



## Service Priorities and Programmes Electronic Presentations

**Convention ID:** 373

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### **A paradigm shift in M&G admission policy through staff engagement**

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#### **Keywords:**

Admission policy

Staff engagement

#### **Introduction**

Bed occupancies above 85% can adversely affect safe and effective hospital function. KWC serving the largest aging population will provide 2.7 beds per 1000 population, which is still far below the target of 4.2 beds in the coming 5 years. The persistently high bed occupancy rate of over 110% for past years in PMH M&G has been a discernible risk for timely access of care. The old admission system by ward occupancy aimed to share out patient load but unavoidably scattered the unit and subspecialty patients amongst 14 in-patient M&G wards located in 4 different building blocks. Medical staff's long travel time, unmatched nursing skill-mix and complex admission triage have negative impacts on the safe and efficient operation and lead to: (1)Frequent access block (2)Induced and delayed consultation, referral and treatment (3)Increased hospital-associated infection rate (4)Lenghened hospital stay (5)Exacerbated ward conflict (6)Aggregated staff fatigue and turnover

#### **Objectives**

Incentive for a value- based change in admission policy to improve staff productivity, cost-efficiency, clinical quality, patient and staff safety, patient and staff satisfaction and finally financial reward from a controllable bed occupancy depend on staff's receptivity and locus of control . The dramatic reform of admission flow to a unit and subspecialty- based approach is to create a self-initiated internal efficiency and incentive of proactive, speedy and appropriate patient discharge, thus reducing bed-occupancy to a threshold level.

#### **Methodology**

(1) Review the complexity and bottleneck of past admission logistic resulting in unresolved high bed occupancy. (2) Engage staff to explore the potential of different admission triages. (3) Adopt a radical "unit and related subspecialty" team based admission flow to stop crossover admission. (4) Designate team liaison officers and a bed manager for overall bed monitoring and admission triage. (5) Each admission team plays a self-regulatory role to boost up own bed capacity by expediting patient treatment and discharge, and maximizing use of extended-care and day beds. (6) Utilize non-medical overflow beds strategically to support team with bed pressure. (7) Regularly monitor outcomes to secure staff motivation and system safety.

## **Result**

The initiative has been implemented since 16 November 2015 and total matching with zero cross team emergency admission was achieved. The medical staff travel areas amongst 14 wards was greatly cut to within 4-5 wards of same parent team. The average length of stay (LoS) was significantly reduced by 0.77 days indicating prompt treatment process and speedy discharge with reference to previous month. The post one-month outcome showed that despite of similar emergency admissions, bed days occupied was reduced by 3.7% and overall bed occupancy rate was decreased by 1.2% as compared to the same month of previous year. The extended trial in second month facing increased emergency admission in winter surge by 7%, the occupancy rate and LoS could be maintained steady. The unplanned readmission rate was similar. The team harmony and familiarization in clinical handover and ward practice were resultantly enhanced through cooperation between medical and nursing staff under one parent team.