

**Background**

- Place of death is considered a marker of quality, because it is related to quality of life and bereavement outcomes. It also indicates the extent to which care meets people's preferences at the end of life, since most people prefer to die at home or in their usual place of living and care
- As our population ages, we envisage that more people will be residing in nursing homes towards their end-of-life (EOL).
- In two of the St Andrew's Nursing Homes (SANH), only 25% of residents had an Advance Care Plan (ACP) before they passed away. Only 15% of residents pass on at the homes in 2019.
- We set out to honour the EOL care preferences of residents. A Palliative Care programme called The Violet Programme (ViP), was introduced in 2020 to improve the palliative care capabilities of NHs through a pro-active patient-centric clinical model, involving system review and resource enablement and thereby allowing more residents to die-in-place.

[The programme is named after the SACH Violet Ward, a palliative care ward. The acronym also reminds the team that those who are at the EOL deserve to be treated as Very Important People.]

**Objective**

To improve ACP rate from 25% to 50% within a year in those who are terminally ill and achieve at least 60% concordance rate in preferred place of death.

**Methodology and Problem Analysis**

ACTIVITIES	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021
Stakeholder Engagement	Completed	Completed	Completed	Completed	Completed
Workgroup Formation	Completed	Completed	Completed	Completed	Completed
Landscape Survey and EOL Gap Analysis	Completed	Completed	Completed	Completed	Completed
Ground Study	Completed	Completed	Completed	Completed	Completed
Training Process and Review	Completed	Completed	Completed	Completed	Completed
Spread	Completed	Completed	Completed	Completed	Completed

Gap Analysis of EOL care at SANHs (carried out through interview with management team and staff):

Clinical	Systems	Resource
Complex Communications	Integration across care settings	Manpower
Clear and Comprehensive Plans	Right siting	Equipment
Access to Specialised Pall Advice		Medication
Role Clarity between staff		Infrastructure
Bereavement Support		

Gap Analysis of Current EOL care models in NHs:

**RHS(P6A)**

- Manpower
- Training
- Other Resources
- Integration with RHC
- Comprehensive (ACP driven)
- Telehealth Support

High Systems Cost  
Regional Coverage

**Home Hospice**

- Provides specialist support
- Leverage on hospice charity's subsistence
- Integration with IPH (possibly)

Not comprehensive  
No systematic Training  
Funding goes to Hospice services  
Bereavement Support left to FH

**GP-led**

- Most cost efficient

Depends on strength of individual GP  
Difficult to sustain if single GP systems

None of these models addresses Structural and Organizational Factors

Ground Study indicated that staff were ready, given the right environment:

- 100% of staff surveyed were "very willing" (78%) or "willing" to provide EOL care in their NH.
- 80% of nursing staff feels that they know how to take care of dying residents "most of the time".

**Implementation Plan**

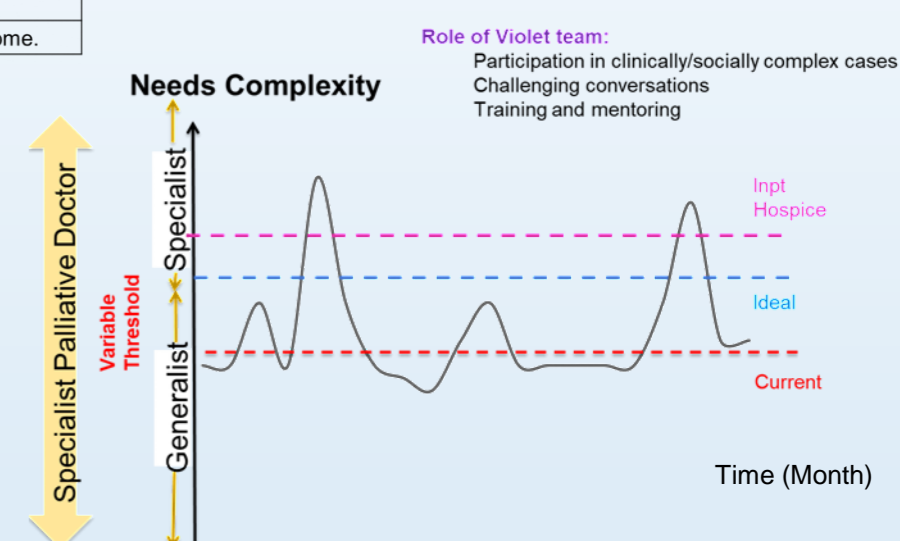
1. Based on Gap analysis, a 3-pronged approach was adopted



