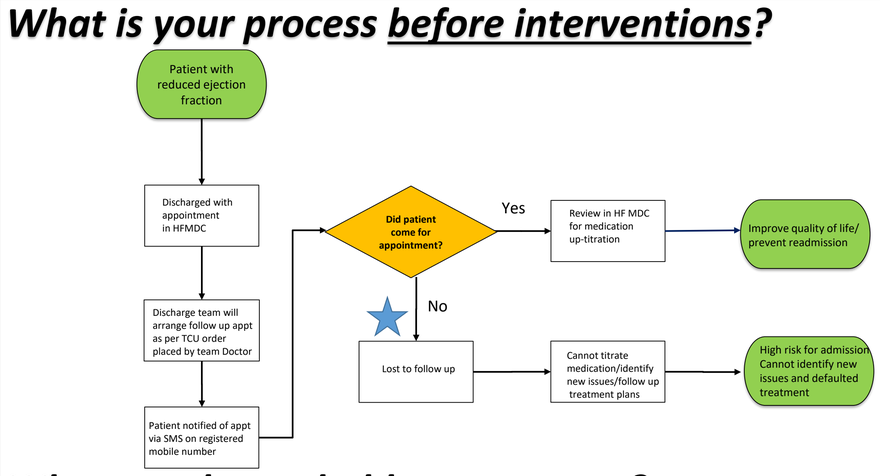
Patient who got wrong or no appointments
---------- X 100%
Total of patient called from post discharge

Process Measure: No. of appointments scheduled prior to discharge

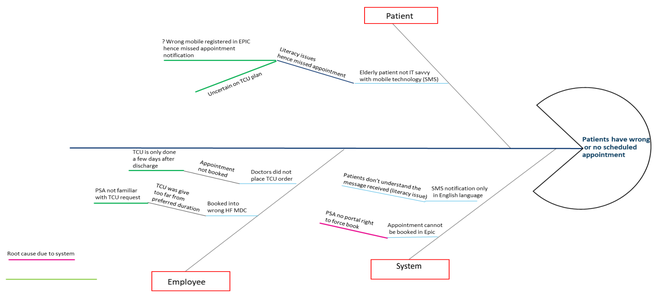


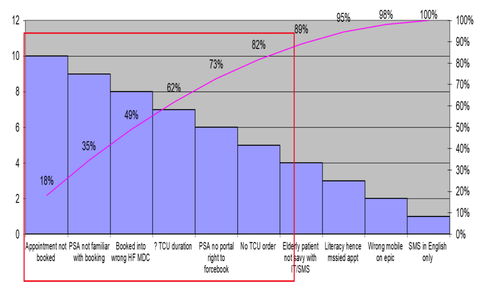
Analyse Problem

What is your process before interventions?



What are the probable root causes?

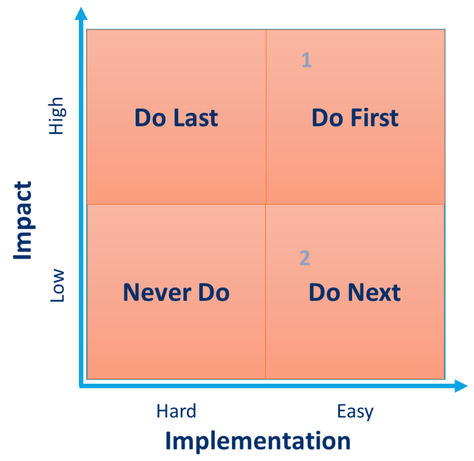




Select Changes

What are all the probable solutions? Which ones are selected for testing?

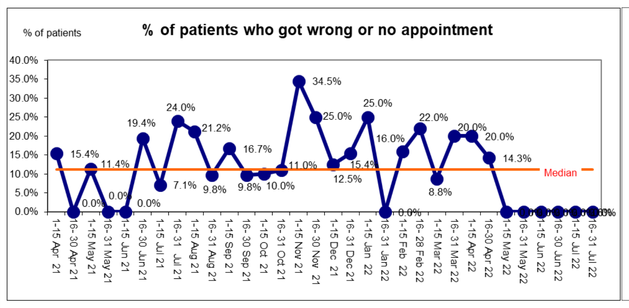
Root Cause	Potential Solutions	
• Missed appointment due to wrong registered number on the system (appt send via SMS) • No TCU order placed prior to discharge • Wrong TCU duration given	*1*	HF nurse to arrange HF MDC appointment prior to discharge
Wrong appointment booked due to PSA lack of knowledge on HFMDC structure	*1*	HF Nurse to arrange follow up appointment prior to discharge
	2	Assigned Executive to assist in HF MDC appointment bookings
Booked into wrong HFMDC clinic	*2*	Assigned Executive to assist in HF MDC appointment bookings
Limited portal rights for some PSA	*2*	Assigned Executive to assist in HF MDC appointment bookings

