“I’m a Confident ESTHER!”

ESTHER
Network for Health & Social Care
SINGAPORE

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Introduction

This ESTHER project escalation derived from the experience of one ESTHER case series with the history of 11 DEM visits and 8 hospitalizations over 5 months in July 2016. With the intervention of the care from the community nurse and community partners, ESTHER managed to stay free from DEM visits and readmission till date.

Following through this case series, we piloted this concept on 11 patients that were admitted to Singapore General Hospital (SGH). We collaborated with NTUC Cluster Support in Bukit Merah Zone. We were able to ensure a smooth transition from acute care setting to the community. The 11 ESTHERs maintained well in the community from February 2019 till date. The pilot was conducted for patients under the hospital to home (H2H) programme living in the 5 communities of care (Bukit Merah, Tiong Bahru, Chinatown, Katong and Telok Blangah).

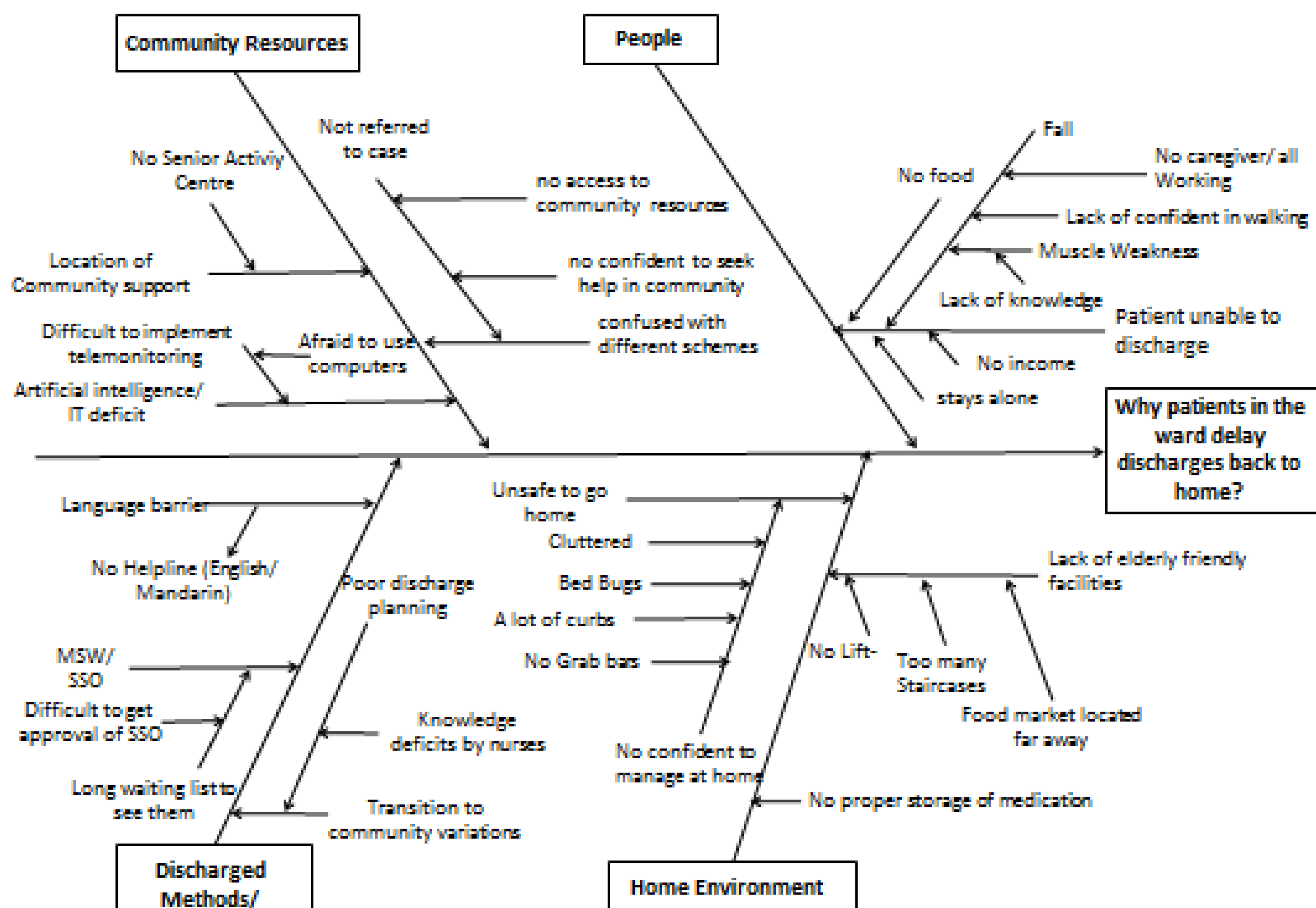
The project was escalated to a bigger scale to recruit more ESTHERs to this improvement project.

