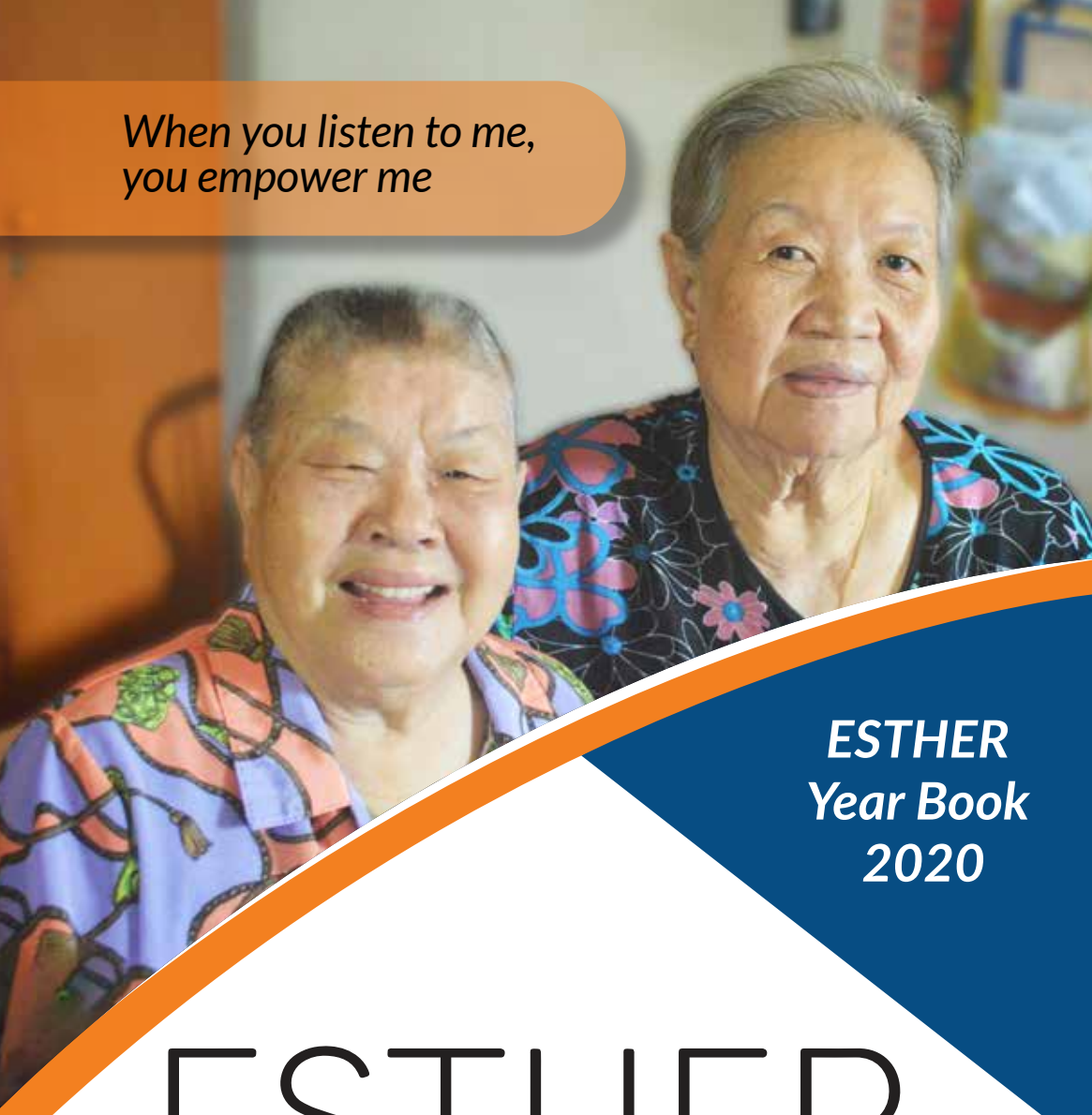


ESTHER Year Book 2020

ESTHER

Network for Health & Social Care

SINGAPORE

ESTHER

Network for Health & Social Care

SINGAPORE

Content Page

Foreword

Over the years, the needs of seniors and our community have grown and become more complex. With an ageing population and more seniors with dementia, we will need to provide more support in helping to navigate our health and community support system and also look beyond physical well-being to also address social and emotional needs. COVID-19 accentuates these needs, particularly for seniors who are more likely to face social isolation and be left behind in a digital world.

The ESTHER Network's person-centred approach and commitment to help seniors live confidently and independently, addresses these issues and is all the more relevant during this time. NTUC Health has been an advocate of the ESTHER Network since its inception. As a provider of community support for seniors, we have witnessed the benefits of the Network in enabling more effective intervention care for seniors with complex care needs.

One of our first projects was where we partnered with Singapore General Hospital to help one Esther remain out of the hospital by boosting her confidence as she transited from hospital to home. Through this project where the hospital and community partners listened to what really mattered to Esther and joined forces to keep her safe at home, Esther's hospital re-admission was reduced from over 10 times a year to 0 in the first year. We are happy that more than 60 other Esthers have since benefitted as a result of this project.

The spirit behind the ESTHER Network echoes NTUC Health's own vision to build communities of "ageless seniors" - where seniors continue to live life with passion and purpose, and exercise choice in how they would like to be supported to be able to do so.

With an expanding ESTHER Network, I am confident that our collective experience and skills will enable all of us to uncover even more opportunities to make a difference to the lives of the seniors we support in the community.

I would like to extend my heartfelt congratulations to our graduating ESTHER Coaches. You are the life force of the ESTHER Network as you work to understand needs at the frontlines, introduce ideas, and provide much needed empathy to each of our Esthers. May you continue to impact the lives of many in our community.

Ms Chan Su Yee
Chief Executive Officer, NTUC Health

Introduction

1. What is ESTHER Network?

Esther Lim
Head Coordinator, ESTHER Network Singapore

Introduction to ESTHER Network

In Sweden, the Jönköping County Council set up ESTHER Network in 1997 to meet the needs of the elderly. The Network constantly seeks to answer the question, "What is best for Esther?", by putting the individual at the heart of all its work. In 2016, SingHealth adopted the concept and successfully launched ESTHER Network Singapore.


CNN Money

Coolest innovations around the world

Höglandet, Sweden

BACK NEXT

Sweden

Sweden has one of the world's highest percentages of seniors, and in the late 1990s Höglandet's local hospital began overflowing with patients.

Officials from the Jönköping region and healthcare employees collaborated on a better system to care for the elderly, who frequently ended up in the hospital.

They dreamed up their fictional character Esther, a reasonably self-sufficient 88-year-old pensioner with some chronic health issues. Then they asked, "What is best for Esther?"

A feature article on ESTHER Network by CNN

Esther

A persona of an 88-year-old senior with complex care needs, who requires the coordination of two or more care providers.

What is ESTHER Network?

ESTHER Network advocates a philosophy of person-centred care that always asks 'What matters to Esther?'. The Network partners health and social care providers to deliver care that is meaningful to our patients and meets their recovery goals. To achieve this, we explore person-centred measurements that include confidence level in self-care, and functional abilities achieved to meet life goals such as gaining employment, going back to a hobby, doing grocery shopping or cooking for the family again.

Who is Esther?

Esther is a persona of someone with care needs who requires the coordination among hospital, primary care, home care, and social service agencies. Esther can be a patient, caregiver or resident receiving preventive healthcare.

What is an ESTHER Café?

ESTHER café creates a safe and welcoming environment where Esthers and various care providers can meet and exchange ideas as equals.

In this café, Esthers are encouraged and feel safe to share their good and bad care experiences. This is a crucial factor in maintaining the ESTHER model. ESTHER coaches learn how to organise an ESTHER Café at the coach workshop.

Co-production of care with Esthers through ESTHER cafés

Who are ESTHER Coaches?

ESTHER coaches are recruited from among the staff working closest to Esthers. They are the 'eyes and ears' of Esthers and are trained to coach fellow care providers to constantly improve the work they do.

In their training as ESTHER coaches, social and health care providers conduct a journey mapping of their Esthers, shadowing them as they navigate the systems, as well as interviewing them on the pain points and what matters most in their care experience. The feedback collected from Esthers will then be processed with the coaches and consolidated into themes.

These themes guide the solutioning phase where coaches work together to derive tools to measure what matters to Esther on a larger scale, before they work on person-centred improvement projects that aim to benefit Esthers' overall well-being.

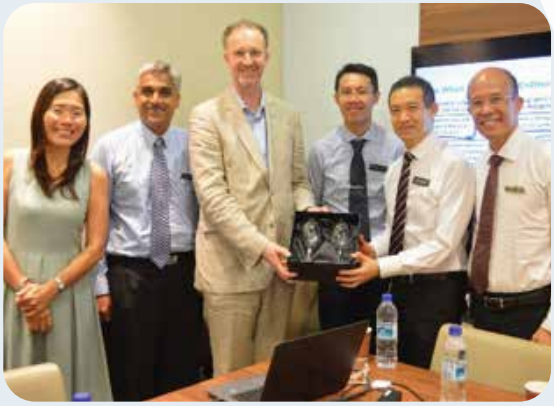
2019 ESTHER Coaches

189
ESTHER Coaches as of 20 Aug 2020

67
Person-centred Improvement Projects

Continuing Education for ESTHER Coaches

ESTHER Network Singapore was honoured to have A/Prof Johan Thor from the Jönköping Academy for Improvement of Health and Welfare, Jönköping University, visit SGH from 15 to 16 January 2020. During his visit, A/Prof Johan engaged in meaningful discussions with our leaders and ESTHER Coaches on the ESTHER Network model and ways to reinforce the ESTHER philosophy in our workplace. We hope to engage in more of such fruitful discussions with domain experts in the near future.



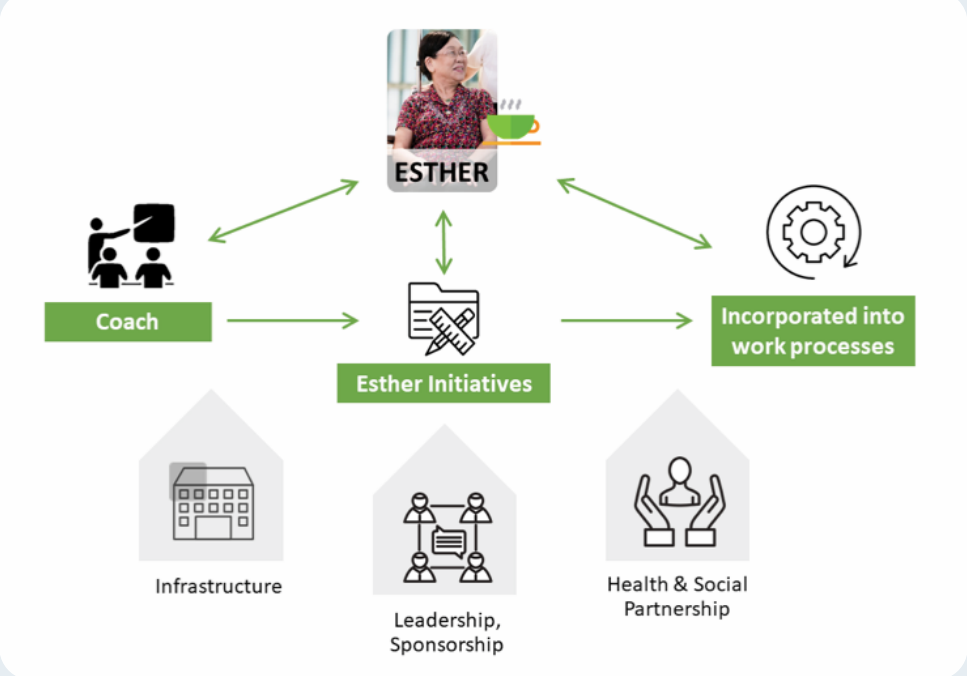
(From left) Esther Lim, A/Prof Ruban S/O Poopalalingam (Chairman, Medical Board, SGH), A/Prof Johan Thor, A/Prof Low Lian Leng (Director, Population Health and Integrated Care Office, SGH), Prof Kenneth Kwek (Chief Executive Officer, SGH), Ang Kwok Ann (Chief Financial Officer, SGH)

(From left) Prof Julian Thumboo (Director, Health Services Research Unit, SGH), Esther Lim (Head Coordinator, ESTHER Network Singapore), A/Prof Johan Thor

Connecting the Dots

This diagram puts all the components that make up ESTHER Network together. It always starts with the involvement of Esther, usually through an ESTHER Café. During their training, the coaches pick up the concerns raised by Esthers and start their person-centred improvement initiatives. The final aim is to upscale and incorporate these initiatives into work processes to benefit more Esthers and the organization.

To do this successfully, building a strong foundation with various critical enablers is important. Besides having fundamental infrastructural support such as people and resources in place, leadership commitment from the institution to drive a person-centred approach to achieve co-production of care is perhaps the single, most influential factor. Having a platform to encourage cross-sector collaboration ensures the congruence and sustainability of the changes made in view that Esthers' care is along a continuum and not limited to the health or social arena alone.



Components of Esther Network

2. What Exactly is Person-centred Care?

Next year June will mark the 5th anniversary of Esther Network Singapore. It is timely to revisit the fundamental question: What exactly is person-centred care? How does it lead to the empowerment of individuals? Why is co-production important, and what should patient and client participation involve? How do these terms co-relate?

Patient and Client Participation *is seen as a strategy to facilitate a* ***Person-centred Care Approach*** *in order to achieve the* ***Empowerment of Individuals*** *and* ***Co-production of Care****. This is how I see their interconnection and we will discuss each of them.*

Patient and Client Participation

"People Own What They Help to Create"

There are many levels of client participation and the most basic involvement is in the area of self-management and shared decision-making. Care support and education for patients is beyond knowledge transfer, and includes integration of the social, behavioral, emotional and clinical aspects of the disease. The provider actively invites the patient to participate in reflecting on self-management efforts and experiences, and the setting of self-identified behavioural and care goals. The next level of participation would involve individuals in sharing their inputs and ideas based on their experiences, to improve organization processes and sense-making, and to shape health and social services and policy at the national level.

Person-centred Care Approach

An Accepting Environment The crux here truly is what constitutes a person-centred approach? The key component we need to develop firstly, is the creation of an accepting environment that considers the needs of individuals from a biopsychosocial perspective. The key word here is 'accepting'. Do our patients and clients feel that what they bring to the table as part of their care is accepted by the professionals? I remember the story of a senior health administrator about her Esther experience. She had injured her arm and had to undergo heat therapy to manage the pain. During one treatment session, she felt that the heat was unusually hot and alerted the therapy assistant to it. The therapy assistant checked against the care protocol and assured the patient that everything was in order and told her to 'bear with it'. It turned out to be a malfunctioning equipment and on top of her pain, the administrator suffered minor burn injuries. As we reflect, it is not uncommon to find that we trust protocols more than the patient's lived experience and feedback to us. There are better ways we can engage our patients as equal partners in care, that can avert harm and achieve greater value for both the individual and the system.

The Compassion of a Leader How does one communicate compassion? 'Communication' and 'Compassion' are the most frequently used words by Esthers when we ask what matters most to them.

At the Microsystem Festival 2020, Göran Hendriks, Chief Executive of Learning and Innovation, Jönköping County Council, Sweden, shared the story of a urologist and surgeon, Dr Miden Melle-Hannah who found out that her patient, scheduled for a 3rd operation after a cancer relapse, was asked to return home because the surgeon's previous operation overran. Her patient had fasted and bathed to get himself ready for this. Dr Miden Melle-Hannah's unwillingness to accept the patient's plight prompted her to gather a technical team to improve the situation. A revolutionary instrument for cancer diagnosis and treatment that can speed up surgeries was invented as a result. This equipment has cut down patient's suffering and led to timely treatment and significant cost savings. It all started with her compassion for her patient. Her compassion drove her to action to find the gap and fill the gap.

Closer to home, our Esther coaches who are full-time allied health professionals, nurses or clinicians make others wonder where they find the time to do ESTHER projects. "The idea that we don't have time (immobilises us)", said Göran. Physiotherapist Amber Wong was one who made time. She was perturbed that her ward patients spent most of their time on bed even though they were assessed to be safe to walk. Most of them were previously moving well in the community and at home, and Amber and her colleagues had great concerns over the patients' deconditioning after their hospital stay. Her drive and desire for Esthers to maintain a good quality of life with satisfactory functional abilities at home resulted in a movement to get patients moving in the wards. Saying no to bedpans, making walking aids readily available in the wards, training nurses and mobilising family members to be ready and confident to assist patients resulted in an increase in the number of walking patients in the wards from 9% to 91%! Amber's compassion for her patients resulted in her drive to partner with nurse clinician Lizhen to identify the gap and fill the gap.

As we conscientiously exercise the above, we would find ourselves involving patients in shared decision-making, and sparing no effort to integrate and coordinate care in a logical way from the patient's perspective.

Shared Definition of Person-centred Care

Empowerment of Individuals & Co-production of Care

Empowerment is supporting the autonomy of individuals in determining priorities and needs in accordance with their values, and providing them with the self-efficacy to gain mastery of these issues self-identified as important.

A person-centred care approach positions empowerment of individuals as the end goal. This is most relevant where majority of care is provided by the individual or family members at home and in the community. The individuals feel assured to bring their environmental considerations, concerns and feelings to the table with the health and social care providers for an open discussion. Patients and their family members also bring with them resources and skills that can be tapped on. This is the central idea in co-production of care where equal partnerships between professionals and patients are crucial to the improvement of care services.

In conclusion, person-centred care is ever more important and relevant with the COVID-19 pandemic. The goal of person-centred care is to achieve the empowerment of individuals who feel more confident, motivated about their own care, and have the competence to go about it. With the reduction in home visits during the circuit breaker, it was pertinent that health and social service users have the basic know-how, are well-connected with providers so that they know who to call and when to escalate for help. An ongoing community ESTHER project between NTUC Health and SGH community nurses has enabled a timely transition to telephonic intervention, with the spirit of person-centred care as the mainstay.