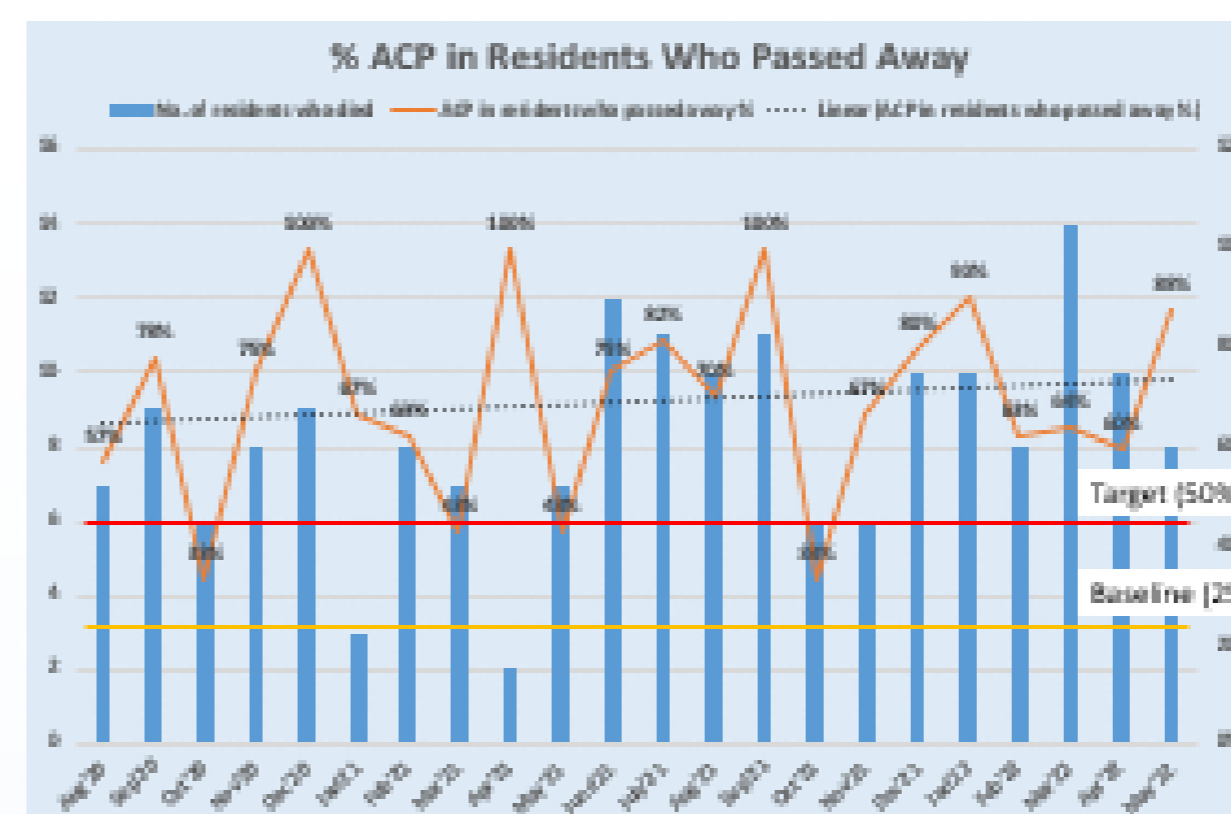
Staff Ranking of Top 10 Most Important Elements with Implementation

Medication Access	1	CD Drug access arranged, formulary amended.
Hygiene Factors (NH staffing and leadership)	2	Appointment of EOL Nursing Leads.
Specialist Palliative Care team attending to complex cases	3	SACH Pall Care Team provided support.
MDR to discuss cases	3	GP-led ward rounds and MDR to identify EOL cases, mortality rounds to audit care and bereavement needs.
Trained and willing GP	4	GP 'vendors' invited to join as staff or were replaced by staff. Sent for training.
Technology	4	Telehealth introduced, WhatsApp SBAR protocols.
Environment e.g. single room	5	Renovation works planned
Integration with RHS	5	Two-way fast-track access with RHS.
EOL champion	5	EOL champion appointed in each NH.
Palliative Care NC to oversee the NH	6	Palliative Care Nurse Clinician oversees each home.