Aim: To work on the project escalation through the extension of cluster support services with 5 communities of care and community nursing team.

Objectives: To treat each ESTHER with compassion and dignity. Having a close collaboration with community services and working together to achieve common goals for ESTHER in the community.

Mission Statement: To improve the confidence level of ESTHER in self-care in the community within the 5 COC (Communities of Care) zones by 50% over a period of 12 months.

The team also facilitated the ESTHER café with residents in the community to understand their needs better.



Methodology

To measure patient’s confidence levels, the team used the Confidence Level Questionnaire (Diagram 2). Patients would self rate their confidence level in Basic ADLs and iADLs at four different time points (at admission, within 1 week, 3 months and 6 months). A score of 0 represents no confidence, and 10 represents very confident.

Each ESTHER were also given a care plan (Diagram 3) to remind them of their own personal goals.

Diagram 2: Confidence Level

Increasing the confidence level of ESTHER during transition from hospital to home

Pre/Post Survey Questionnaire:

How confident are you on your capability to perform the following activity of daily living on a scale of 1-10. 1-10. 0 is no confidence, 10 is very confident

	Activity											
1.	Moving around at home	0	1	2	3	4	5	6	7	8	9	10
2.	Showering	0	1	2	3	4	5	6	7	8	9	10
3.	Toileting	0	1	2	3	4	5	6	7	8	9	10
4.	Dressing	0	1	2	3	4	5	6	7	8	9	10
5.	Preparing meals	0	1	2	3	4	5	6	7	8	9	10
6.	Eating	0	1	2	3	4	5	6	7	8	9	10
7.	Medication taking-knowledge	0	1	2	3	4	5	6	7	8	9	10
8.	Housekeeping	0	1	2	3	4	5	6	7	8	9	10
9.	Shopping	0	1	2	3	4	5	6	7	8	9	10
10.	Moving around	0	1	2	3	4	5	6	7	8	9	10
11.	Sleeping	0	1	2	3	4	5	6	7	8	9	10

Diagram 3: Care Plan

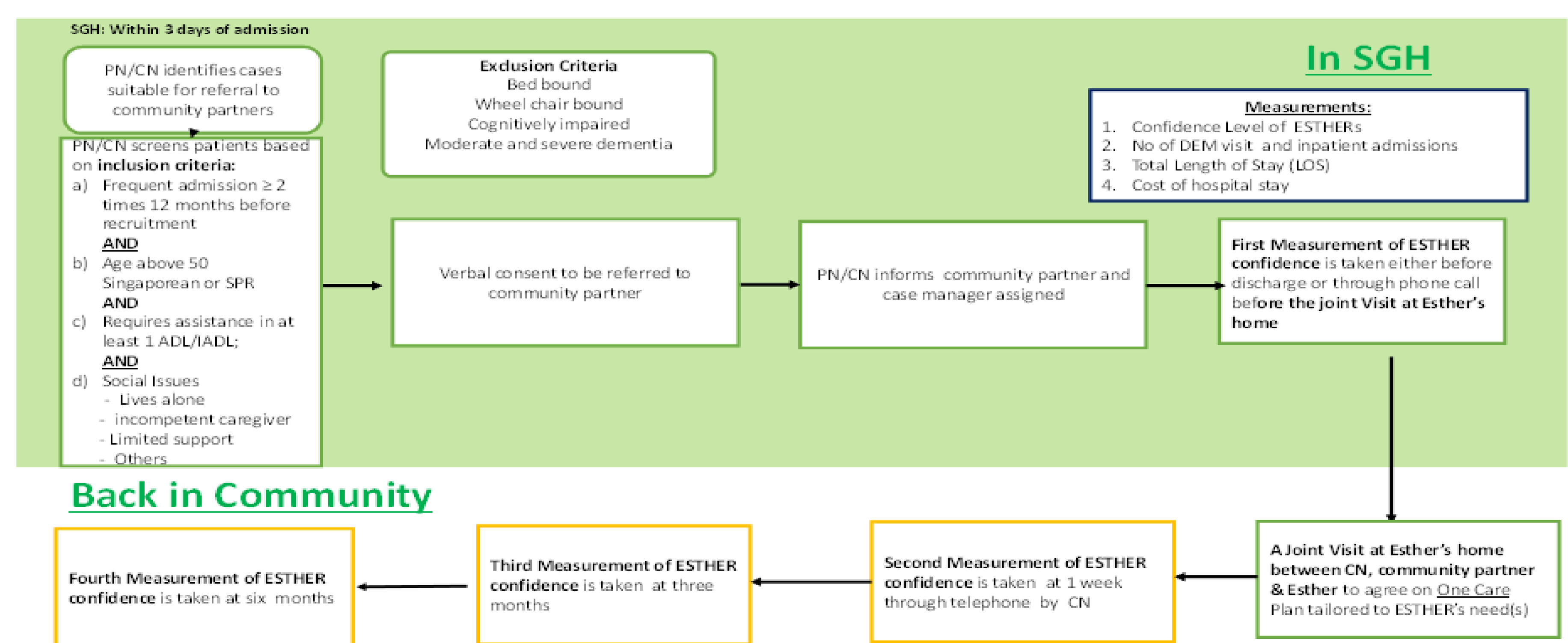
My Care Plan — Name: / IC: / Date: (affix sticker if available)