As we support the motivation of people to want to get better by enabling self-efficacy, and shorten the time from worrying about their illness to having an improved quality of life, we are making chronic illness a manageable experience for each patient. If helping Esther to be on top of her care is our priority, then it is our job to make it possible to include Esthers and create a workplace culture of always asking 'What matters to you?' first.

Many times, well-meaning colleagues would tell our fellow ESTHER coaches that 'we are already doing person-centred care' and 'we cannot ask patients what they want lest we are unable to deliver; we just need to do what we know is good for them'. This sharing attempts to put the key concepts in driving person-centred care in perspective. This is so that as an institution and community, we give person-centred care a shared meaning that we can collectively work towards, and proudly live up to.

Learnings from Jönköping, Sweden (25 Feb – 3 Mar 2020)

Valencia Lim
SGH Population Health & Integrated Care Office

As part of the journey of continuous improvement, a team of three SGH staff went on a study trip to learn more successful practices with the Region Jönköping County Council. We attended the four-day International Clinical Microsystem Festival 2020, and a two-day study trip with the local care teams in a Swedish municipality. Our objective was to learn and update ourselves with new practices and innovations to better facilitate care delivery in SGH.

Left: Snowy day at Qulturum (Jönköping, Sweden), Right: Group discussion in the festival's main hall

The Compassion of a Leader

The Microsystem Festival 2020 was organized by Qulturum, the improvement unit of Region Jönköping County. Qulturum is the centre for quality, leadership and management development for county employees, and also for healthcare of the regional and national level.

The theme for this year's festival was CoMePassionIT, a meaningful wordplay is inspired by the concept of compassion. It also encompasses Co-Creation from a global network, full of PASSION for quality improvement and making a difference for ME and you, using IT as an enabler!

COMEPASSIONIT

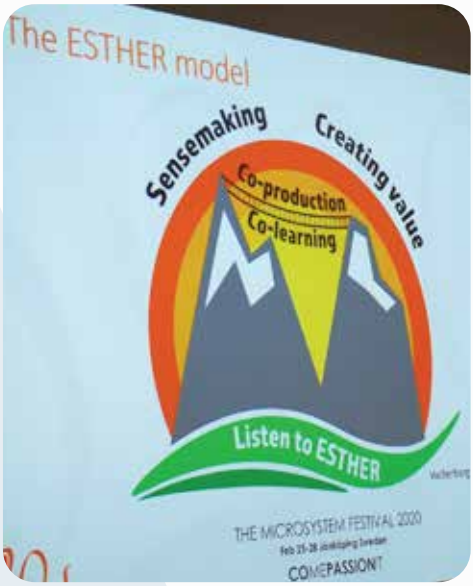
THE MICROSYSTEM FESTIVAL
Feb 25-28 Jönköping Sweden
www.microsystemfestival.com

The entire festival emphasizes the importance of practising compassion in our daily work in healthcare, building trust among us providers and users of the system.

Make Disease a Manageable Experience: Esther Is On Top of Her Care

As providers and improvers of healthcare, we have to lead from a place of love and compassion. In order to build compassion, we have to work with humanity in our services. This means supporting people to take care of themselves based on each person's abilities. Compassion can help build trust, support motivation, promote patient self-efficacy and make diseases a manageable experience for each individual.

We should always strive to make it possible to improve the inclusion of patients in healthcare, instead of being a passive part of the system. How can we do so? The first step is acknowledging a patient's situation, treating them with respect and dignity every day.



Khee Giat Yeng (Principal Clinical Pharmacist, SGH) presenting her work and ESTHER Coach experience at the Microsystem Festival 2020

(From left) Esther Lim (ESTHER Lead, Singapore), Helen Bevan (Chief Transformation Officer, NHS), Nicoline Vackerberg (ESTHER Lead, Sweden), Khee Giat Yeng (Principal Clinical Pharmacist, SGH), Anna Carlbom (ESTHER Lead, UK)

From Technology to Social Innovation

Another way of practising compassion is shifting our mindset from a technical to social innovation point of view. An innovation process cannot start by designing a solution. We have to start from a place of compassion! We have to include the well-being, needs and contexts of those involved before creating solutions. ESTHER Network Sweden and Singapore do just that, championing compassion through continuous co-production and social innovation.

From Forecasting to Foresighting

We also learned the practice of foresighting instead of forecasting. Forecasting is predicting what will happen based on current circumstances. Foresighting on the other hand, is envisioning a goal based on farsightedness and mental preparedness. It goes further than forecasting – envisioning a future state, making a plan to achieve this future state from the current point. This includes planning more roadmaps and acquiring resources than what we have now, if needed. It is an abstract paradigm, but a fulfilling one if each of us can grasp and exercise it daily.

"Partnership Is the Next Big Thing" – Göran Henriks

The conference comprised a good mix of keynote speeches, mini team discussions and seminars, which allowed for plenty of networking and learning from best practices across the globe. I particularly enjoyed getting to know the Esthers who were tasked to lead our discussions. These Esthers were active caregivers, past patients and current patients. Their perspectives lent a fresh perspective and essential dimension to the care we are trying to improve, ensuring that outcomes that matter most to the patients are met.

Site Visit – Intermediate Care Facility in Nässjö Municipality

We had the opportunity to visit Community Care teams in the Nässjö Municipality. I spent the morning shadowing Nurse Anna in an intermediate care facility. The residents will stay there till discharge to home or to a nursing home. Anna and her team of nurses are passionate and skilled, and spoke to every resident with kindness and compassion. Anna shared how the ESTHER approach is very engrained in all staff, and how the philosophy is so essential in their duties. Nurse Anna spent a bit of time talking to an elderly man who had difficulty adjusting as he had just moved in to the home. She promised him some blackcurrant juice in his next meal to help with his appetite and mood.

Nurse Anna speaking to a resident

A typical resident's room in the intermediate care facility

Site Visit – Primary Care Nyhälsan (Swedish: Bräcke diakoni Nyhälsan)

The team also visited a non-profit, private Primary Care centre named Bräcke diakoni Nyhälsan (BDN) in Nässjö Municipality. Despite being a private NGO, the centre works closely with Region Jönköping County to embark on more preventive approaches and provide more digital health services. BDN works together with other entities in the community. This is a depiction of the region's systemic move in population health, ensuring the best healthcare for the county.

BDN situates itself to be the default destination and natural coordinator for residents who need healthcare, at any stage in their lives. The manager of the center, Emma Olofsson, highlighted the need of adapting to new health challenges such as increasing number of patients with chronic diseases and an increasing need of support for psychological health.

(From left) Jennie Lundström (Care Manager, BDN), Khee Giat Yeng (Principal Clinical Pharmacist, SGH), Valencia Lim (Senior Executive, Population Health and Integrated Care Office, SGH), Simon Ekhen (Specialist nurse in diabetes and Asthma/COPD, BDN), Esther Lim (Deputy Director, Population Health and Integrated Care Office, SGH), and Emma Olofsson (Manager, BDN)

Our team was introduced to Sweden's warm hospitality throughout our stay. We were especially fascinated by the Swedish practice of Fika – by definition it is a coffee and cake break, but it means making time for friends and colleagues to share a cup of coffee (or tea) and little something to eat (often pastries). It's a ritual that we happily indulged in every day we were in Sweden!

Emma with her home-baked cinnamon buns

Summary

There are many great attributes of the Swedish culture that continually contribute to the success of the Swedish healthcare system. For one, Swedes have a strong sense of national identity and trust in their government. Region Jönköping County oversees care in all aspects, from daily activities to specialised care for the population it serves. This windsock diagram (below), **"Together for the best possible health and healthcare, on equal terms"**, was consistently showed by different care providers we met. It emphasises on an all-inclusive, collective goal to help everyone to achieve the best possible health and healthcare.

Region Jönköping County recognises the need for a systemic change in order to guarantee the county's healthcare for the future. There are frequent engagements and collaborations involving people and families to do just that. It is ensured that every citizen has sufficient and affordable access to the care they require. Being able to achieve so requires close collaboration with providers and users, and great trust in the system.

Swedish citizens have a profound culture of respect and compassion for each other, and this is deeply embedded with each act of service in their healthcare system. This is evident in their daily interactions, up to the systemic practice of person-centred care in Esther. These work in parallel and culminate to a conducive environment where everyone can live their best possible life.

(From left) SGH team with **Johan Thor** *(Jönköping University) and* **Nicoline Vackerberg**

(From left) SGH team with **Göran Henriks** *(Chief Executive of Learning and innovation, Region Jonkoping County)*

We left Sweden with new connections forged and new ideas brimming. It was a privilege to have had a first-hand experience observing and interacting with Sweden's healthcare system, lifestyle and people, and seeing it all come together to form a culture that enables one of the best healthcare systems in the world to prosper!

New Ways of Connecting with Socially Isolated Seniors.

We are Together, Offline to Online.

Wang Yu Hsuan
Director, Eldercare Services, Montfort Care

As a community social worker, we often feel uncertain and even frustrated, especially during the circuit breaker period. No one has experienced handling a pandemic like this. What we did was to provide the next best alternative to our seniors, including getting them 'online'.

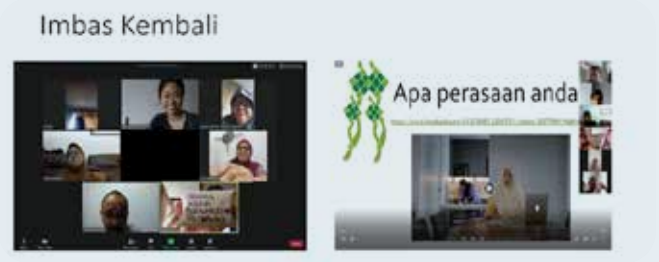
For many seniors, GoodLife! is not just a physical center. We go wherever they are, from void decks, coffee shops, to their houses for case management and group work. It is challenging to move everything online (given restrictions on physical interactions), for both residents and social workers, but this pandemic has pushed us to meet that challenge.

When it was nearing Ramadan, our social workers received calls from makciks (referring to middle-aged or elderly Malay women) who shared their personal difficulties in going through the festival alone as family members were unable to visit them during this period. Many of them cried over the phone with us. We also experienced the same loneliness and helplessness.

However, the emotions that arose motivated us to kickstart our first online groupwork, "Bulan Renungan", which means "Month of Reflection". This was held for our Muslim seniors during the month of Ramadan and this stretched to the first week of Phase One (Safe Re-opening, early June 2020).

The preparation was tedious. Through phone calls and Whatsapp video calls, our social workers gave seniors a basic tutorial on how to download Zoom software. They went through countless of technical runs with the seniors. It was tough for the older folks, but none of them dropped out of the group.

The seniors shared their thoughts and bounced ideas on coping during these unprecedented times. Topics such as mental health, physical health, and caregiving were discussed in the conversations. Health tips given by our nurse even encouraged a particular makcik to do a health check-up. The participants were even immersed in the mood of festive celebrations through various games and engagements we prepared for them.



Our social workers and group of senior volunteers also initiated an art-based project titled "#Sincerely,Me", 分享，爱". For most volunteers, it was their first time using Zoom! Despite some initial technical difficulties, the volunteers were very excited when the participants successfully entered the Zoom virtual room. These participants were seniors from Blocks 7 and 32 in Telok Blangah. Their first question to the group was "How is everyone doing during this circuit breaker period?" It was met with cheerful and resounding responses.

Together, we have embarked on a project that connects our residents and share positivity with each other. Everyone even agreed to create a piece of artwork that spread words of encouragement and kindness. Our hope is that we will eventually be able to continue spreading love and positivity to our seniors and residents in Telok Blangah.


团结就是力量
"Love is like a tree, filled with colourful and blossom flower"
Stay Healthy
生活愉快
让我们迎接灿烂的阳光
戴着口罩微笑
Png
❤️爱是分享

How Esthers Manage During Covid-19: Findings from SGH Community Nurses

Lim Yi Wen
SGH Population Health & Integrated Care Office

Contributed by:
Sister Magdalene Ng
ESTHER Network Champion

Nurse Clinician Siti Hajar Ninhadi & Telecare Hospital to Home (H2H) Team
SGH Hospital to Home Programme

As we continue our long-drawn battle against COVID-19, there is a group of people we need to look out for more than ever – our seniors - many of whom are also our Esthers. With a weaker immune system and a higher likelihood of having more than one health condition, seniors are more likely to develop complications from COVID-19. As such, the Multi-Ministry taskforce has implemented strict measures to safeguard the health and well-being of seniors. However, this has inadvertently restricted their freedom and social interaction, as well as impeded their access to care and services.

At ESTHER Network, we are deeply concerned for the overall well-being of our Esthers. As such, ESTHER Coaches made telephone follow-up calls to their Esthers, over the past few months, to find out their experiences and to provide the appropriate advice to help them cope better during the pandemic.

Telecare Hospital to Home (H2H) Team

Feeling restricted

Just like anyone else who is living through COVID-19, Esthers simply cannot wait for it to be over. The loss of freedom and restriction in movement outside of their residences is taking a serious toll on their mood and mental health. One Esther said he "felt restricted" that he was "unable to move around like he used to, such as taking the MRT". He also shared that he tends to "dream of his late parents" and "thinks he is leaving the world soon". After hearing words of comfort and assurance from his ESTHER coach, he promised that he will take good care of himself and "won't do anything silly". Towards the end of the conversation, he expressed eagerness to meet up for makan and fellowship again.

This Esther's experience not only sheds light on the psychological struggles that seniors go through during COVID-19, but it also reminds us to be empathetic individuals who care to pause and listen to other peoples' difficulties amidst a shared crisis.

Support during COVID-19

With the gradual resumption of essential services, Esthers are also receiving more health and social support in the community through services like medical escort, medication delivery and community nursing. In addition, community service providers such as NTUC Cluster Support, and pioneer support groups, are providing much needed assistance to Esthers during COVID-19. Aside from help given by Social Service Agencies and institutions, we were heartened to hear that help was rendered between neighbours - one Esther shared that she felt very appreciative towards a neighbour who helped her to buy vegetables from the market.

It certainly warms our hearts to hear stories of individuals, support groups and organizations, showing kindness and compassion towards those in need in the face of an unprecedented global crisis, when solidarity is key to overcoming challenges and obstacles.

Going digital for better care

We are happy to hear that Esthers are receiving undisrupted care at Singapore General Hospital (SGH) amidst COVID-19, as many continue to visit the hospital for essential treatments and follow-up care. For quicker access to test results and management of health outcomes, patients can download and use the HealthHub app. One Esther was introduced to this app to access her blood test results but she was unable to use it on her own. As existing safety measures limit face-to-face interaction, helping Esthers receive better quality of care through digital means can improve their ability to self-care, and build their mental health and resilience during the pandemic.

Through the follow-up calls, ESTHER coaches were able to gain insights into their Esthers' experiences during COVID-19, and provide the necessary support and practical assistance. All Esthers were genuinely happy to receive calls from their ESTHER Coaches. This just proves that a simple phone call made out of concern can go a long way in brightening someone's day. We are happy to hear that most Esthers are coping well. As for those who are facing difficulties adjusting to the "new" normal, we hope that more care and practical support can be provided to them before life eventually settles - slowly, but surely, as we stand in unity.

ESTHER Network Champions with Esthers during an inaugural Mandarin ESTHER Café (picture was taken in 2019)

Featured Stories from Sengkang Community Hospital and Changi General Hospital

Empowering the SKCH esTher – HEalth JouRnal – The Journey Continues

Dr Luke Low
Site Coordinator, SingHealth ESTHER Network Task Force

In late 2018, an ESTHER project team from SingHealth Community Hospitals and Sengkang General Hospital started a health journal for Esthers at Sengkang Community Hospital (SKCH), one of the three community hospitals managed by SingHealth Community Hospitals. The juxtaposition of a possible decline in patient involvement against a longer length of stay in the community hospital presents an inherent opportunity for a platform to further engage patients. This is critical for the health of SKCH patients, who are mainly the elderly[1] (referencing 1). With close to two-thirds of patients interviewed preferring to have a file or book that lists their needs, preferred options, type of treatment and medicine received, a health journal was developed for SKCH Esthers.

One of the key limitations gathered in the earlier stage of implementation of the health journal was the novelty of it within prevalent inpatient care settings, and elderly patients were not used to such empowerment. Further to the unfamiliarity of patient empowerment, a significant number of patients did not understand English, or were unable to write in their English or mother tongue language as well. This added to further challenges in administering the health journal.

A pilot implementation of social prescribing that started in October 2019 underlined that trust and relationships are important precursors in patient empowerment. Social prescribing is a model of care that connects individuals to their community to improve social determinants of health[2] (referencing 2). It helps frontload an assessment of these social determinants, which can affect health outcomes for patients when they return to the community.

Through the wellbeing coordinator[3] (referencing 3), patients are engaged through a plethora of engagement activities. Relationships are formed through the average length of stay of 21 days (see Figures 1 and 2). The patients shared their motivations, beliefs and values in health, aiding in the assessment of social determinants of health. Besides an early understanding of patients' social determinants of health, the team understood that a desired level of trust with patients is required for them to share their preferences and goals. The health journal was edited to reflect this new development (Figure 3).

[1] 90% of SKCH patients are at least 60 years old and above.
[2] Social determinants of health are the conditions in which people are born, grow, live and work, which include factors such as socioeconomic status, income, education and education.
[3] A non-clinical staff that works with the multi-disciplinary team of clinical colleagues to give time to the patients and co-curate social prescribing plans for patients.

Fig 1: Staff and volunteer playing Rummy-O with patient

Fig 2: Wellbeing Coordinator having a chat with patient

Going Home, in Good Health

I have achieved all my goals and am ready to go home. I play a part in my good health, **and will continue** with the exercises and medication and having a good diet.

I was admitted at _____ (Hospital name)

for _____ (Reason for admission) on _____ (Date of admission)

I have discusses with the care team, and I hope to be home by

_____

I usually see my regular doctor at _____

I am currently living with:
○ Alone ○ Spouse only ○ Domestic Helper ○ Family ○ Others _____

I will contact my _____ at _____
to update my needs

On discharge, I will need to make arrangements to:

- See my primary care doctor at _____ on _____
- See my hospital doctors at _____ on _____
- Attend activities at _____

Things I do that give me the most joy...