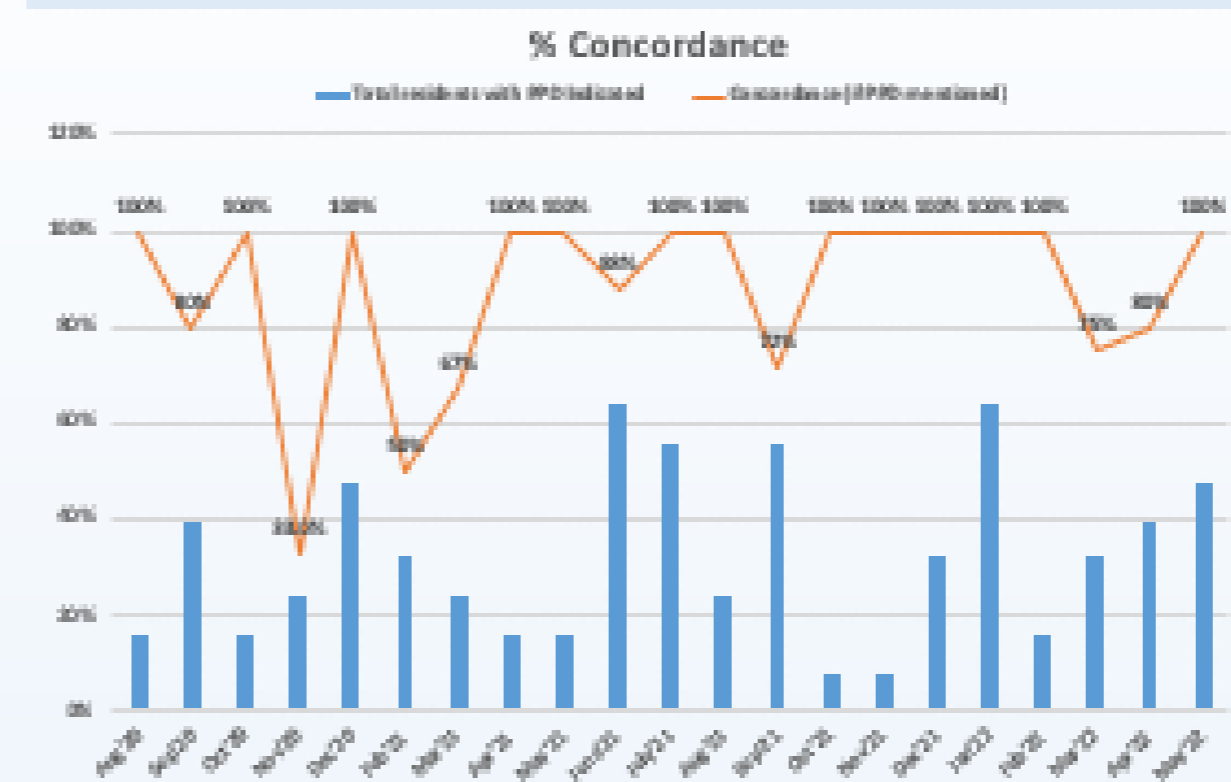
- The Gap Analysis indicated high willingness and perceived knowledge, hence system changes and process development needs to be paired with training.
- Implementation of a Specialist-on-Generalist model,



