CommunityCare EXCELLENCE AWARDS 2022

ViP@NH

ST. ANDREW'S COMMUNITY HOSPITAL

ST. ANDREW'S NURSING HOME

St Andrew's Community Hospital / St Andrew's Nursing Home

Shaun Nathan[1], Catherine Teo[1], Mok Foong Yue[1], Doris Tchen[2], Joan Lee[2], Ng Li Ling[1], Darren Koh[1], Angel Lee[1]

[1]St Andrew's Community Hospital [2]St Andrew's Nursing Home

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, system review and resource enablement and thereby allowing more residents to die-in-place.

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.

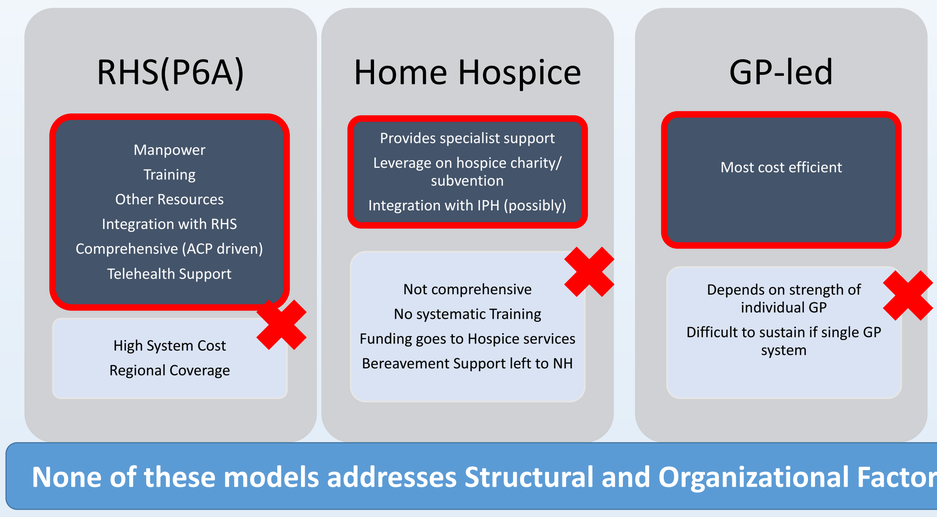
Methodology and Problem Analysis

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

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

Clinical	System	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:



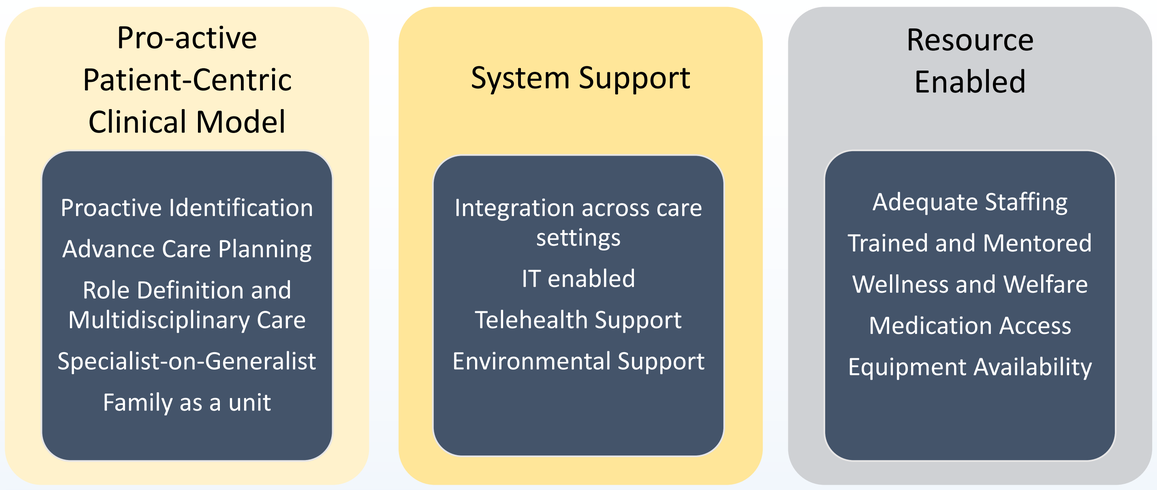
None of these models addresses Structural and Organizational Factors

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 analyses, a 3-pronged approach was adopted.