○ Cook for my family ○ Walk around the neighbourhood
○ Send my grandchildren to school ○ Go out with my friends
○ Others:_____

When I return home, what I want to do most is...

_____

_____

What I do not like...

_____

_____

I am concerned about my:

○ Healthcare
Healthcare bills
Access to healthcare facilities
Ability to manage health

○ Expenses
Cost of living
Getting financial assistance
Ability to afford medical expenses

○ Social Life
Feel lonely/ discriminated
Can't find suitable social activities
Lack of support system

○ Health Behaviours
Require help to quit smoking, drinking
Access to health eating options

○ Physical Environment
Don't feel safe at home/in the community
Limited transport/mobility to go out
Lack of housing

_____

_____

Fig 3: New edits to the health journal to reflect the inclusion of social determinants of health

Wellbeing coordinators, as a new job role focusing on spending time with patients and linking them to community assets (based on patient's beliefs and goals for health outcomes), have been helpful in bringing the health journal to the next phase of development.

Empowering Esthers to Self-Monitor their Health in the Community

Project Team

Dzulhelmy Idrus (Senior Community Coordinator), Nur Kamilah Abdul Karim (Community Assistant), Noorhaslina Noor'ain (Community Assistant), Quek K.T. (Community Assistant), Shamini Kannan (Medical Social Worker Project)

Sponsor

Cheryl Lau (Senior Community Manager)

Background

Neighbours for Active Living was developed to help vulnerable seniors and adults living in the east and especially those with high care needs. This Health-Social integration programme came about as a collaboration between Changi General Hospital (CGH) and South East Community Development Council (SECDC). Since its inception in 2013, the Neighbours programme has served more than 8,000 clients, with a large proportion of these clients afflicted with chronic diseases.

During home visits and subsequent assessments, we found that a number of our Esthers were not motivated to adhere to healthcare professionals' instructions on ways to manage their health. Some of these reasons they shared with us seemed to be due to low health literacy and poor understanding of their disease. A review on a study on motivation suggested that when working with older people, one may need to focus on the factors that affects their motivation.[1] Hence, we were interested to explore ways to motivate our Esthers to take ownership and participate in their own self-care.

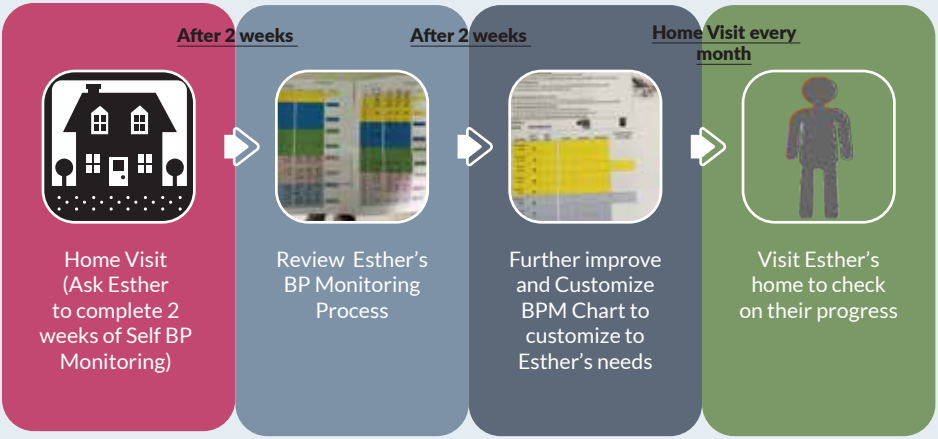
Aim of the Project

This project aims to explore whether an Esther-centred and social approach would be effective in encouraging and motivating Esthers with chronic diseases to initiate self-monitoring of their blood pressure and to actively participate in their own self-care.

Proposed Solution and Methodology

10 Esthers were identified for the project through assessment interviews during home visits to new and ongoing clients. These Esthers, who were from three areas in the eastern part of Singapore, had blood pressure issues and faced difficulties complying with their healthcare professionals' instructions. Out of the 10 Esthers, two had received secondary school education, while 3 had primary school education. The rest did not receive any formal education.

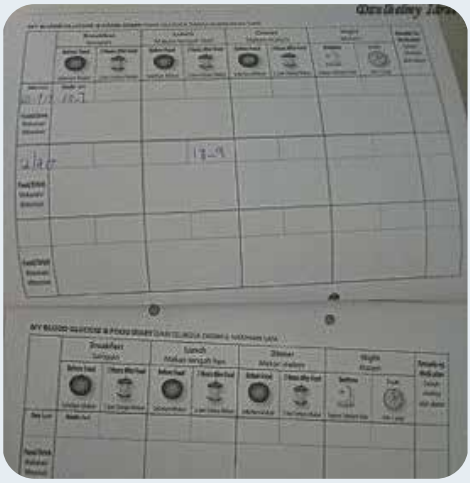
After consultation with our Esthers who said that they could not understand the original English version, the Neighbours team went about to develop new blood pressure monitoring (BPM) charts with English-Malay and English-Mandarin language versions with translated instructions. 10 Esthers were surveyed, but 2 could not continue as they were hospitalized.



All in all, the Esthers were visited by the Neighbours Team for a total of 3 months between May to July 2018.

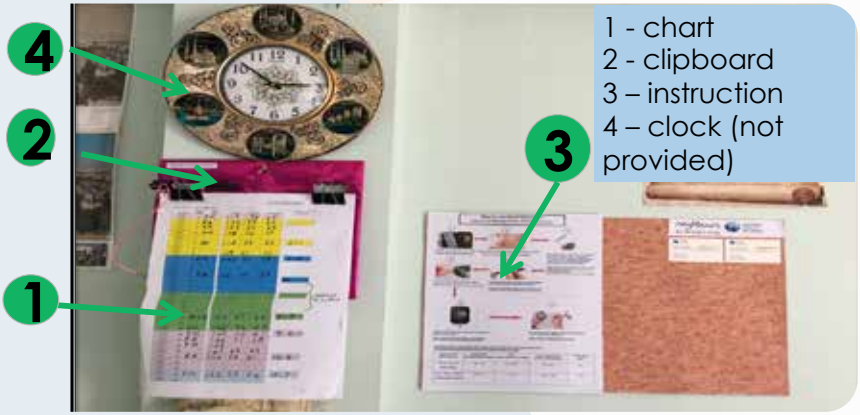
Description of Intervention

BEFORE



- Esther not able to record properly due to poor eyesight and understanding of chart.
- Chart has small fonts and narrow columns.

AFTER

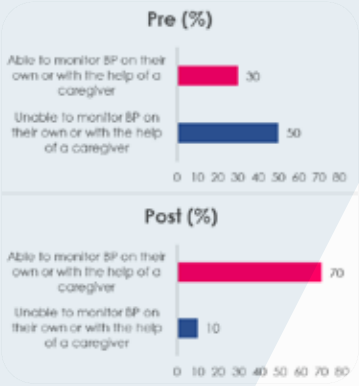


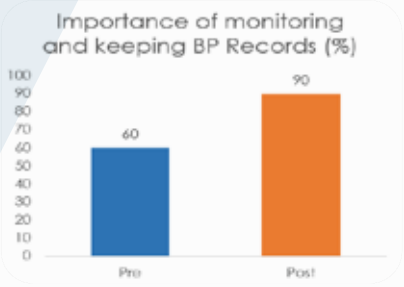
- Redesigned chart and customized clipboard for better visualization (bigger ,colour-coded and monthly-based) and recording
- Instructions for use of Blood Pressure Unit were placed on the wall
- Bilingual instructions were placed on the wall next to the chart (English-Malay or English-Mandarin languages)
- Developed 4 different versions of the BP Monitoring Template
- Rolled out in May 2018 and used by 10 Esthers.

Outcomes

Survey done on 10 Esthers in August 2018:

80% of the participants were more confident and motivated in relating their BP/health issues to a doctor.

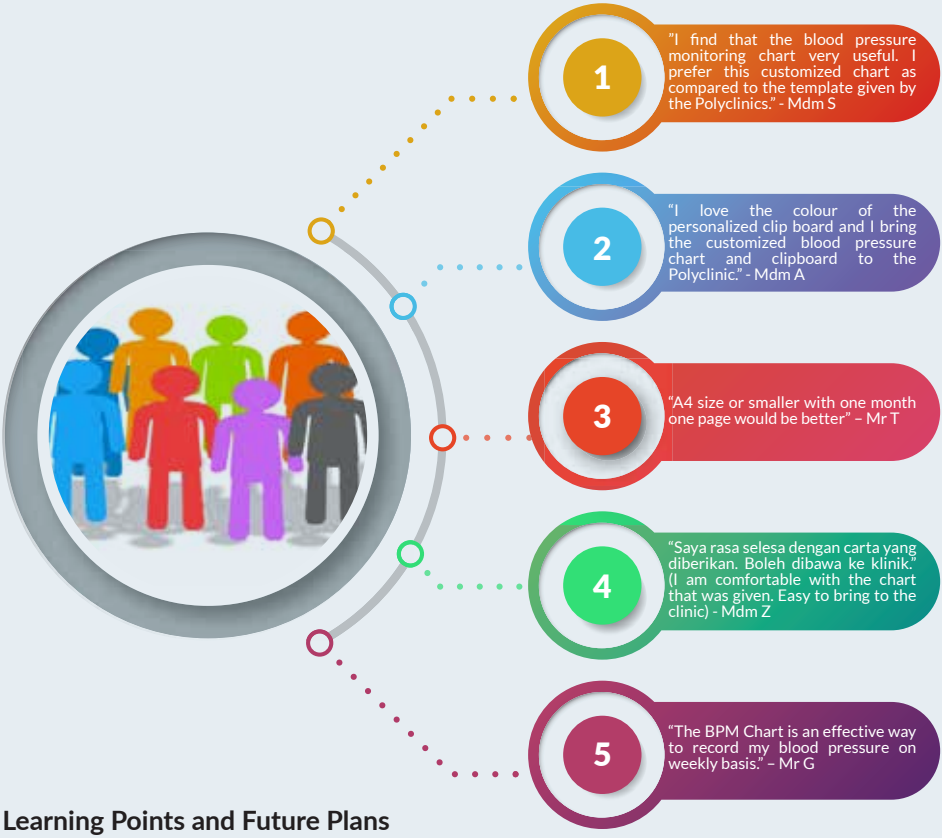




Post intervention - 90% of of the participants were more knowledgeable and aware of the importance of measuring their BP routinely.

Post intervention - 90% of the participants felt that the BP monitoring chart was a useful tool.

Feedback by some of the clients who participated in the project:



Learning Points and Future Plans

We learned that the challenges our Esthers faced were related to low health literacy, difficulty in remembering instructions, and visual impairment. These were the key issues that affected Esthers' motivation to carry out their own blood pressure checks. However, after the project was implemented, Esthers became more motivated to continue self-monitoring and recording of their blood pressure. This could perhaps be attributed to our efforts at educating our Esthers, and customizing the instructions to each Esther's preference in the tracking log, to make them linguistically and visually appropriate. The team had also shared these new blood pressure monitoring chart templates with the hospital and the polyclinics, and they were well-received by healthcare professionals who have also offered to use the charts for their patients whom they wish to monitor in the community. Moving forward, the Neighbours team would like to replicate this initiative to a bigger cohort of clients through referrals from the hospitals and Polyclinics, and to work with community partners in order to encourage and motivate clients to manage their self-care.

[1] Israel et al, 1994

ESTHER Projects 2019-2020

Accessibility

1. "I'm a Confident Esther!"

Team Leader
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Team Members
Rachel Marie Towle (SNC), Neo Sze Mine (SSN)
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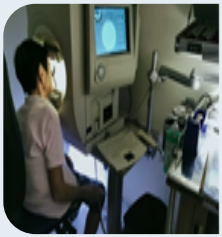
Kalsom Bte Saptu (NC), Herman Lim (Montfort Care),
Felicia Wong, Oh Yew Tiong, Jess Ho (NTUC Health)

Facilitator
Magdalene Ng (ESTHER Champion, Nursing QI Coach)

Sponsor
A/Prof Tracy Carol Ayre




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 Esther 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.

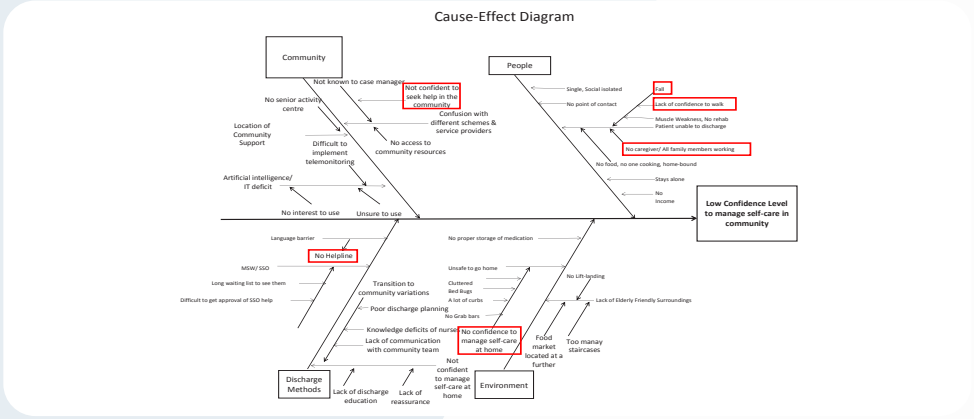
Objectives

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.

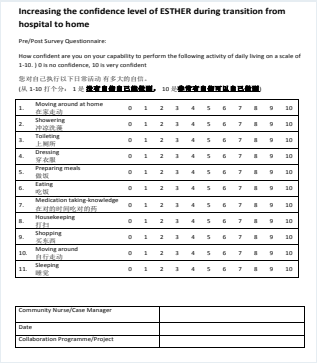
The team also facilitated the ESTHER café with residents in the community to understand their needs better.



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.



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 0 is no confidence, 10 is very confident

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

Community Nurse/Case Manager	
Date	
Collaboration Programme/Project	

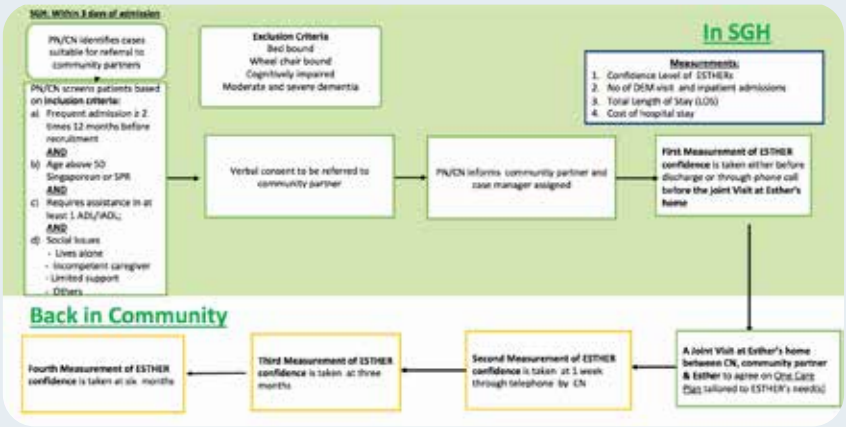
Diagram 2: Confidence Level

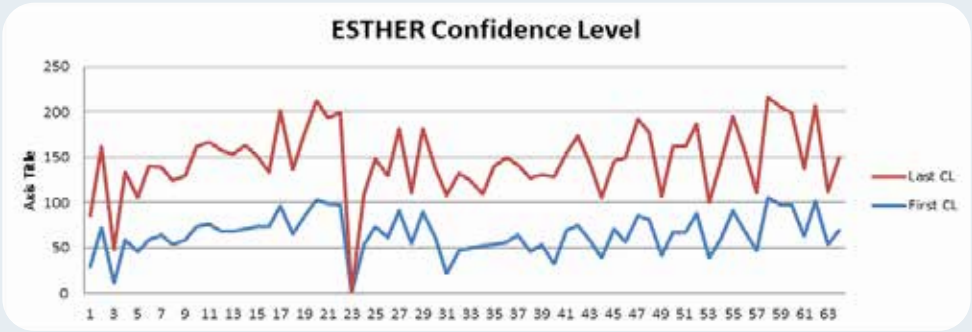
My Care Plan	Name _____ (IC/Pt sticker if available) NRIC _____ Date _____
My Personal Goal	**Date Goal Started**
I will look out for signs of low blood sugar (dizziness, palpitations, sweating, lose coordination, hunger)	
I will look out for signs of gout flare (intense joint pain, warm, swollen and redness on joints) & eat my medication (gout attacks)	

Diagram 3: Care Plan

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.

2. Collaborative Community Virtual Pain Clinic for Mobility Impaired to Enhance Access to Care and Quality of Pain Management for Improved Outcomes & Reduced Admissions

Team Leader
Dr Jane M George

Team members
Dr Lin Xu Feng, Sew Choy Ngor, Rachel Lee,
Susan Lim Suyu

Sponsors
Dr Tan Kian Hian, A/Prof Ruban Poopalalingam

Facilitators
Khee Giat Yeng, William Yap

Background and Methodology

Chronic pain incidence in community is approximately 20% and increasing with age:

- Conducted a survey of 93 consented patients from SGH Pain Centre over 2 months and an ESTHER café with 3 patients.

Results of survey:

- 50% of patients had 3 or more comorbidities and 70% had mobility difficulties
- 78.5% had spine or joint related pain but only 40 % received physiotherapy

Preceding year:

- **Visits to healthcare facilities:** 55% (≥ 4 visits), 17.2% (≥ 10 visits)
- **Visits to emergency department (ED):** 32.3% (≥ 1 visit), 9.7% (≥ 2 visits)
- **Hospital admission:** 32.3% (≥ 1 admission), 2.2% (≥ 3 admissions)

Results of ESTHER Café:

- Esthers with chronic pain face mobility & transport difficulties when accessing treatment
- Esthers want more time and clearer communication in familiar language regarding health issues.

