Project Title

Violet Programme @ SANH: A Nursing Home End-of-Life Care Initiative

Project Lead and Members

Project Lead: Dr Shaun Gerald Nathan

Project Members: Dr Angel Lee, Catherine Teo Pai Pai, Mok Foong Yue, Doris Tchen, Joan Lee, Dr Ng Li Ling, Dr Darren Koh

Organisation(s) Involved

St. Andrew's Community Hospital, St Andrew's Nursing Home

Healthcare Family Group(s) Involved in this Project

Medical, Nursing

Applicable Specialty or Discipline

Palliative Care Medicine

Aims

To introduce a palliative care approach in 2 nursing homes that will increase the uptake of Advanced Care planning (ACP) from 25% to 50% in those residents who are terminally ill, and achieve at least 60% of these residents to die-in-place in accordance to their preferred plan of care.

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

It is often thought that poor palliative care is due to inadequate care staff. What we learnt was that it is the lack of understanding of what matters to residents that is the most important. The staffing situation continues to be dire and in fact, worsened as a result of the pandemic. But care has improved with better understanding and support.

Conclusion

EOL Care provision in NH may seem a daunting challenge. However, we have found that with the 3 prong approach, by breaking down the process into more manageable steps, the process becomes more manageable, and with each measure implemented, there is an incremental improvement in the care for our residents at end of life.

Additional Information

The ground work for this programme was laid from Jan-Jul 2020 with the programme starting in August 2020.

Despite the influence of the COVID pandemic with the various restrictions, implementation proceeded and 2 rounds of training has been conducted in our 2 homes.

As mentioned above, with the increased demand from other homes in under our SAMH umbrella, ad-hoc care provision has also begun in 3 other nursing homes, as we continue to plan to on-board and implement the full Violet Programme in these homes.

Project Category

Care & Process Redesign

Clinical Practice Improvement

Keywords

End-of-Life-Care, Advanced Care Planning, Die-in-place, Nursing Home

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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.

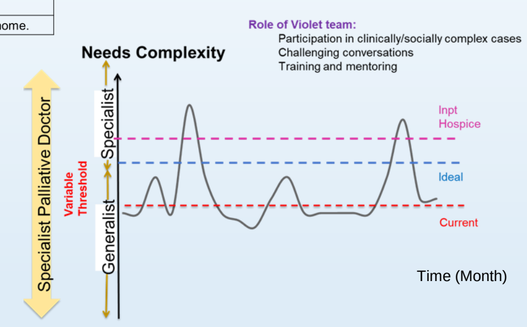
Implementation Plan

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

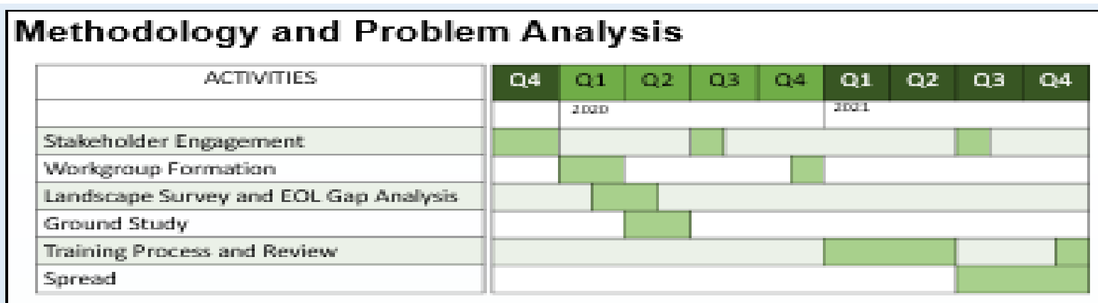
Staff Ranking of Top 10 Most Important Elements with Implementation

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		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		Telehealth introduced, WhatsApp SBAR protocols.
Environment e.g. single room	5	Renovation works planned
Integration with RHS		Two-way fast-track access with RHS.
EOL champion		EOL champion appointed in each NH.
Palliative Care NC to oversee the NH	6	Palliative Care Nurse Clinician oversees each home.