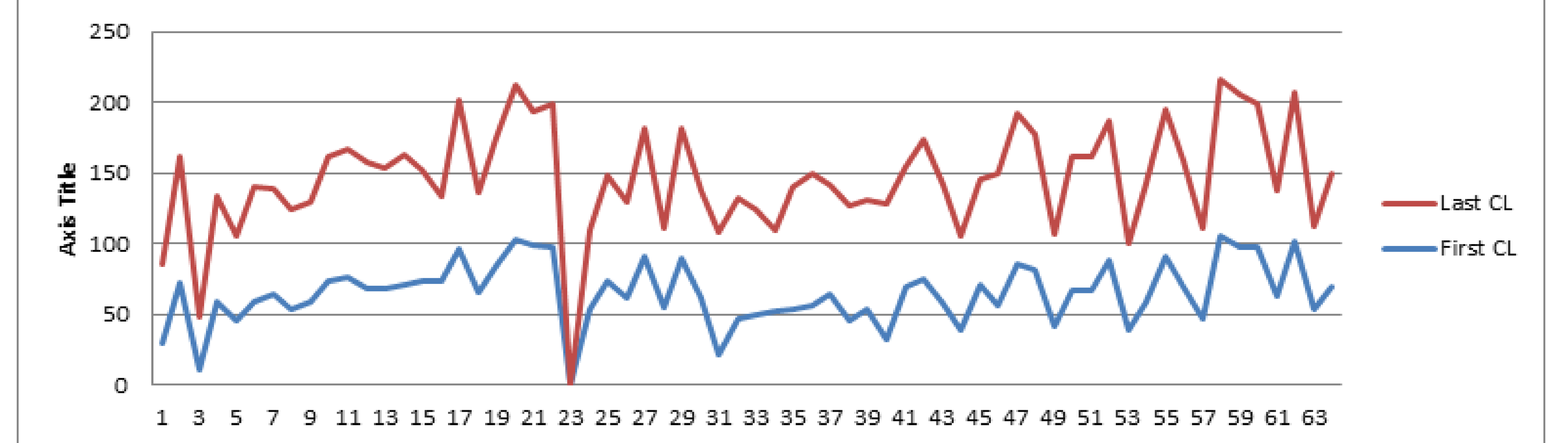
My Personal Goal	Date Goal Started
1. To drink water up to 1litres/ day only (Fluid Restriction)	
2. Check blood sugar readings (pre-meal) twice a week	

SAMPLE

Proposed Solution

Identified Inclusion Criteria for ESTHERS to be recruited in this project and screen patient using the flow table below.





Results

Total 64 patients were enrolled and 1 dropped out in between data collection.

- Median CL on admission (first reading) = 66
- Mean CL after intervention (last score) = 85
- Difference in median = 19

The median difference of 19 showed an improvement in the confident level (CL) of 64 patients, represented in the above chart.

Readmission 12 months before and after intervention are still being analyzed.

Conclusion and Learning Points

This project has demonstrated that with early collaboration between acute hospital and community partner, and performing a comprehensive discharge care plan in collaboration with the patient, we can achieve better care and patient outcomes as demonstrated in the results.

The workflow aligns with our Regional Health System (RHS) mission of partnering communities to keep well, get well and age well. The strong partnership developed with community partners help keep patients anchored in the community for as long as possible.