Summary of Findings from Esther Café

Esthers with chronic pain and mobility impairment had multiple healthcare visits and admissions for pain, resulting in poor satisfaction

- Cause and effect analysis done ascertained main causes for dissatisfaction as:
  - √ Multiple healthcare visits
  - √ Transport difficulties
  - √ Inadequate contact time with healthcare professionals
  - √ Poor treatment compliance

Mission Statement

Enhance access to care and quality of pain management for mobility impaired patients with chronic pain in the community over 3 months

Goals

- Reduce number of healthcare visits for pain to less than 2 and admissions to zero
- Improve treatment compliance to medication and exercises
- Improve patient satisfaction by at least 30 %

Intervention

- Introduced Collaborative Virtual Pain Clinic in Community for mobility impaired patients
- Established collaboration among Pain Specialists, Pharmacists, Physiotherapists in hospital for virtual pain clinics in the community
- Conducted clinical assessment of patients in their home by doctor & nurse with medication stock evaluation and education
- Reconciled medications with changes as required by Pain Specialist
- Educated patients on 5 basic home exercises using chart formulated by Physiotherapists. This was evaluated by Physiotherapists via video conferencing.
- Prescriptions filled out by Pain Physicians after community review
- Pharmacists arranged for home delivery of medication with written and verbal (phone) instructions in language best understood by patients
- Set up VPN access for community visits with mobile hot spots for comprehensive assessment and documentation in the hospital's Electronic Medical Records system

Teaching caregiver to help with exercises

Testing cognition

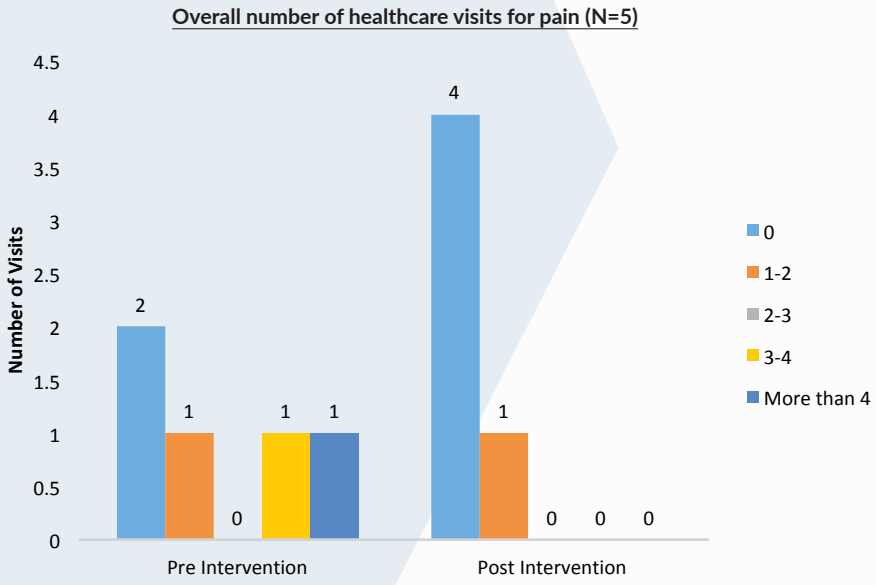
Our Team
Multidisciplinary team of Pain Specialists, Nurses, Physiotherapist and Pharmacist with Patient

Results & Outcomes

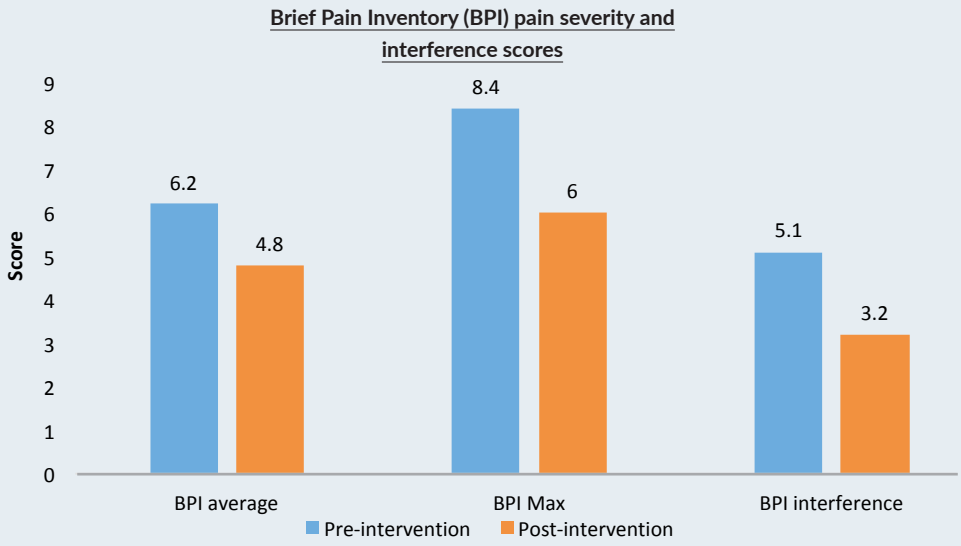
Summary

- Reduced healthcare visits for pain and no admission
- BPI scores indicated reduced pain and improved function
- EQ5D indicated improvement in impression of health
- Edmonton Frailty Score (Mean) improved by 46.6% with 2 patients reporting improved mood and 2 improved impression of health
- 3 of 5 Patients increased exercise duration (minimum 30 min/day) to improve function
- Improved medication compliance, reduced waste and discarded expired drugs
- Satisfaction score improved for all with 1 improved by 233%
- Referrals made to existing community teams for continuity of care

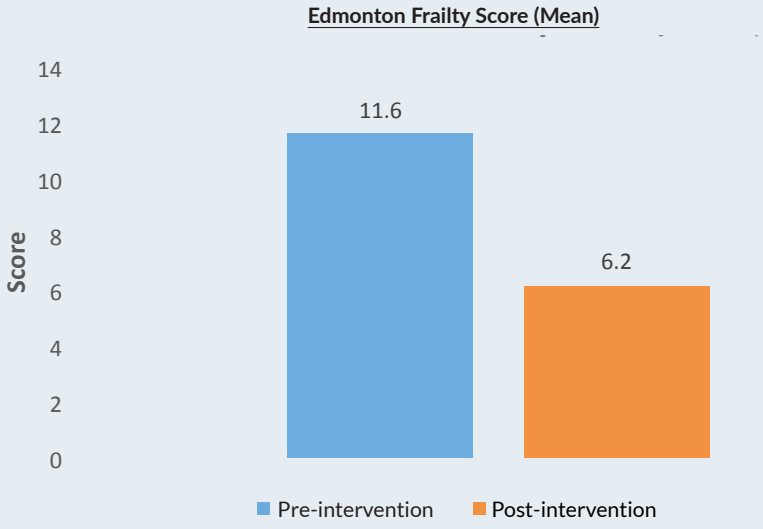
Healthcare Visits & Health Assessment



Overall number of healthcare visits by Esthers reduced

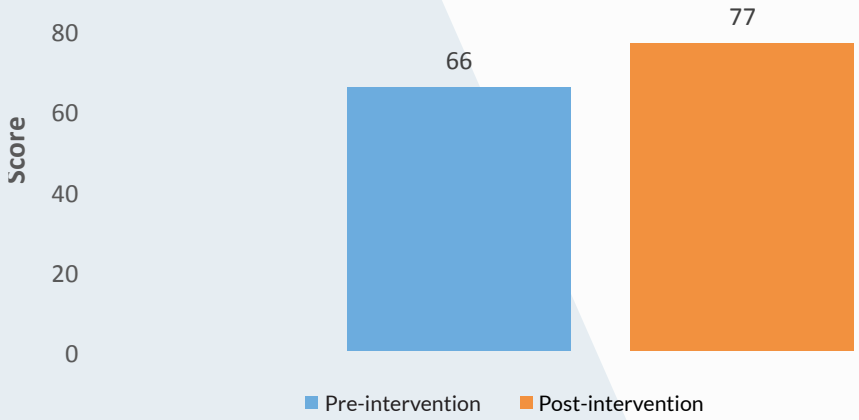


BPI scores indicated reduced pain and improved function



Edmonton Frailty Score (Mean) improved by 46.6%

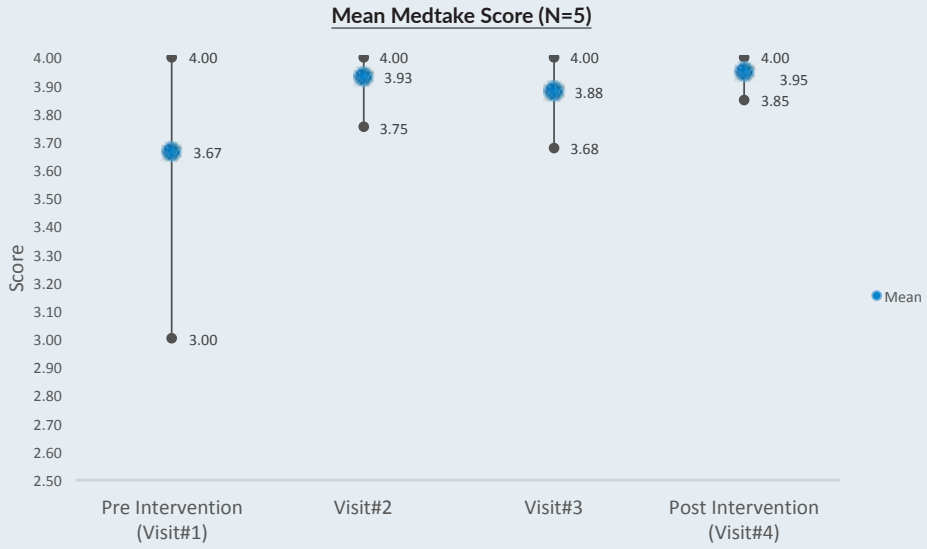
EQ5D Impression of Health Score



Impression of Health Score (Mean) improved by 16.7%

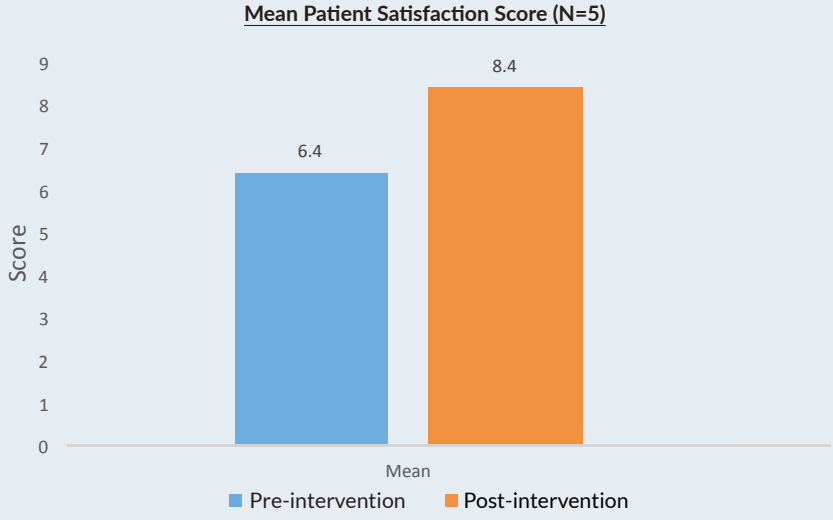
Medication Reconciliation

Medication reconciliation	Patients (No.)
Overstocked drugs not supplied to reduce waste	5
Detected opioid overstocking	2
Cleared expired drugs	2
Corrected serious dosage flaws	2
Reduced side effects	2
Introduced helpful drugs	3

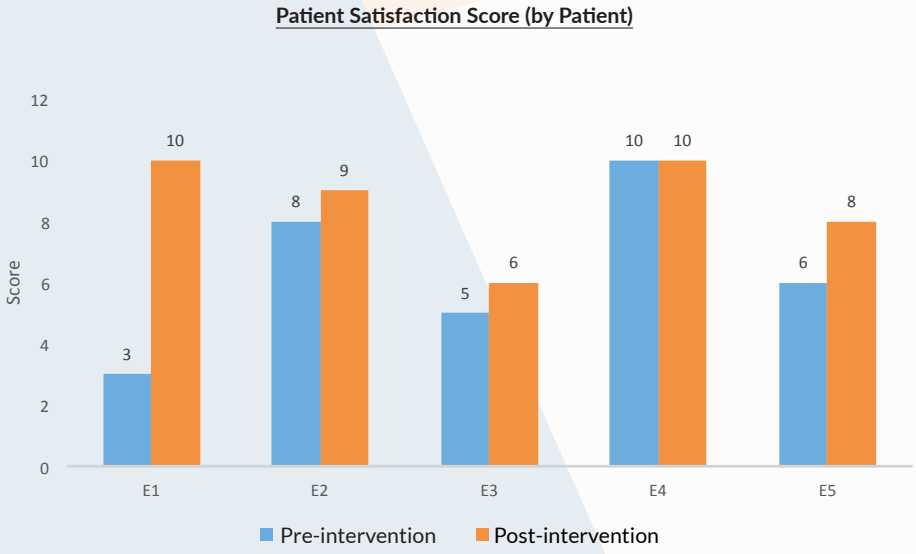


Mean Medtake scores improved with education, correction of dosage flaws and adjustments to reduce side effects

Patient Satisfaction



Patient Satisfaction Score (Mean) improved by 31.3%



All Esthers showed an improvement in their satisfaction score with E1 showing an improvement of 233%

Conclusion and Future Plan

A multi-disciplinary approach with collaboration among Pain Physicians, Pharmacists and Physiotherapists through a Virtual Pain Clinic in the community reduces healthcare visits, admissions and improves treatment outcomes.

Future Plan

- Referral of mobility impaired chronic pain patients to existing community nurses.
- Periodic review in the community by Pain Team from hospital.
- Home delivery of medications prescribed by Pain Physicians under Pharmacists' supervision through phone.
- Training of existing community teams to supervise chronic pain patients to perform exercises. initiated by Physiotherapist. Videos sent to Physiotherapist for feedback.
- Monitor frequency of Emergency Dept visits and Hospital admissions.

3. Partnering COmmunity Nurses & Pharmacists in MEDication Management in the Community (COMED)

Project team members

Terence Wong (SGH), Phyllis Quan (SATA, CommHealth), William Hoo (SATA, CommHealth), Marcus Teo Eng Hwa

Facilitators

Susan Lim Suyu, Rachel Gan Ee Ling, Hwang Yi Kun, Khee Giat Yeng, Seow Yee Ting

Background and Methodology

Medication management, as a form of person-centred care, optimizes safe, effective and appropriate drug therapy. It is a key component in ensuring safe medication use.
We conducted 3 ESTHER Cafés that involved 9 Esthers of different age groups, to gather insights into what really matters to them regarding medication management Based on the insights gathered, the top 3 concerns were:

- Medication labels
- Accessibility to medication enquiries
- Contact time with healthcare professionals

While there is on-going effort in improving medication label, our team aims to increase accessibility to medication enquires as well.

Community Nurses from Singapore General Hospital (SGH) are stationed strategically in the community, to support and manage senior citizens' chronic diseases and medications. Currently, there isn't any referral point established to assist Community Nurses with timely medication management or medication enquiries.

Mission Statement

Improve assistance provided to SGH Community Nurses in medication management and related enquiries, by SGH Pharmacists from July to Dec 2019.

Proposed Solutions / Outcome

PDSA1: Improve Community Nurse's confidence & knowledge in medication management
Learning need analysis was conducted by the Pharmacists to identify challenges faced by Community Nurses in medication management.

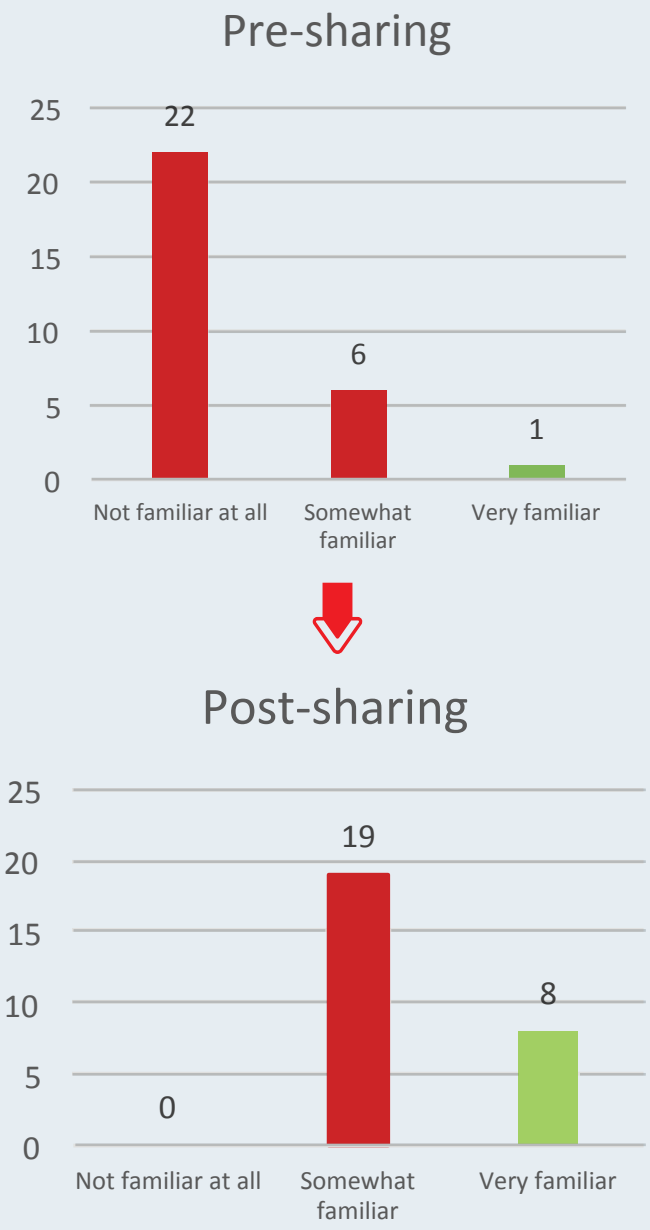
A sharing session was planned according to the top 3 areas identified (accurate identification of medications without labels, handling of complex medication-related issues and managing medication side effect.)