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



Methodology and Problem Analysis

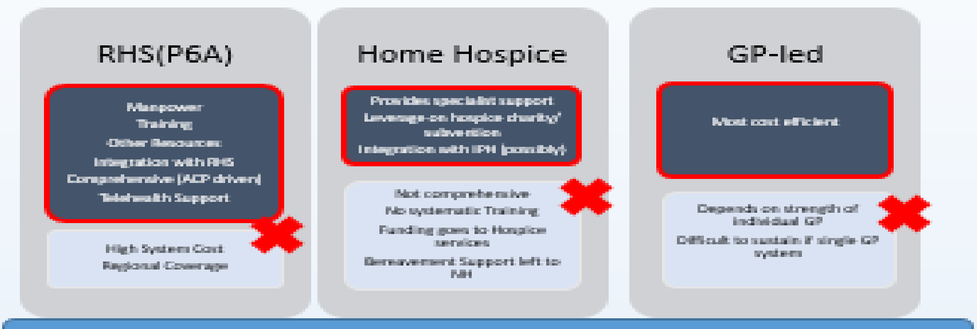


ACTIVITIES	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
		2020				2021			
Stakeholder Engagement									
Workgroup Formation									
Landscape Survey and EOL Gap Analysis									
Ground Study									
Training Process and Review									
Spread									

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:

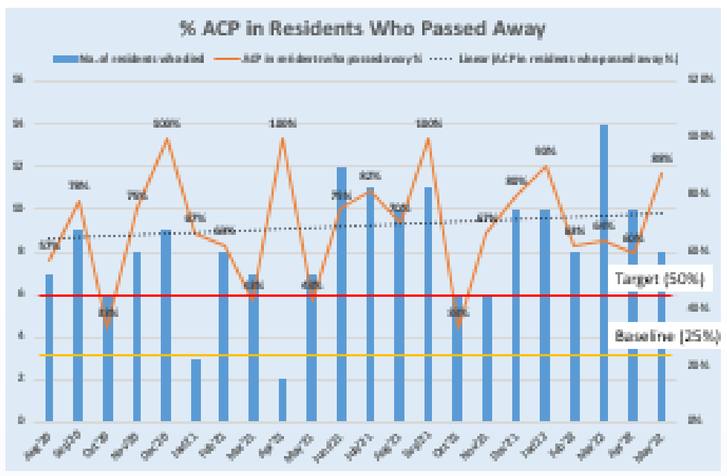


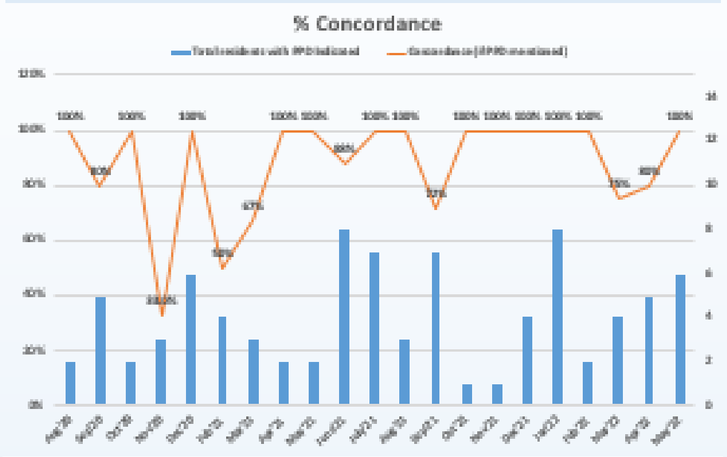
None of these models addresses Structural and Organizational Factors

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".

Results

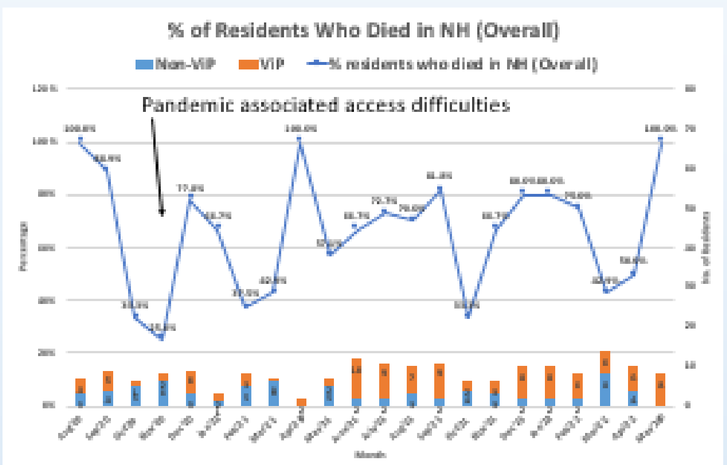




191 residents were cared for in the programme. ACP was conducted in 95% of residents in the ViP group and 25% in the non-ViP group.

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[1] (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.

ST. ANDREW'S COMMUNITY HOSPITAL

ww.goldstandardsframework.org.uk/cd-oads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf
s per day = $1000 – (norm cost for NH stay, $106) – (norm cost for home palliative care support, $40) = $854
at 15% would have readmitted anyway based on baseline data. 63%-15% = 48% of admissions saved.