"Help me remain and cope at home, please."

ESTHER
Network for Health & Social Care
SINGAPORE

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Background

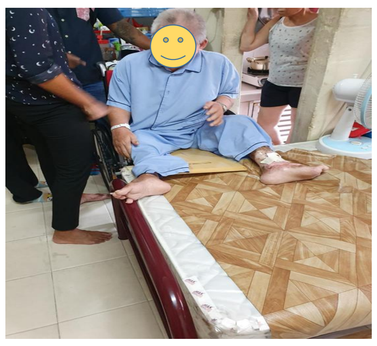
Based on AIC IRMS (BVH) data, senior group homes, and Integrated Home and Day Centre (IHDC) based services that cater to patients who are not fully independent, observed high withdrawal rate of more than 80% between January 2019 and June 2019.

Between January 2019 and August 2019, 4 of 5 patients withdrew from IHDC services as 2 of them were admitted to Voluntary Nursing Home and the other 2 were re-admitted to the hospital.

We identified our Esthers to be the inpatients at Bright Vision Hospital (BVH) who are not fully independent (RAF Category 2 and above) and have limited social support, but would like to remain at home instead of being admitted to an institution.

** (Info taken from AIC website : IHDC packages are comprehensive and personalised to support seniors with multiple care needs. With the packages, frail seniors who might otherwise enter a nursing home are able to continue to live at home with their loved ones.)*

Methodology



During ESTHER Cafe, our team noted that 8 of 9 (89%) patients wish to stay at home. Currently, the team has identified 5 Esthers who wish to continue staying at home with support services from IHDC.

Figure 1: Joint home assessment with IHDC service provider at Esther's home.

Mission Statement

Increase Esthers' length of stay in the community from 67% to 75% within the project period from 23 August 2019 to 31 December 2019.

- Length of stay in the community is measured from the day of discharge from hospital to the next hospital admission

Proposed Solutions

PDSA 1:Prediction: Low referral rate to IHDC is due to MDT's lack of understanding of IHDC services.

Plan:
- Visit IHDC service providers to understand the services and financial assistance schemes available.
- Conduct CPE to introduce the benefits of IHDC services and Esthers who have started IHDC services
- Collect data from AIC referral system (IRMS) on the number of IHDC referrals before and after intervention

Do:
- CPE talk was conducted on 22 August 2019
- 100 MDT staff including nurse, dietician, pharmacist, therapy staff and MSW attended the talk.

Study:
- Based on IRMS data, number of referrals to IHDC had increased from 5 cases between 1 January 2019 and 30 June 2019, to 12 cases between 1 July 2019 and 31 December 2019.
- MSW colleagues also feed backed that they are now more familiar with and confident in IHDC services.

ACT:
- Project Team decided to improve Esthers' awareness of IHDC.

PDSA 2: Prediction: Esther not familiar with IHDC services hence reject the referral.

Plan:
- Share with Esthers about IHDC services using pamphlet and YouTube video
- Accompany Esthers for initial assessment, if required.
- Use AIC IRMS data to compare the number of IHDC take-up rate before and after intervention.

Do:
- Explained the cost, daily activities involved and transport arrangement for IHDC services
- Accompanied 2 of 5 Esthers and 2 single elderly for initial assessment .
- Included patients with social support but without full-time caregiver.

Study:
- Based on IRMS data, only 1 of 5 patients took up the service before intervention. Fortunately, 7 of 12 patients started IHDC services after intervention.

Act:
- Continue to enroll Esthers who fulfill the criteria
- Spread /open IHDC services to other patients who can benefit.