The 10-item Likert scale was used to assess the confidence level of Community Nurses in various aspects of medication management. Pre- and post-intervention surveys were administered to evaluate effectiveness of the sharing session.

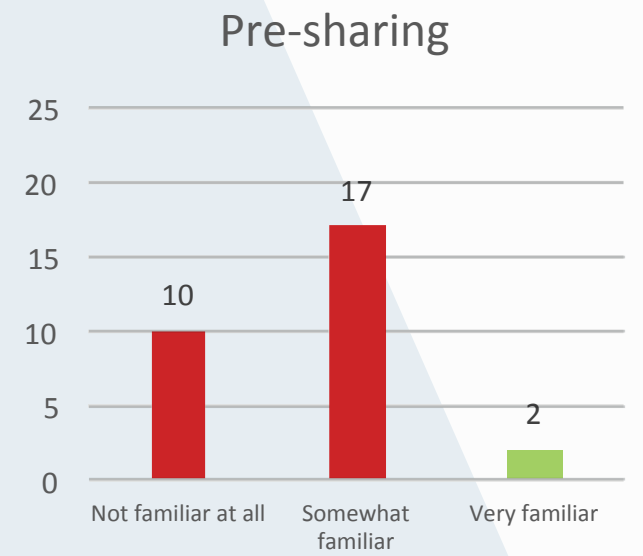
	Before Sharing	After Sharing	% Difference
Aspects of medication management	Median (N= 29)	Median(N=27)	
Appropriate education of administration technique	8	8	0
Accurate explanation of indication of medication	8	8	0
Managing medication accumulation	7	8	14
Managing medication side effects	6	8	33
Handling complex medication related issues e.g. drug interactions, non-adherence, duplication of therapy	6	8	33
Accurate identification of medication (for those without labels or boxes)	5	8	60

Table 1: Community Nurses' confidence level on various aspects of medication management (1= least confident; 10=most confident)

Mediview


Pre-sharing
25
20
15
10
5
0
22
6
1
Not familiar at all
Somewhat familiar
Very familiar
Post-sharing
25
20
15
10
5
0
19
8
0
Not familiar at all
Somewhat familiar
Very familiar

UpToDate


Pre-sharing
25
20
15
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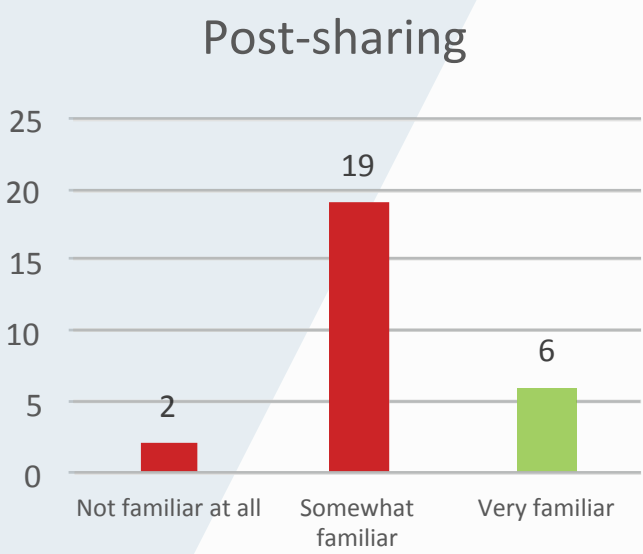
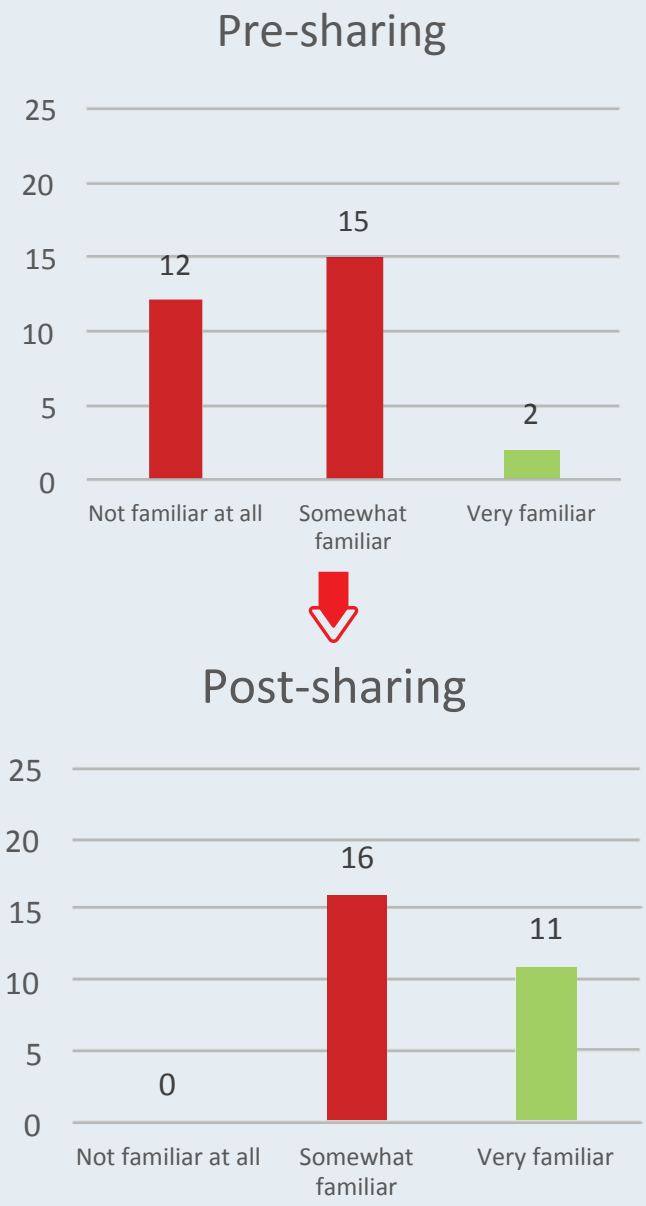
5
0
10
17
2
Not familiar at all
Somewhat familiar
Very familiar


Post-sharing
25
20
15
10
5
0
2
19
6
Not familiar at all
Somewhat familiar
Very familiar

Medication stock form



NEHR

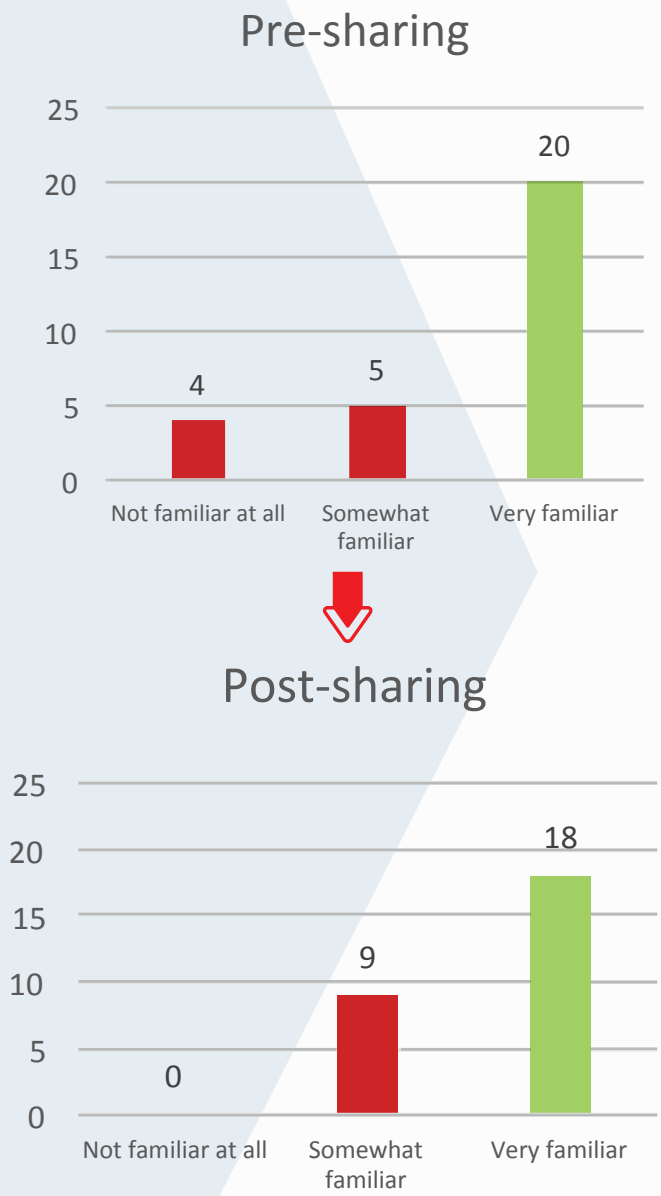


Diagram 1: Community Nurses' familiarity with using medication-related resources

Medication images (answer)	% of correct answers	
	Pre-sharing (n=29)	Post-sharing (n=27)
 Amlodipine	69%	96%
 Warfarin	93%	96%
 Celecoxib	45%	81%
 Issue Date	69%	78%
 Expiry Date	76%	93%

Table 2: Community Nurses' knowledge in medication identification and medication issue/expiry date location

Skills assessed	% of correct answer	
	Pre-sharing (n=29%)	Post-sharing (n=27%)
Identification of resource to use	62%	89
Interpretation of information to provide appropriate advise	4%	15

Table 3: Community Nurses' ability in handling drug-drug interaction enquiry.

At the end of the session, 100% of the community Nurses were aware of how to contact a Pharmacist when medication-related issues arise.

PDSA 2: Increase Esthers' accessibility to healthcare professionals for medication-related enquiries/issues

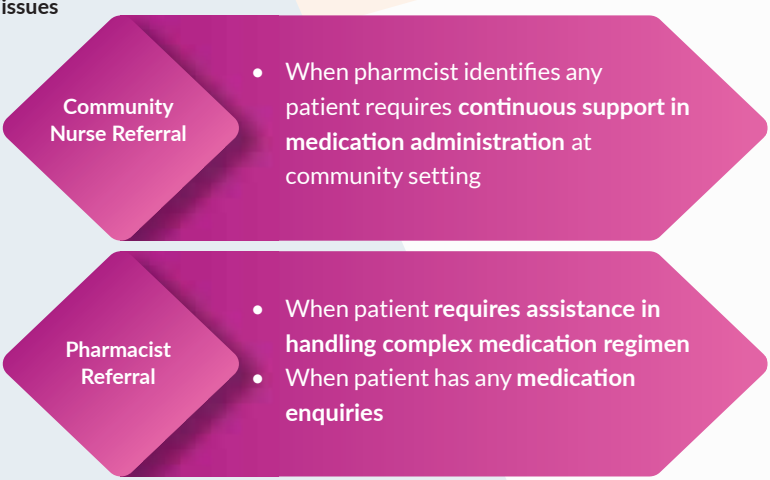


Diagram 2: Cross referral between Community Nurse & Pharmacist for Medication-related enquiry/management

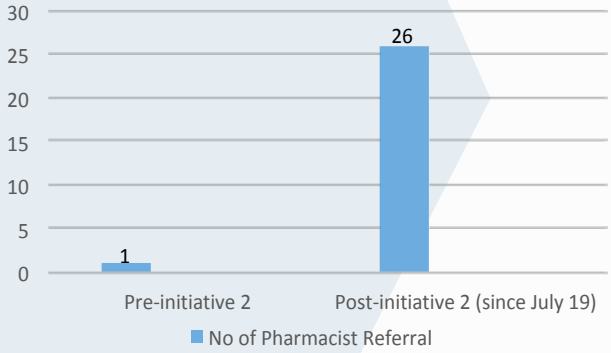


Table 4: Number of cross referral between SGH Pharmacists and Community Nurses since 1 July 2019

By the end of the study, a total of 26 referrals were made.

Conclusion / Future Plans

The partnership between SGH Pharmacists and Community Nurses has led to an increase in the residents' accessibility to medication-related assistance and/or enquiries. The sharing session with SGH Community Nurses has also improved their confidence level and skills in managing medications. The following future plans have been made:

- Further increase the cross referrals by 50% in 2020 with publicity to all SGH Pharmacists to raise their awareness about the partnership.
- Continue sharing sessions in 2020 on other topics or areas of interest highlighted by the Community Nurses from the LNA.

4. Increasing Readiness to Employment for Stroke Survivors

Team members

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Masshahira (Shira) Masri (TTSH Community Health),
Janet Lim (TTSH Care & Counselling)

Sponsors

Sharon Sew (TTSH Rehabilitation Centre),
Clarice Woon (TTSH Community Health)

Facilitators

Ng Tzer Wee, Peter Cheng

Background and Methodology

Tan Tock Seng Rehabilitation Centre (TTSHRC) provides holistic management of patients with acquired disabilities after stroke. Many of such patients continue to live with some form of impairments after discharge back home. They report challenges faced in reintegrating back to the community post recovery.

Target Population

In Singapore, the total number of young stroke patients aged between 15 and 59 years who were admitted to public hospitals increased to 2,122 in 2016 from 1,263 in 2008[1]. Stroke survivors belonging to this age group are expected to be in their productive years. Despite the higher likelihood in having better prognoses in terms of physical recovery, they are greatly impacted by their acquired disabilities in their familial and societal roles. They are also more likely to have a stronger need to be re-engaged and return to work, reducing productivity lost due to impairment. The target population was identified to be stroke survivors between 18 to 60 years old.

Methodology

Based on the ESTHER Café conducted with this group of Esthers, the findings are as follows:

ESTHERs' Experiences
Financially-challenged
Low self-esteem
Loss of independence
Lack of control in life
Frustration over the gaps and inconsistencies of the healthcare systems
Felt that their stroke symptoms are not being properly managed by the hospitals
Lack of information and knowledge in getting resources

Hence, the Esthers concluded that it is important for them to…

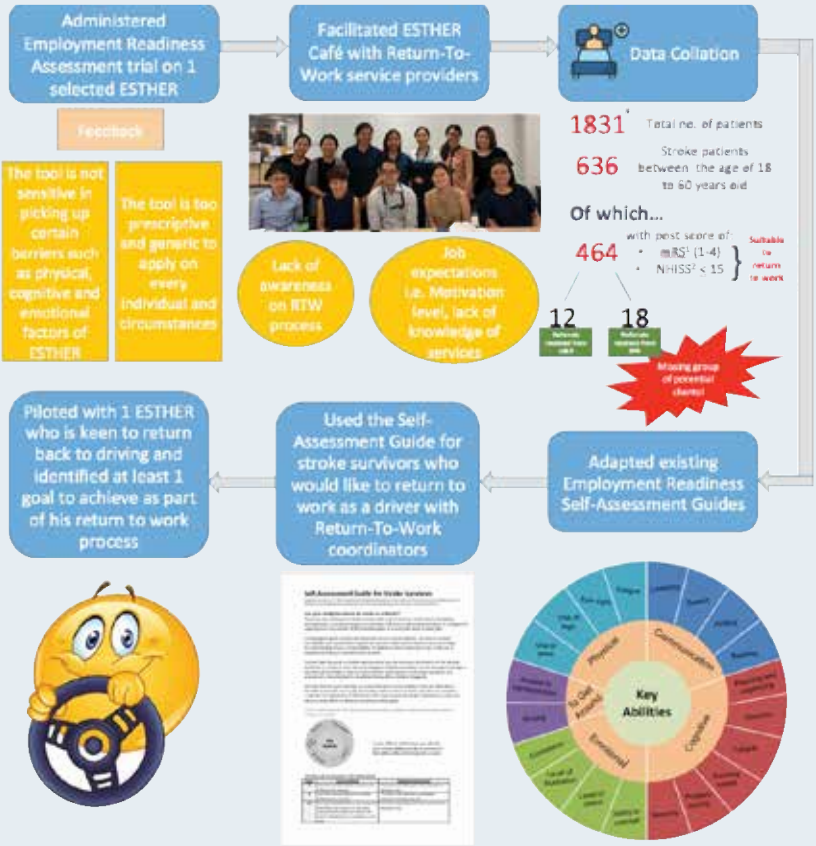
However…

Esthers Challenges
Unaware of which organizations to approach
Unaware of where and how to start the process of returning to work
Rejection faced by organizations that employ physically disabled persons

Objective

The aim is to increase stroke survivors' readiness in employment through improving their awareness of employment barriers. This was facilitated using a self assessment guide which identifies at least 1 achievable goal as part of the Esthers' return-to-work process.

Proposed Solutions and Outcomes



Future Plans

- To encourage the use of a common Self-Assessment Guide for the following professions on their patients who are keen to return to vocational driving:

  √ Return-To-Work Coordinators in TTSH
  √ Care & Counselling Department in TTSH (Medical Social Workers)
  √ Nurse Clinicians in Stroke Clinic at NNI
  √ Respective service providers invited at ESTHER Café (SPD, SG Enable, ABLE, HWA and TRIFAM)

- To develop Self Assessment Guides for stroke survivors of other industries like blue-collar and white-collar workers with the Return-To-Work Coordinators in TTSH

Learning Points

- Appreciation of the importance of Esther Cafes in understanding perspectives of both groups of Esthers (stroke survivors and service providers) and what matters to them
- Importance of exploring Esthers' personal strengths which can guide and influence their personal goals
- Importance of leveraging on existing data, resources and research evidences to optimize team productivity

 # Ischemic and Hemorrhagic patients known to National Neuroscience Institute in 2018
[1] modified Rankin Scale (mRS) – measures the degree of disability or dependence in ADL. Score of 1 to 4 means mild to moderate severe disability
[2] National Institutes of Health Stroke Scale (NHISS) – measures the impairment caused by stroke. Score of 1 to 15 means NIL to moderate stroke symptoms.
[1] Health Promotion Board (2018). Singapore Stroke Registry Annual Report 2016. Retrieved from National Registry of Diseases Office website https://www.nrdo.gov.sg/docs/librariesprovider3/Publications---Stroke/singapore-stroke-registry-annual-reprot-2016_upload_nrdo_website.pdf?sfvrsn=c81670e4_0
[2] Southwestern Ontario Stroke Network (2015). Return to Work - A Self Assessment Guide for People with Stroke. Retrieved from Southwestern Ontario Stroke Network, London Health Sciences Centre website - www.swostroke.ca/rtw-self-assessment-introduction/

ESTHER Projects 2019-2020

Empowerment

5. To Increase Awareness Level of Esthers in Fall Management at home from 22% to 50% within 6 months

Steady P🔥mPiPi

Team Leader
Ong Li Jiao (SGH)

Team Members
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Sponsors
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Facilitators
Magdalene Ng (SGH), Teo Shao Chu (SingHealth)

Background

Falls and fall-related injuries are common among the seniors. One in five seniors aged ≥ 65 years old reported to have fallen at least once each year (HPB, 2016). Many of them experienced recurring falls, resulting in greater morbidity and mortality and contributing to early admission to long-term nursing facilities.

