Hospital Authority Convention 2019

Modernization of Discharge Planning in Princess Margaret Hospital (PMH)

LI Ka Ying
APN (CNS), PMH

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Background

Discharge planning by ward nurse

? Receiving any community care service before admission

? Accurate / complete information collected

➡ Difficult & +/- delayed discharge planning

When request on community care service

1. Create, print out & fax referral form to CNS
2. Call CNS to confirm fax
3. CNS take the call & reschedule the work

➡ Complex referral workflow & decreased productivity
Electronic Referral System for Post-discharge Community Care Services

- Initiated by PMH CNS
- Jointly developed with Information Technology department

**Before Admission**
- Patient is under Community Program
- Identify patient receiving community services through OPAS web services

**During Hospitalization**
- Service needs after discharge
- One-Click-To-Refer for CNS
- Email notification for:
  1. Admission
  2. New referral
  3. Discharge
  4. Cancellation

**Outcome**
- All information recorded in web pages
- Mitigated risks of missing / delaying referrals
- Generate reports for:
  1. Daily work scheduling
  2. Service planning & monitoring
Objectives achieved

✓ To provide timely post-discharge support services

✓ To save administrative efforts and workload in daily patient care and liaison duties

✓ To promote better patient outcomes and discharge experience

Result & Outcome

From mid-Aug 2018 to March 2019

• Total 7464 referrals received
• Average of 1000 referrals per month

✓ No loss of service request

✓ Improved work efficiency & increased productivity

✓ Full communication with patient and carers for discharge planning
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Thank you