**Results**

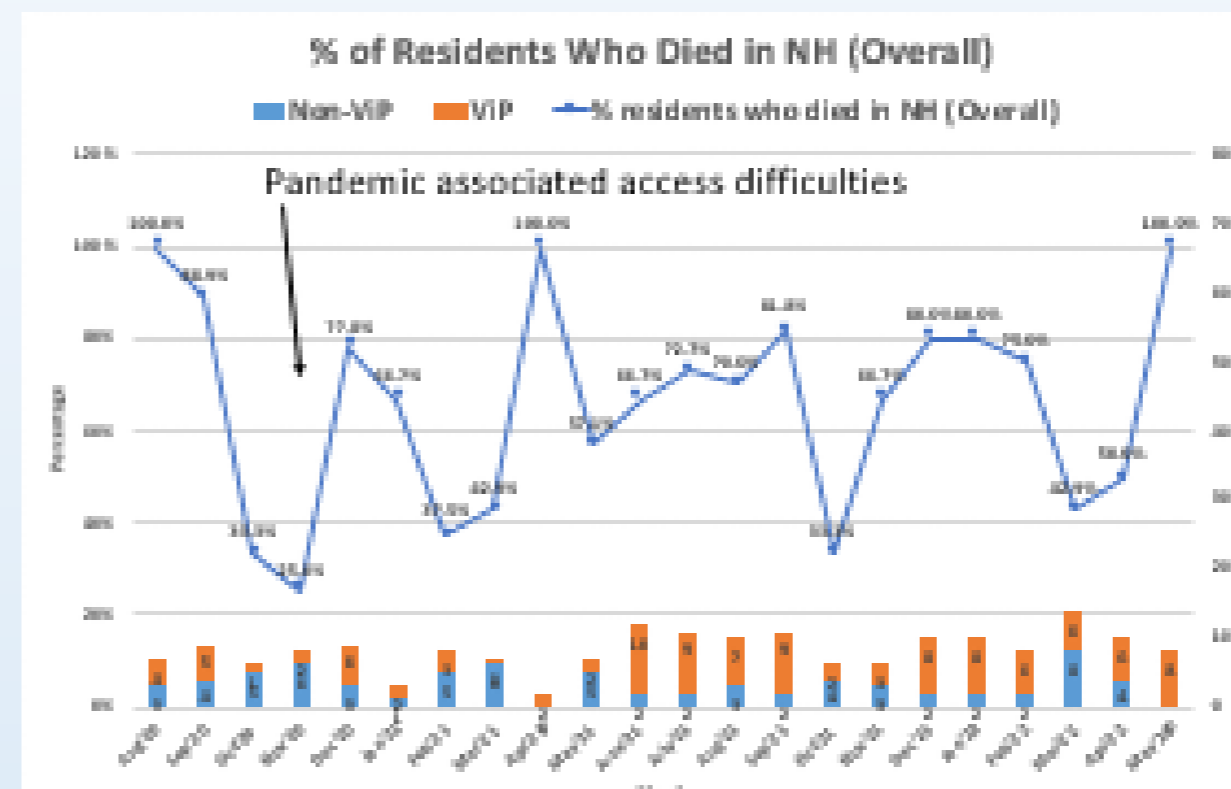


191 residents were cared for in the programme. ACP was conducted in 95% of residents in the ViP group and 25% in the non-ViP group.



The majority of those in the non-ViP group were those that did not meet the "no-surprise" and prognostic criteria.

There was high concordance rate for preferred place of death with 95% in the ViP group and overall 89% in the NHs.



Of the 191 residents in the ViP group, 110 have passed away, 93% of them in the NHs.

Overall, 63% of residents passed away in the NHs compared to 15% baseline pre-programme introduction.

**Comments and Conclusion**

- The programme has demonstrated that focusing on proactive patient-centric care, with system review and resource enablement can assist residents to die-in-place with high preferred place of death concordance. Staffing turnover continues to be a challenge. Crucial elements to ensure sustainability is the availability of medication, support from a specialist team for more complex cases with primary care by GPs and nursing staff, and introduction of proactive screening to identify potential residents who are reaching the end of life (refer to #1 of Implementation Plan).
- Estimated system savings range from \$74,605<sup>1</sup> (low bar, assume 1 day admission saved) to \$522,238 (high bar, assume 7 days).
- There was strong support for the programme with staff reporting a sense of empowerment and accomplishment in fulfilling residents' wishes to pass on in the nursing homes. There was also very positive feedback from bereaved family members.
- There are plans to spread the interventions to other NHs under St Andrew's Mission Hospital.