Many falls happen at home due to home hazards e.g. slippery flooring, loose mats and cluttered environment, and such incidents are preventable. It was found that 17.8% (N=190) of seniors had high fall risk and required further screening and follow-up during the Community Falls Prevention programme conducted by SGH Community Nursing team over a period of 10 months. Among them, 33.2% (n=63) of seniors had at least one fall in the past 12 months (Figure 1).

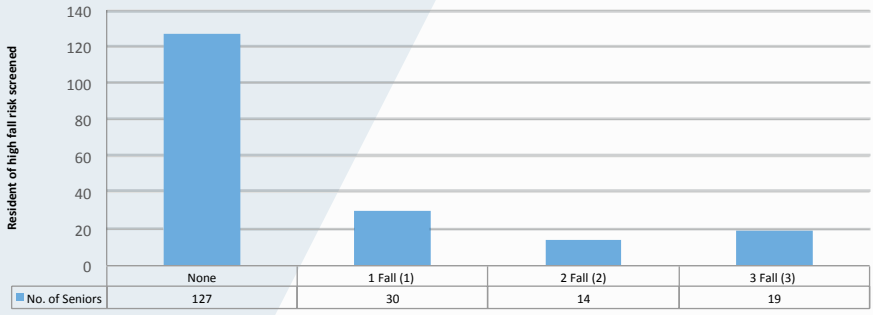


Figure 1: Residents screened with high risk of falls (Aug 2018 - Jul 2019)

Most of the elderly had misconceptions on what warrants a hospital admission post-fall. Many expressed fear of falling, unsure of fall management at home and have difficulties managing their activities of daily living after the falls (e.g. moving around, showering).

Mission Statement

To increase awareness level of Esthers in fall management at home from 22% to 50% within 6 months.

Methodology

The team recruited 10 Esthers with a) high fall risk, b) no caregivers, c) at least one fall incident (include near miss) reported within the past 12 months and d) expressed fear of falling. Focused discussions (via ESTHER café) were conducted at the participants' home to understand the factors that contributed to their falls, their knowledge in post-fall management and their confidence in performing instrumental daily activities (IADL). Self-rated modified efficacy scale (from 0 to 10) was used. Figure 2 indicated the flow of data collection.

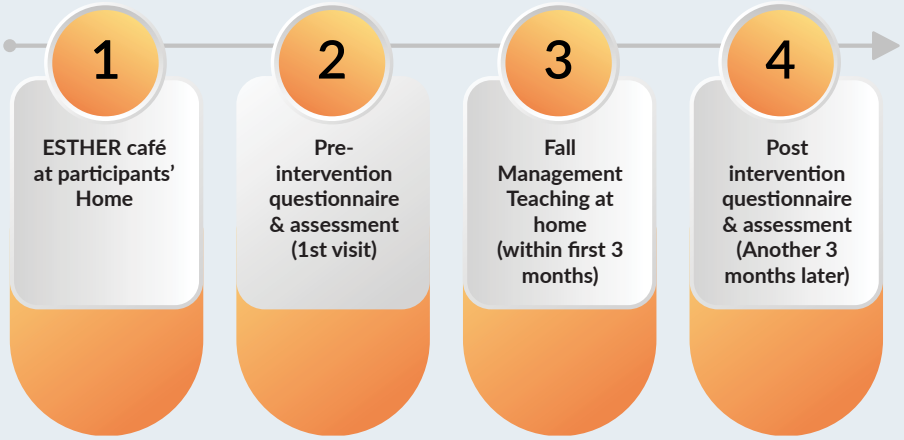


Figure 2: Data Collection

A Cause & Effect diagram (Figure 3) followed by a Pareto chart enabled the team to identify the top 3 root causes for lack of awareness in managing post fall:

1 lack of awareness on getting up from falls,
2 no ready emergency contact after fall and
3 lack of understanding on prevention of next fall.

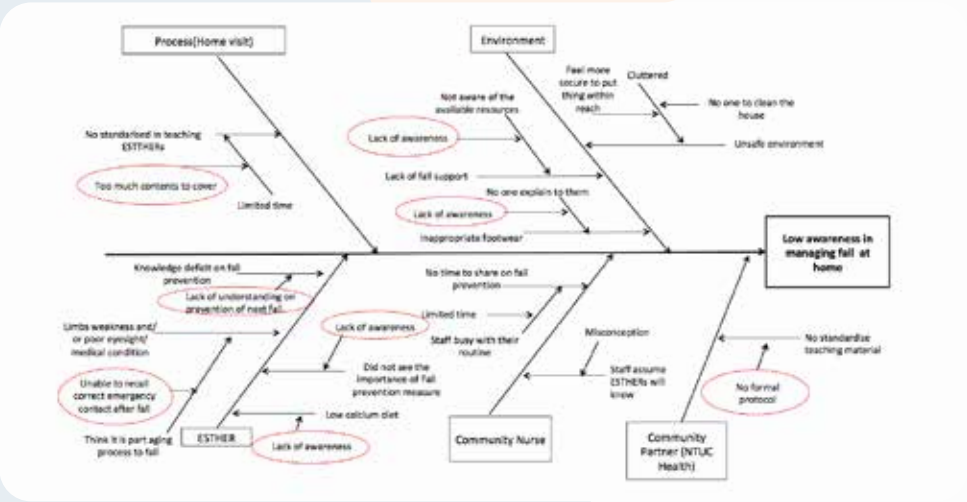


Figure 3: Cause and effect diagram

Proposed Solutions

Three interventions were identified.

PDSA 1 – How to Get up from a Fall

- Coaches to demonstrate with pictorial guide on how to get up after a fall and managing Instrumental ADL
- Esthers to re-demonstrate (or verbalize the 5 steps) on how to get up from fall

PDSA 2– Get Help

- To display wall decal at Esthers homes with emergency contact numbers to call after a fall.

Falls Prevention Guidebook by HPB

PDSA 3 – How to Prevent Next Fall

- To increase awareness & knowledge
- Diet advice for strong bone, proper foot wear and home safety;
- Education on managing fall with injury: primary care vs. emergency visit.

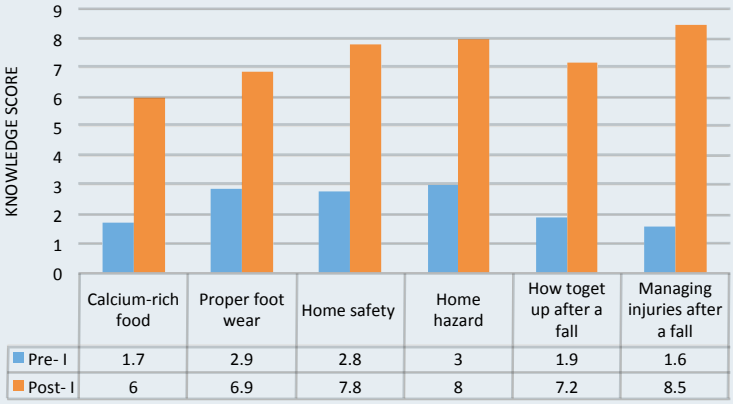
Outcome

Esthers had an overall 51% (23% vs. 74%) increase in their knowledge of fall management (Figure 4) and greater confidence of 14% (58% vs. 72%) in managing their IADL post fall (Figure 5) ($p<0.05$).

Nine Esthers felt that the wall decal was useful especially in contacting their next of kin during emergency.

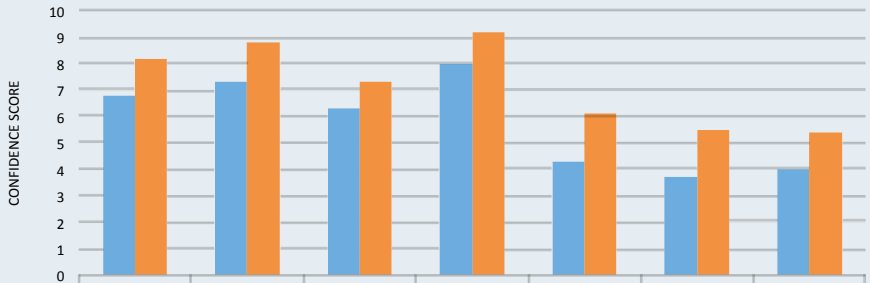
The number of Esthers with emergency visits were reduced from 5 to 1 over the period of 6 months. Most of the falls pre-intervention were due to home hazards such as tripped off from loose mat and improper footwear. One of the fall incidents post intervention was due to the ESTHER's unsteady gait.

There was a total of $484 cost avoidance to Emergency Department visits based on the 4 fall incidents prevented. (Figure 6)



	Calcium-rich food	Proper foot wear	Home safety	Home hazard	How toget up after a fall	Managing injuries after a fall
Pre- I	1.7	2.9	2.8	3	1.9	1.6
Post- I	6	6.9	7.8	8	7.2	8.5

Figure 4: Knowledge on post fall management



	Moving around at home	Dressing	Showering	Toileting	Preparing meals	Housekeeping	Moving around in community
Pre- I	6.8	7.3	6.3	8	4.3	3.7	4
Post I	8.2	8.8	7.3	9.2	6.1	5.5	5.4

Figure 5: Confidence level in managing IADL

	No. of Emergency Visits	No. of Hospital Admission
Pre- I	5	1
Post- I	 4	1
Saved		**0**
Cost Saved	**S$484 ($121 per visit)** **Projected $7,623 savings per year** (ref data in Figure 1)	This cost excludes hospitalization charges

Figure 6: Cost avoidance for Emergency Department visits

Learning Points & Future Plan

The experience gained from engaging Esthers highlighted the importance of inculcating fall management awareness and preventive measures to seniors. Engaging Esthers and their caregivers in fall management, and increasing their autonomy can significantly reduce healthcare costs and hospitalizations. The project team will advocate these enhanced interventions to a larger community including community partners and community nursing teams for a more successful falls prevention initiative in the community.

6. Improving Geriatric and Special Care Dental Esther's Confidence Level in Managing their Oral Health

Team Members
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National Dental Centre Singapore
SingHealth

Sponsor
Dr Lui Jeen Nee

Facilitator
Seow Yee Ting

Introduction

The NDCS Geriatric and Special Care Dental Clinic is a purpose-built, age-friendly clinic established to provide specialized and holistic dental care for the elderly, special needs patients and patients with specific medical conditions requiring dental clearance and treatment. Our Esthers' ability to care for their oral hygiene can be affected by their medical conditions which can potentially increase the risk of dental decay and gum disease. In addition, their diminished ability to communicate and co-operate with dental professionals can make treatment more difficult.

Pictures: NDCS Geriatric and Special Care Dental Clinic (GSDC)

Methodology

ESTHER café was conducted among 10 Esthers and their caregivers. The majority expressed lack of knowledge in the following domains:

A) Implications of their medical conditions on their oral health
B) Breakdown of treatment costs prior to commencement of treatment.

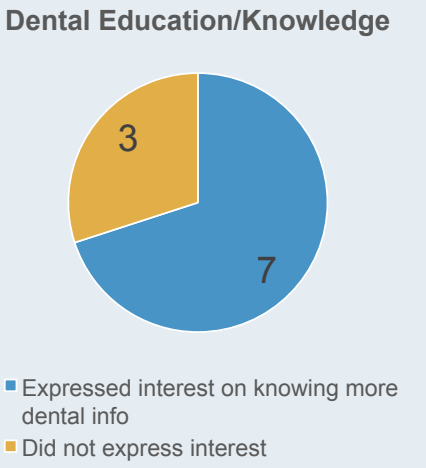


Figure1: Esthers' verbal feedback on acquiring dental knowledgepertaining to their medical conditions

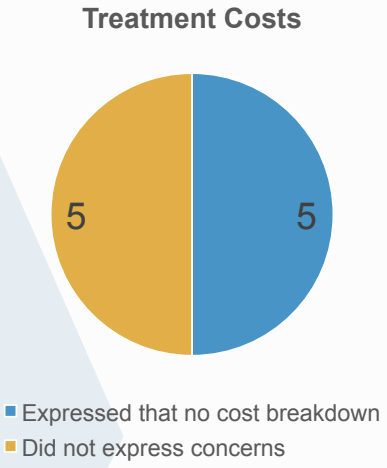


Figure 2: Esthers' verbal feedback on treatment costs

In order to collate baseline measurements, a questionnaire was conducted among 30 Esthers on their dental knowledge, understanding of the dental treatment costs and their confidence level in managing their oral health. Based on the questionnaire, the following gaps were identified:

1. Oral health knowledge

33.3% scored very poor to neutral for their knowledge in dental oral health pertaining to their medical conditions.

36.7% scored very poor to neutral for their knowledge in dental aids/tools to help with tooth brushing.

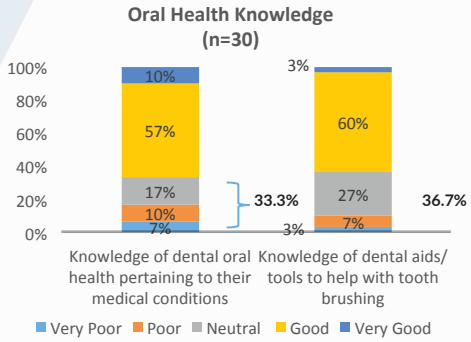
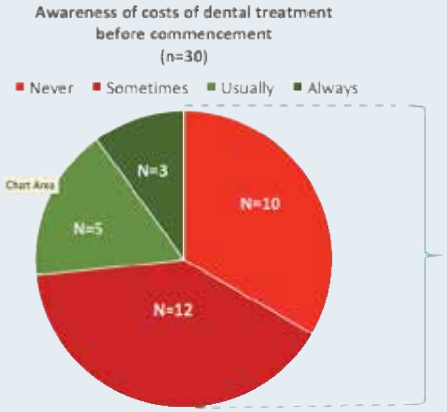


Figure 3: Esthers' oral health knowledge

2. Awareness of costs of dental treatment before commencement



22 Esthers (73.3%) are not counselled about costs of dental treatment before commencement.

Figure 4: Esthers' awareness of dental cost prior to treatment

3. Esthers' confidence level in managing their oral health

Only 17 Esthers (57%) scored their confidence levels as good and above in managing their dental oral health.

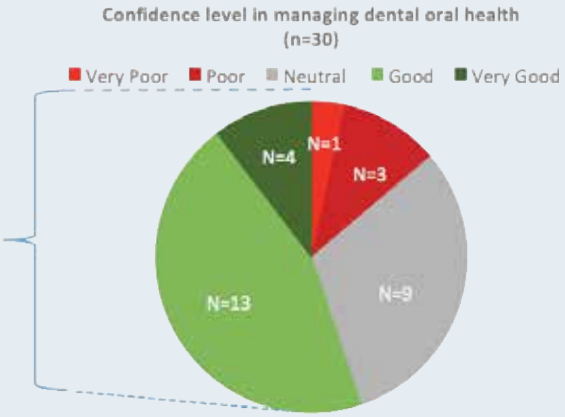


Figure 5: Esthers' confidence level in oral health management

The mission statement was formulated through in-depth analysis of the baseline survey responses.

Mission Statement

To improve Esthers' confidence level of managing their oral health from 57% to 75% from Q4 2019 to Q2 2021

Proposed Interventions

Based on Esthers' feedback and discussion among the team members, the following interventions were proposed:

(PDSA 1) Educational videos
Dental educational videos can be made to educate these patients on oral healthcare regimes. These videos can be played in the GSDC waiting area.

(PDSA 2) Financial counselling
After the first consultation visit, clinicians formulate a dental treatment plan. Based on the charge codes of these dental services, the frontline staff can provide financial counselling services.

We are currently working on the contents of the educational videos and financial counselling forms. After each PDSA, we will evaluate Esthers' responses to the intervention uisng a questionnaire.

Learning Points

Esthers' involvement is key to the provision of a patient-centric model of care. By involving them, Esthers feel empowered as they gain confidence in taking charge of their healthcare needs. This will boost their confidence, improve the patient-provider relationship and increase the efficiency of health care delivery systems.

7. Empowering Esthers in Self-Management of COPD in the Community with the use of a COPD ePlan

Team members
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Sponsors
Joanne Yap (NM), Gan Peiying (NC/APN)

Facilitators
Cheryl Lau, Kee Mong Nee

Background

Chronic Obstructive Pulmonary Disease (COPD) is a progressive life-threatening lung disease that causes breathlessness (WHO, 2019). In Singapore, it is the 10th leading cause of death in 2014 (MOH, 2017) . In FY 2018 (April 2018 – March 2019), CGH's Hospital to Home Programme (H2H) received 60 referrals for post discharge follow up care for patients diagnosed with COPD. In consideration that majority of hospitalized COPD patients were Chinese males, divorced, widowed or single, or lived in low income public housing apartments (MOH, 2017), there is a need to develop appropriate education materials to help the community niurses better empower this population in the community.

Methodology

ESTHER Cafe was conducted with 8 Esthers with COPD to identify what matters most to them, as well as current challenges faced. Information was collected via a standard questionnaire and guided one-to-one interview.

WHAT MATTERS MOST

3 Recurrent Themes Identified

Improving and maintaining their health

- Improving and maintaining their health
- Maintaining their independence and freedom
- Spending time with their family members

WHAT DO YOU NEED HELP WITH

The following issues with regards to COPD Management were revealed

- Poor understanding of condition
- Frequent episodes of shortness of breath
- Readmissions to A&E
- Unwillingness to participate in interventions to improve COPD

These issues were examined separately via cause and effect diagrams *(refer Diagram 1 for an example).* A common factor: Knowledge in emergency management of COPD, was found to underlie all 4 issues examined.