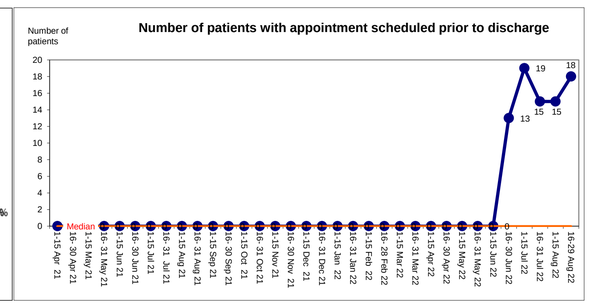


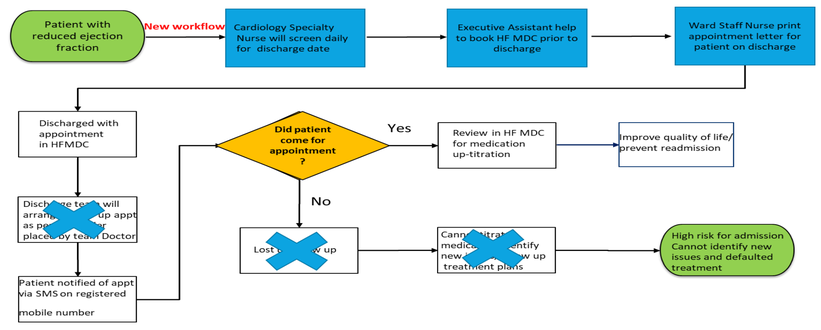
Test & Implement Changes

How do we pilot the changes? What are the initial results?

Cycle	Plan: "What will happen if we try something different?"	Do: "Let's try it."	Study: "What happened"	Act: "What's next?"
1	➢ Conduct post discharge telephone call at later date to give discharge PSA team ample time to arrange TCU after discharge (including email clinic to force book TCU, clarify TCU duration with doctors) ➢ So that TCU is arranged by the time telephone call is conducted by Cardiology Specialty Nurse	To conduct telephone follow up on Day 4 post discharge instead of Day 2	Still have about 8% of patient's appointment was not arranged on Day 4 post discharge ➢ Including wrong appointment given, or no TCU ordered at the time of discharge	Abandon workflow Duration of tell call follow up from Day 2 to day 4 is not the key component that causing no appointment given to patient after discharge. ➢ Problem identified Streamline post discharge TCU arrangement prior to patient discharge
2	Cardiology Specialty Nurse will intervene as gate keeper to ensure TCU is arranged prior discharge ➢ Cardiology Specialty Nurse will track the discharge TCU plan during patient hospitalization and book appointment ➢ Cardiology Specialty Nurse will place TCU order and blood test if required	➢ Cardiology Specialty Nurse will include this as part of pre-discharge planning action ➢ Cardiology Specialty Nurse will inform assigned Ops Executive Assistant with portal rights to arrange TCU	100% patients were aware of the TCU plan hence increase TCU compliance rate TCU is booked into the right HF MDC (there are 3 HF MDC by different Cardiologists)	Adopt workflow







Spread Changes, Learning Points

What are/were the strategies to spread change after implementation?

The Specialty Nurses have included this process as part of patient discharge planning with effect from mid May. The Assistance Executive assists in scheduling appointments have been briefed on the desired appointment duration, the specific HF MDC clinic and to book appointments prior to patient discharge. Ward Nurses were informed to print hard appointment letter for patients prior to leaving the ward.

What are the key learnings from this project?

While we recognize timely follow up is imperative to identify early complications and mitigate growing issues to keep patients out of hospital readmission, this is often not well managed. Patients are either lost to follow up, given a follow up that is too far away or booked into the wrong clinic.

With the introduction of the new healthub app, which is supposed to make it easier and convenient to check appointment at your finger tips, this somewhat had posed a big challenge for the most of our elderly patients who are not savvy with IT technology. Consequently they often missed the appointment. Although a SMS message was also sent to remind patients of upcoming appointments, it is only in English language which poses literacy issue for the older generation.

With these obstacles, we believe a printed copy of appointment letter remains the best option to inform patients of planned appointments particularly the elderly patients. This also minimize the odd chances of patients slipping through the nets with no or wrong appointments.

We have learnt from patients that with appointments given prior to discharge, this allows family members ample time to make arrangement to either accompany or apply leave in advance and avoiding clashes with other appointments which are equally important. When making changes ,we need to have special considerations for the elderly for the reasons above. Specialty Nurses have now spent less time during post discharge telephone call to track and arranging appointments. The workflow is much smoother and less time consuming. More importantly patients are seen timely in the right HFMDC clinic.

Ng Teng Fong General Hospital

Jurong Community Hospital