Outcomes

	1 Jan 19 to 22 Aug 19 (Before)	23 Aug 19 to 31 Dec 19 (After)
IHDC Take-up rate	20%	58% ↑
IHDC Withdrawal	80%	33% ↓

Figure 2: All IHDC referrals from BVH including non-Esthers (Based on AIC IRMS data from Jan 2019 to Dec 2019)

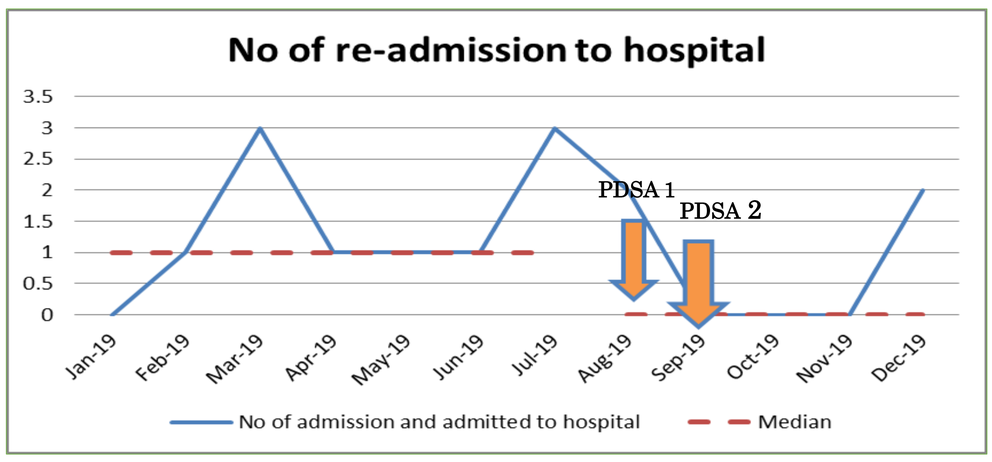


Figure 3: Number of re-admission for 5 Esthers under ESTHER Project (Based on SCM visit history from Jan 2019 to Dec 2019)

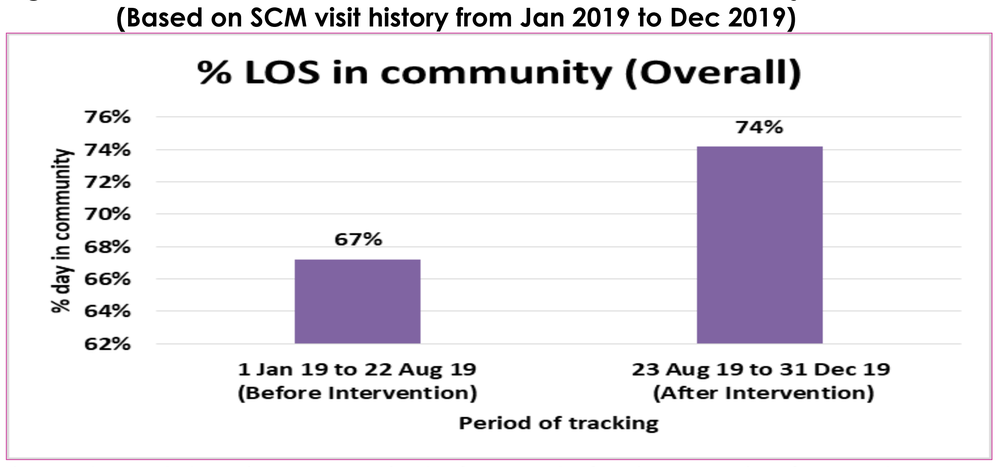


Figure 4: Total days in community before and after intervention for 5 Esthers under ESTHER Project (Based on SCM visit history from Jan 2019 to Dec 2019)

Verbal Feedback from Patient and Family members

Learning Points

The team visited IHDC service providers to understand their services, activities and overall schedules. During our visit, we noticed that each service provider delivers their services differently. This information can be disseminated to patients and MDT colleagues.

It is time-consuming to make monthly phone calls to follow-up on patients' post-discharge conditions. The team finds it more manageable to make 3-monthly follow up phone calls instead, especially when number of patients increases.

Future Plans

To continue networking with IHDC providers and visit more centres to gain a better understanding of their services.

To continue tracking the length of stay of Esthers in the community for better evaluation of the project, and also to outreach to more patients who can benefit from IHDC services.