Aim

To empower Esthers on COPD medication management during emergency situations.

This will help to improve disease control, prevent readmissions and independence, inline with what matters most to Esther.

During ESTHER café

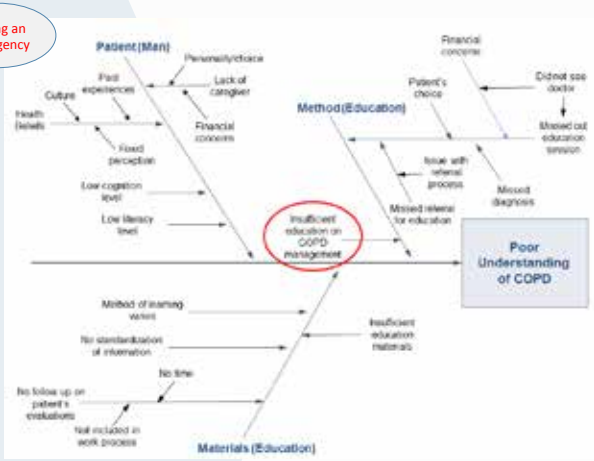


Diagram 1: Cause and effect analysis for poor understanding of condition

1st Esther that received ePlan

Proposed Solutions

Based on findng from the ESTHER Café, a COPD ePlan was developed - A colour-coded, pictorial diagram available in English and Mandarin language for easy reference *(refer Diagram 2)* on what to do during an emergency situation.

Interventions

A) Usual care (Education & caregiver's training) **AND**
B) Use of COPD ePlan

Inclusion Criteria

A) Esther with normal/mild cognitive impairment
B) Enrolled under CGH H2H Programme

A total of 4 ESTHERs were enrolled for this project.
Their feedback of the ePlan, improvement in compliance and A&E attendances/admission were monitored.

Diagram 2: COPD ePlan

Outcomes

Interventions were conducted over a period of two months. The ePlan was generally well accepted by 3 out of the 4 ESTHERs. There was an improvement in treatment compliance with the use of the ePlan. Esther D demonstrated both an improvement in medication compliance and a reduction in ED attendance/readmission during this 2 months project.

ESTHER	Education level	Feedback on eplan	
A	Primary level	✓	'Easy to understand'`
B	Secondary level	✗	'I don't want, I know it all'. - Declined intervention
C	Secondary school level. Mild cognitive impairment	✓	'Tool is ok to use'
D	No formal education.	✓	'Tool is ok to use'.

Table 1: Feedback on the COPD ePlan

ESTHER	Compliance at baseline		Compliance at 2 months		ED Attendance / Readmission	
					2 months pre-intervention	**2 months post-intervention**
A		Compliant		Compliant	2	2
B		Compliant		Compliant	1	0
C		**Needs reminders**		Compliant	0	0
D		**Non-compliant**		Compliant – Helper refers to ePlan	1	0

Table 2: Compliance to Treatment and ED Attendance/Readmission

Learning Points

- It is important to assess Esthers readiness and suitability for an intervention as not one size fits all!
- The ePlan seems effective as a tool empowering both Esther and their caregivers in medication management of COPD in emergency situations and improves compliance.
- Targeting improvement in medication compliance may potentially decrease ED attendance and readmissions.

Future Plans

- To continue to engage Esthers and improve the usability of the ePlan e.g. by further simplifying the pictorial diagram and creating a larger (A3 sized) ePlan for Esthers to attach on the wall, near their medication supplies.
- If successful in a bigger test cohort, consider rolling out COPD ePlan to Esther with COPD in the community. Benefit may be more evident in Esther with frequent ED attendance/ admissions.

References
Ministry of Health (February 2017). MOH Clinical Practice Guidelines 2/2017: Chronic Obstructive Pulmonary Disease Executive Summary. http://www.moh.gov.sg/cpg
World Health Organization (2019). Chronic obstructive pulmonary disease (COPD). http://www.who.int/news-room/fact-sheets/detail/chronic-obstructive-pulmonary-disease-(copd)

8. "Pills-on-time" kit: Empower Parkinson's Disease Patients in Managing Medication at Out-of-Home Setting

Team members

Minnie Koh (NE), Wang Yuting Kathlyn (NE),
Usanee Chotphoksap (NC APN),
Goh Rui Hao (SSN, Resident Nurse)

Sponsor

Tan Ah Pang (DDN)

Facilitator

Andy Sim

Introduction

Parkinson's Disease (PD) is the second most common neurodegeneration disease. They are considered vulnerable groups due to the progressive nature of the disease. Particularly the complexities of PD medication schedule related to self-management adherences a significant challenge. Nonadherence is linked to increased readmission rate and premature mortality. Baseline survey and one-to-one interview have been done for PD patients. The reason for nonadherence involves intending to take PD medication as scheduled but failing to do so for some reasons, such as, neglecting the importance of bringing medication when going out. Thus, the patients might not be able to take their medication on time, leading them to develop various complications. The goal of this project is to increase the confidence level of PD patients in self-managing disease-related medications out of home setting by 30% in 3 months. This project will present the key intervention to enabling PD patient in self-managing PD related medications at out of home setting.

Methodology

Baseline survey has been done for 19 Esthers (PD patients) about self-managing PD medications (Refer to Figure 1). Most of the patients (79%) are having 1 or 2 types of PD medications. 47% of them expressed that they needed family members to remind them bringing PD medication when going out. 63% of them mentioned that they have forgotten to bring the PD medication out. Thus, the aim of this project is to increase the confident level of PD patients in self-managing disease-related medications out of home setting.

No	Survey Questions	Respond	Total Responder	% responded as Yes
1	Can you list down 3 main concerns regarding managing PD medication?	9: need people to remind to bring the medication when going out 4: difficult to follow and remember the timing of medication	19	47% needed people to remind to bring the medication when going out 21% had difficulty to follow and remember the timing of medication
2	Do you think it is important to bring the medicine when going out? 0-10 give a number to describe. (0 - not important, 10 – very important)	15 responded as 10.	19	79% felt important
3	When you are out of the house, have you ever forgotten to bring your PD medicine?	12: Yes	19	63% ever forgot to bring the PD medication out
4	If "Yes" to Question 3, How many times do you forget to bring the PD medicine per month?	3: 4-6 times/mth 9: 1-3 times/mth 7 : none	19	47% forgot to bring medication 1-3 times per month 16% forgot to bring medication more than 5

Figure 1: Problem Identification Survey Result

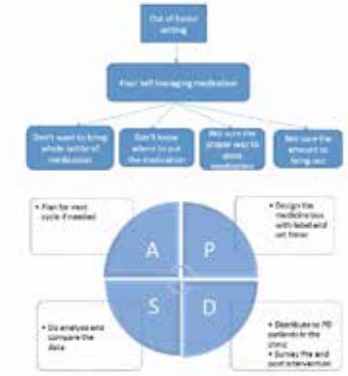
Proposed Solution

Design "pill-on-time" kit: a potable detachable medication box (More convenience for PD patient to bring the medication along when they go out)

- One color for one type of medication
- Label the name of medication in the pill box
- Do not keep the medication in the pill box for more than 24 hours
- Remember to unpack the medication when back home

Pre-implementation survey (refer to Figure 2) was conducted during PD support group meeting on 6 January 2020. Potable medication boxes (refer to Figure 4) were given to those PD patients who have forgotten to bring the PD medication when going out and they are willing to participate in this project. Patient education (refer to figure 5) on how to proper use of this potable medication box was provided to patients and family members.

The participants were informed that phone interview will be conducted one week after to find out the effectiveness of this project. 7 PD patients were recruited in this project.



Result

Phone interview was conducted after one week of implementation on 13 January 2020. 6 out of 7 PD patients have completed the post-implementation survey (refer to figure 3). 67% (4 out of 6) expressed they had increased their confident level in self-managing PD medications out of home setting by 60% (confident level score from 2 to 5, refer to figure 6). Three of them also shared that they liked one color for one type of medication as the color can tell the different medication. One of them shared the size of the medication box is satisfactory and convenient for carrying around. Most of them (4/6) expressed the given medication box motivated them to bring the PD medication when going out.

Forms / pictures

Figure 2: Pre-intervention Survey

Figure 3: Prost-intervention Survey

Figure 4: Potable Medication Box

"Pills-on-time" kit: Patient Education

1) Place all medications into the labelled pill boxes when you go out.
2) The box is removable and detachable, so the day's medications can be easily carried with you when you leave home. Remember to bring the box when you are out of home
3) To caregiver: When away from home, carry your loved one's daily pill box with you.
4) We will be contacting you in a week time to follow up with you. This is to mainly find out how you utilize the pill box by yourself or with your loved one.
5) One color stands for one type of the medication
6) Do not keep the medication in the box more than 24 hours.
7) Remember to unpack the medicine when you go back home.

Figure 5: Patient Education

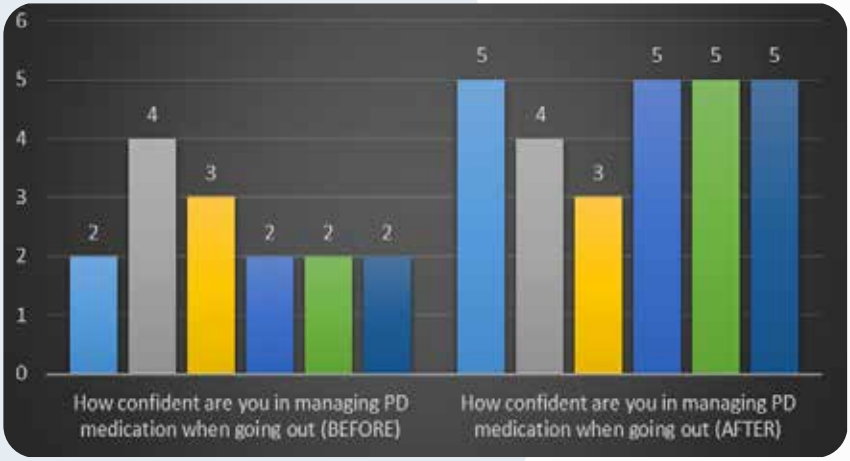


Figure 6: Confident Level Result

Further Plans

Due to the time constraint for data collection, we will continuously monitor the impact on PD patients for another few weeks. We plan to conduct follow up survey to review the sustainability of this project.

Conclusion

Esther plays an important part to enable us to understand their problems by contributing and sharing their needs. The success of this project depends greatly on the deployment of effective communication and acting on constructive feedback given from our PD Esthers and support group partners. Plans in place include regular team meetings to discuss project progression and consistently monitor for the changes. As the total number of the PD patients are limited during the selected period, intervention can be further tested so that it can benefit the patients in a long run.

9. Improving Esther's Satisfaction Level from 16% to 70% in their Special Interest Group so as to Give Meaning and Fulfilment in their Lives over 6 months

Team Leaders
Daniel Ng, Clara Cheah

Sponsor
Sammy How (Manager)

Facilitators
Clarice Woon, Ng Tzer Wee

Background

In the course of our work as coordinators for the Community Befriend Programme (CBP), we often come across seniors who are concerned by the lack of purpose and meaning in post-retirement life. In the process of understanding their sentiments, we learnt about a special interest group comprising a few CBP volunteers (Befrienders) who meet to sing Karaoke and learn the ukulele every week. An ESTHER Café with these Befrienders was conducted to find out about the interest group; explore topics related to active ageing; and find out what matters to them at their current stage of life. Figure 1 illustrates the common responses from Esthers. The discussion also made us realise that seniors can remain active and engaged even in old age. This project seeks to improve Esthers' satisfaction level in the special interest group so as to bring meaning and fulfilment in their lives.

Figure 1

Methodology

A baseline study of Esther's satisfaction level (Figure 2 – satisfaction level scale bar) was conducted before they joined the interest group. The team also administered monthly surveys through telephone calls or meetings over 5 months, to find out Esthers' satisfaction level after joining the interest group.

Figure 2

Proposed Solutions

During the ESTHER Café, Esthers shared that they value life-long learning and a meaningful life. They suggested to have a platform to showcase their talents, as such the team decided to organise a Volunteers Appreciation Lunch on 9 November 2019. Our Esthers performed a song accompanied by ukulele and a total of 200 volunteers were present to help at the event!

Outcomes and Learning Points

Esthers' satisfaction level increased by 84% over 5 months and the peak was observed after their performance (Figure 3 – Overall data graph, Figure 4 – Average score of Esthers' satisfaction level). A debrief session was conducted with the Esthers to gather their feedback and thoughts. Esther 3 mentioned "Honestly, it wasn't about how professional or how well we did, it's good enough to be up on stage with an event of such a size." All of them agreed that they never imagined themselves to be able to put up a performance in front of a big crowd at their age. The team also became more bonded after rehearsing together despite having disagreements in the process of preparing for the performance.

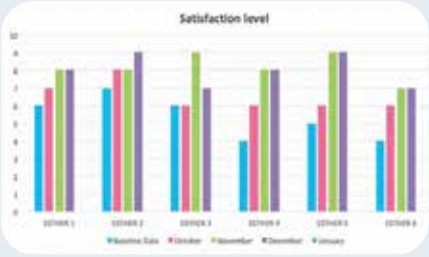


Figure 3

Figure 4

Conclusion / Future Plans

Implementation of similar projects at other constituency wards under the Community Befriending Programme (CBP) to encourage formation of more interest groups among seniors to strengthen peer-support.

First ESTHER Café

Group photo of the interest group

10. "Help Me Remain and Cope at Home, Please."

Project Team
Efen Tan (Snr MSW), Edreon Goei Wen Yang (MSW)

Sponsor
Eunice Chin (Manager, MSS)

Facilitators
Seow Yee Ting (SHHQ), Wong Yuen Yun (SGH)

Bright Vision Hospital

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

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

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

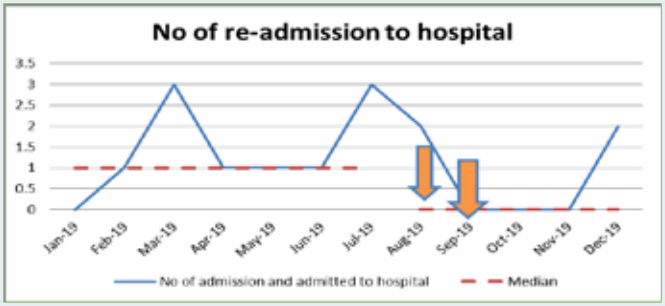


Figure 3: Number of re-admission for 5 Esthers under ESTHER Project (Based on SCM visit history from Jan 2019 to Dec 2019)

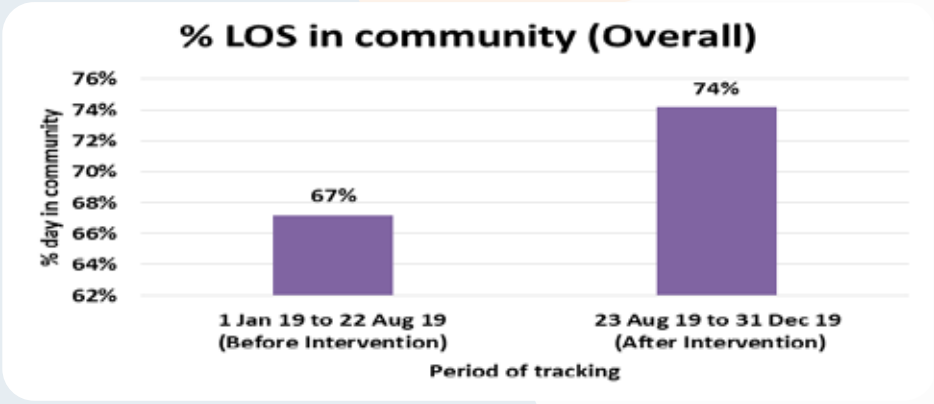


Figure 4: Total days in community before and after intervention for 5 Esthers under ESTHER Project (Based on SCM visit history from Jan 2019 to Dec 2019)

Verbal Feedback from Patient and Family members

"I don't like to attend day care but I am OK with it as long as I can continue to stay at home and not go to the nursing home. "
Patient Mr LKH

"I feel more at ease when I go to work as the staff will come up to the house to fetch my mother. There are staff there to look after her which is better than letting her stay at home and face the wall."
Daughter of Mdm SSH

"We don't want to send my sister to nursing home but she is not keen to hire a maid. With the day care service, I feel assured that my sister is being well taken care of by the day care staff while I'm at work. "
Sister of Mdm CCH

"I like to attend day care because I can make friends. I have someone to talk to and I can exercise everyday at the centre."
Patient Mdm LYL

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.

11. Increasing the Acceptance Rate of Elderly Esthers using Walking Aids to Reduce Falls

Team Members

George Tan (Centre Manager, Sunlove Whampoa Dew SAC) Betty Kong (Health Coach, Community Health, TTSH), Darryl Kok (Community Health Operations, TTSH)

Sponsors

K. Raja. Mohan (Chief Programme Officer, Sunlove), Ng Tzer Wee (Senior Principal, MSW, TTSH), Clarice Woon (Deputy Director, Community Health, TTSH)

Facilitators

Ng Tzer Wee (Senior Principal, MSW, TTSH), Clarice Woon (Deputy Director, Community Health, TTSH)

Introduction

Walking aids assist elderly in their activities of daily living and ensure that they age well in the community. However, it is not uncommon to hear of elderly who refused to use walking aids due to various reasons, and as a result, were seriously injured in events such as falls. Research from Disability and Health Journal[1] (U.S. National Library of Medicine) revealed that the use of mobility aids is often associated with stigmatizing attitudes of dependency. There are also heightened concerns over mobility aid users becoming subjects of negative biases.