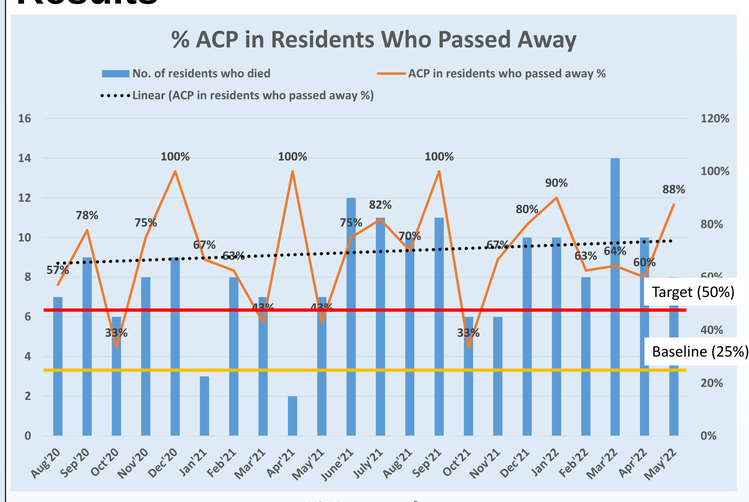


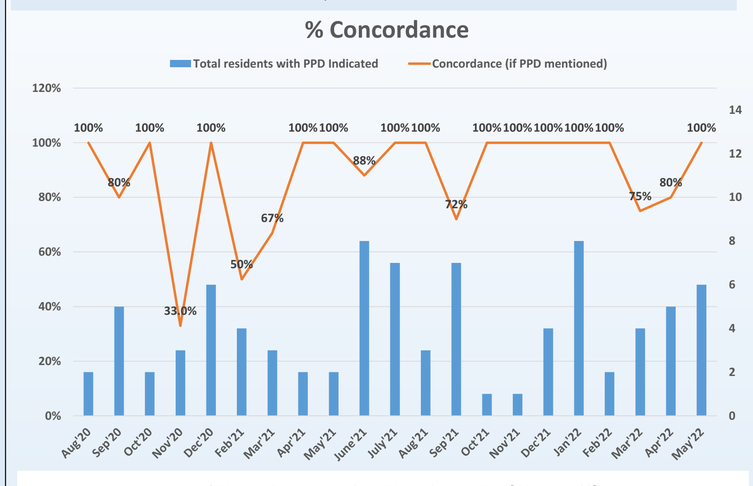
Staff Ranking of Top 10 Most Important Elements with Implementation

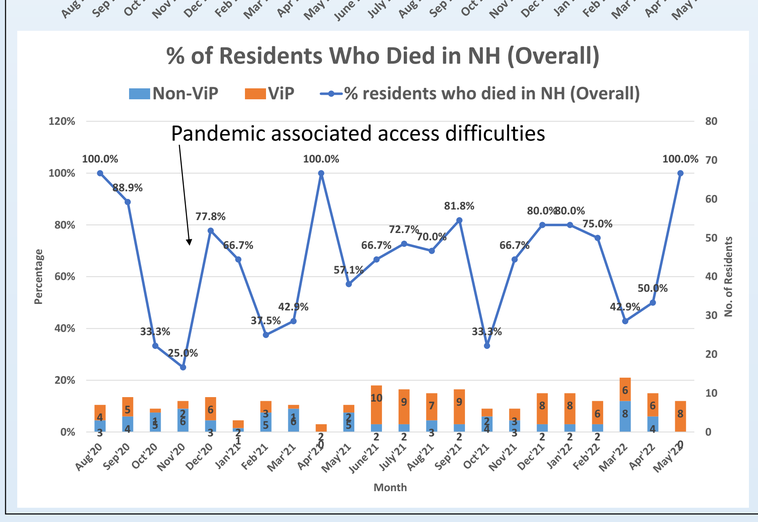
Medication Access	1	CD Drug access arranged, formulary amended
Hygiene Factors (NH staffing and Leadership)	2	Appointment of Nursing Leads with keen EOL interest
Specialist Palliative Care team attending to complex cases		The SACH Pall Care Team provide support (Violet Team)
MDR to discuss cases	3	MDR to identify EOL cases, mortality, bereavement
Trained and willing GP	4	GPs sent for training
Technology		Telehealth introduced, WhatsApp SBAR protocols
Environment e.g. single room	5	Renovation works planned
Integration with RHS		Two-way fast-track access
EOL champion		Appointed in each NH
Palliative Care NC to oversee the NH	6	Appointed in each NH

2. The gap analysis indicated high willingness and perceived knowledge, hence, system changes and process development needs to be paired with training:
   - Proactive identification of patients reaching the EOL using Gold Standards Framework (checklist)
   - Needs recognition and management at the EOL (Using "5 priorities") and SBAR for communication

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.

Conclusion

- The programme demonstrated that focusing on proactive patient-centric care, system review and ensuring adequate resources can enable residents to die-in-place with high preferred place of death concordance. 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, introduction of proactive screening to identify potential residents who are reaching the end of life.
- 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.