[1]U.S. National Library of Medicine, Disability and Health Journal. (2010). Perspectives on Use of Mobility Aids in a Diverse Population of Seniors: Implications for Intervention. Accessed: July 2019

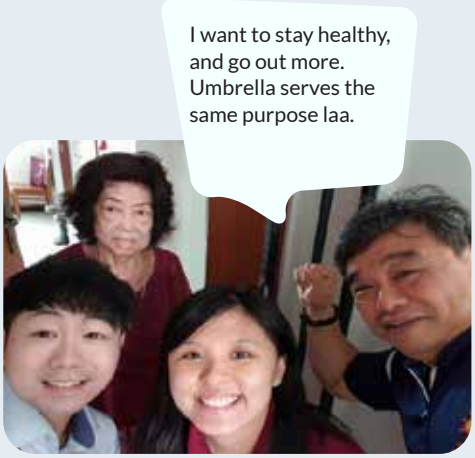
Who are our Esthers?

Our Esthers are elderly residents at Sunlove Whampoa Dew SAC, who showed unwillingness in using walking aids. This has prompted the project team to work towards increasing the acceptance rate of walking aids by elderly Esthers to reduce falls. The team aims to achieve:

50%	50%
Increase in acceptance rate of walking aid 1 month after implementation	Reduction in fall rates

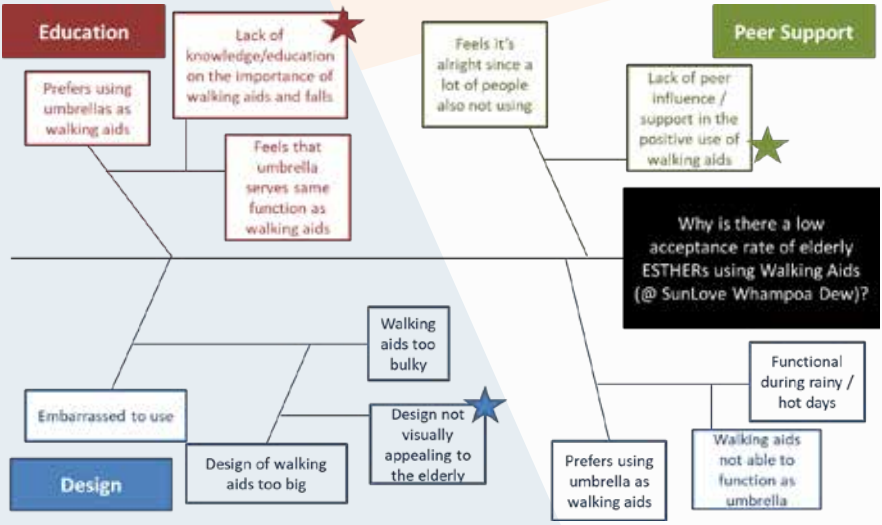
Methodology

Using a person-centered approach, a series of ESTHER Cafes were conducted to better understand why Esthers were not using their prescribed walking aids. ESTHER Cafes also helped the team to better understand what matters to Esthers. Verbatims and data from the ESTHER Cafes were analysed, aiding the team to identify root causes of the problem. Interventions were then co-developed with Esthers and relevant stakeholders to help Esthers understand the importance of using walking aids.



ESTHER Café 1 with Mdm Sim

ESTHER Café 2 involving more Esthers with similar needs

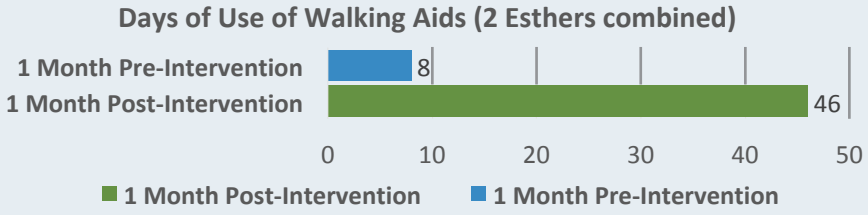


After identifying several root causes through ESTHER Cafes, the team prioritised the need to address Esthers' lack of knowledge on the importance of using walking aids to prevent falls through education. TTSH physiotherapists were engaged to develop a simple and interactive education session - "Walking Aids and You!" comprising topics suggested by Esthers during ESTHER Cafes. Topics include:

1. Why do the Elderly fall?
2. Walking Aids and Umbrellas, Who Wins?
3. Is Your Walking Aid at the Right Height?
4. The Proper Use of Walking Aids

Outcomes & Learning Points

Data collected for a study involving 2 Esthers revealed a 6 times increase in the use of walking aids (in days) after one month of intervention. Furthermore, 1 Esther did not report any falls 1 month post-intervention which was an improvement compared to one month pre-intervention when 1 fall was reported due to inappropriate/lack of use of walking aid. Through "Walking Aids and You!", the team also realized the importance of keeping education sessions for elderly interactive and informal. The move away from lecture-style teaching was beneficial as the Physiotherapist was able to be up-close and personal with Esthers. Aside from that, there was sufficient space for hands-on demonstration and even time for questions.



Future Plans

To further develop "Walking Aids and You!", the team will be working with TTSH's Physiotherapists to develop and incorporate a simple dance routine (involving the use of walking aids) in the center's regular exercise schedule.

The team would also be embarking on phase 2 of the project which allows Esthers to customize the design of their walking aids and tackle the second identified root cause - visually unappealing walking aids. The team has also connected with TTSH Centre for Healthcare Innovation's Living Lab to explore potential areas of collaboration.

12. A Qualitative Study of Esthers Confidence Level in Caring for Seniors

Team Members
Chow Chian Shen, Joe Tan, Stephanie Tan

Sponsor
Daniel Chien

Facilitators
Clarice Woon, Ng Tzer Wee

① Understanding ground needs with Service Providers

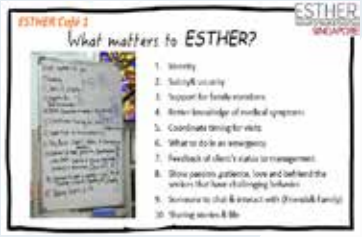
Conduct group discussion with Senior Activity Centre staff, Community Befriender and Caring Neighbours Programme leaders to develop a questionnaire based on Environment, People, Objects, Media / Message and Systems.

② ESTHER Café Session

Esthers placed "Relationship Building with Seniors" as top priority.

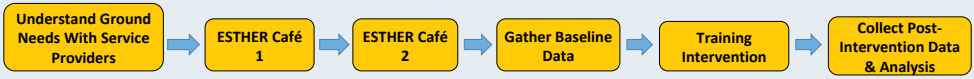
Who are our Esthers?

Our Esthers are retired seniors who volunteer under the Community Befriender and Caring Neighbours Programme. They complement the roles of full-time staff in a social service agency to enhance service delivery in the community. Hence, we see the need **"To Enhance Esther's Confidence Level in Caring for Seniors."**



③ Gather Baseline Data

Through a semi-structured face-to-face interview, our **Esthers' baseline confidence level before enhanced training intervention was rated an average of 60%**



Intervention

1. Conduct and attend group training with other volunteers to build stronger social network. (Enhanced training module / courses – Art of Communicating with Seniors, Caregiver's Journey: Elderly Mental Illness).

2. Collect and share clients' testimonials to appreciate Esthers' efforts in caring for clients in the community.

3. Conduct monthly volunteer gatherings and facilitate support group sessions to strengthen volunteer social network, identity and sense of belonging in the community.

Results

Through face-to-face post-survey interviews, Esthers' confidence level in caring for seniors showed **an increase from 60% to 80%.**

- Esthers shared that in difficult situations, where clients were anxious and worried, they **were able to use the soft skills learned to attend to clients**
- Socially isolated clients were encouraged by Esthers to form new social groups at the coffee corner and join weekly exercises at the neighbourhood park.
- Esthers rated an **average of 4.5/5 for relevance of training material to their volunteering role** for the module: Art of Communicating with Seniors.
- One **Esther applied the emotional regulation methods** that she learnt from the course to her personal life **and** noticed a**n improvement in composure and temper**.

Future Plans

- To capture life stories of clients and Esthers in a personal autobiography.
- Develop volunteer capability for peer-to-peer support learning.

Learning Points

- **Data Collection:** The team decided to conduct face-to-face interviews to elicit core concerns of Esthers.
- **What Matters to Esther:** Using a voting system, the team was able to hear from Esthers and allow them to prioritise their concerns.

13. To Build Esthers' Capability from 70% to 90% in 6 months

Team members

Nur Sabrina Binti Ridzuan (Assistant Case Manager, THK), Jayne Tong (Assistant Manager, TTSH)

Sponsors

Khor Boon Hua (Centre Director, THK),
Celine Ong (Deputy Director, TTSH)

Facilitators

Clarice Woon, Teo Shao Chu

Special thanks to Teo Shao Chu, Clarice Woon and Ng Tzer Wee For their guidance and support. Also to Adelina Chan for volunteers' participation from Community Befriending Programme volunteers' participation from Community Befriending Programme

Background & Methodology

Our Esthers are a group of volunteers managed by THK Cluster Support @ Ang Mo Kio and THK Community Befriending Programme @ Yio Chu Kang, who perform home-visits and befriend clients living in Ang Mo Kio. During home-visits, Esthers may encounter clients with high needs who pour out their emotions to them. As a result, Esthers face difficulties detaching themselves from their clients' problems, and this in turn affects their personal lives and morale as a volunteer.

As such, the project wants to find out if support provided to Esthers in the form of capability building can help them to better manage clients. If so, the project aims to build Esthers' capability from 70% to 90% over a period of 6 months.

WHAT IS IMPORTANT TO Esther?

During our first ESTHER Café, Esthers identified 3 broad areas that they wanted to receive training in – social skills, understanding clients' health needs and self-care. During our second ESTHER Café, we found that Esthers' top concern was in self-care (especially for senior Esthers) and they wanted to receive specific training in these 2 areas: a) How to Deal with Client's and Own Emotions and, b) Mindfulness

Interventions

1. Engaged Clinical Psychologist from SGH to conduct Mindfulness training.

2. Designed pre-training evaluation form to measure Esthers' **skills, knowledge and attitude** before attending the course.

3. Conducted 2 sessions of Mindfulness training in Nov'19 for Esthers to learn concepts and apply mindfulness to daily life.

4. Esthers apply what they have learnt during and after home-visits.

5. Conducted post-training evaluation 3 - 6 months later, to measure improvement in Esthers' **skills, knowledge and attitude.**

6. Collation and analysis of pre- and post-survey results for 6 Esthers.

Outcomes & Learning Points

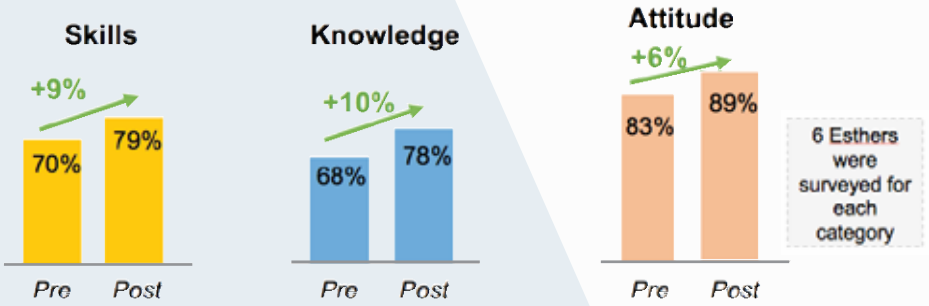
Pre-Training Evaluation		Post-Training Evaluation	
Overall level of competency:	70%	Overall level of competency:	82%
Overall improvement:	+12%	Overall improvement:	90%

Reasons why target of 90% was not achieved:

- Learnings need to be reinforced by Volunteer Coordinators on a regular basis before Esthers can apply them effectively during home-visits

- Survey forms were in English so Mandarin-speaking Esthers had difficulty understanding the questions, hence, affecting the accuracy of their responses
- Post-training evaluation was administered too close to training (i.e. 1 month difference). More lead time should be given to Esthers to familiarise with the techniques taught and apply during home-visits.

Further Analysis into Esthers' Skills, Knowledge and Attitude:



6 Esthers were surveyed and all of them showed improvement in skills, knowledge and attitude after attending the Mindfulness training, with knowledge displaying the greatest improvement. This was expected in view of the training conducted

Other Findings:

- All Esthers agreed that having Volunteer Coordinators to listen and guide them is most important in achieving self-care.
- All Esthers highlighted that they became more aware of the support and resources available after attending the Mindfulness training.
- All Esthers wanted Volunteer Coordinators to be part of their peer support group (if one is set up)
- All Esthers agreed that they feel best supported when Volunteer Coordinators listen to them with empathy.

Future Plans

- ESTHER Café will be conducted with THK Volunteer Coordinators as Esthers
- Volunteer Coordinators will be trained in areas such as showing empathy and active listening
- Another post-training survey can be administered in May 2020. If results are positive, Mindfulness training can be extended to all befrienders of THK.

14. Increasing Esthers' Confidence in Managing Activities of Daily Living (ADLs) at Home

Team members

Monica Cheung (Occupational Therapist), Leong Mei Yan (Assistant Nurse Clinician, H2H Community Nurse)

Singapore General Hospital
SingHealth

Sponsors

Adj. A/Prof Dr. Tracy Carol Ayre (Chief Nurse), Leila Nasron (Head of department, Occupational Therapy)

Facilitators

Magdalene Ng (Assistant Director of Nursing), Ng Shi Ying (Principal Occupational Therapist) , William Yap (Executive, Institute for Patient Safety & Quality)

Background Aim

Our project aims to increase Esthers' confidence in managing activities of daily living (ADLs) at home through collaborative intervention with Esther, H2H Community Nurse and Occupational Therapist.

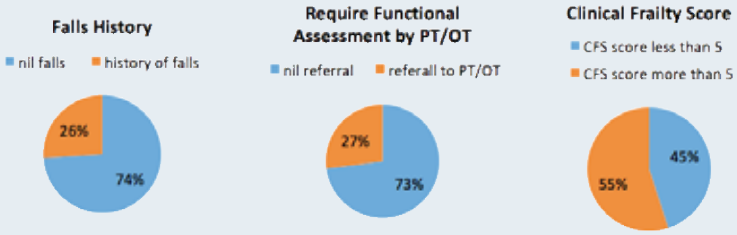
Inclusion Criteria

Elderly above 65 years old; enrolled in H2H programme; stay in Bukit Merah/ Tiong Bahru Community of Care (CoC) zone from July -October 2019; express concerns in managing their daily activities at home; and meet one of the following criteria:

I) Frail (Clinical Frailty Score of 5-7)
II) Experiencing functional performance change affecting their ability to manage ADLs/IADLs at home
III) History of falls in the past one year

Preliminary Data Collection

Retrospective data collected for 108 patients enrolled in H2H programme from April to June 2019, revealed that frailty was a common geriatric syndrome among elderly referred to H2H.



We asked our Esthers what their main concerns were to better understand their experiences. Their comments were as follows:

"I want to go back to my home"
"I have fear of falls"
"I worry about how to manage at home"

A step-wise discussion with Esthers helped us to understand their perspectives of the problems. Here are some of the problems raised by Esthers:

"I have difficulty managing daily activities at home"

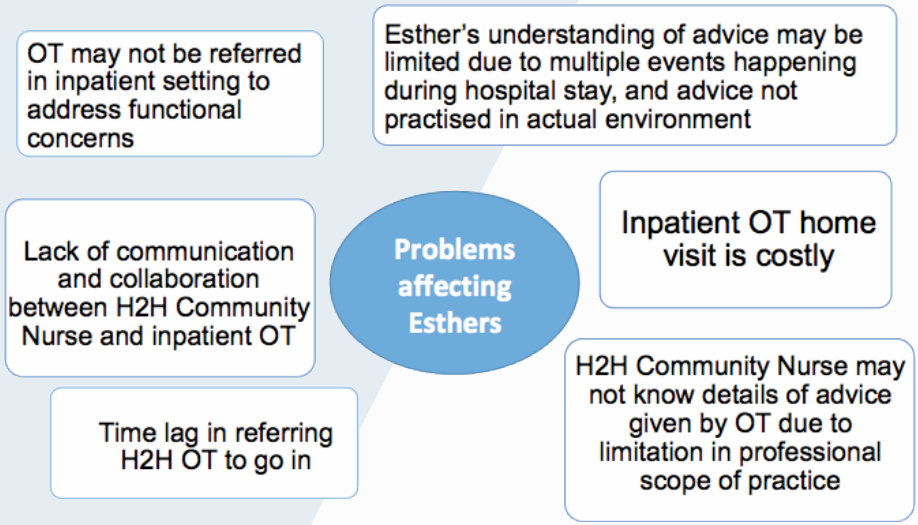
"I feel weak, cannot walk well now"

"I am scared that I will fall at home"

"I don't know what I can do to be safer at home"

"It will be good if healthcare professional can come to my house and advise me further"

Upon reflecting on Esthers' journey and concerns, we have arrived at some possible issues affecting Esthers:



Interventions

Our project aims to increase Esthers' abilities and confidence in managing ADLs safely through collaborative handovers and video call home-visits involving Esther, H2H Community Nurse and Occupational Therapist.

4 Esthers were selected and enrolled in the study, however 3 of the 4 Esthers could not complete the entire intervention flow (2 drop out, 1 readmission).

Intervention Flow:

During intervention, the following actions were completed with Esther and her next of kin :

1. Assessment of home environment safety- Toilet & shower area

2. Assessment of Esther's mobility and performance in home environment

3. Identification of possible areas for grab bar installation in toilet based on home environment assessment

4. Provided fall prevention advice and addressed fall hazards based on assessment of Esther's mobility and performance

Outcome

- Esther reported a 28.6% improvement in score on the Falls Efficacy Scale post-intervention.
- **Subjective report from family: felt more confident in Esthers's ability to manage safely at home** More confident to liaise with HDB EASE contractor
- **Therapist's and nurse's objective assessment that patient was managing safely at home** As observed during home-visit, patient was performing much better at home compared to in the ward - ambulating at a faster speed; ;improvement in lower limb strength was observed from sit-to-stand; and improvement in standing balance. No recent falls since discharge.

Falls Efficacy Scale (FES) (self rated ranking from 1 to 10, with 1 being very confident to 10 being not confident in managing the stated activity)		
Activity	Score before	Score after
Bathing	**5**	**2**
Reaching to cabinet	1	1
Walking around the house	1	1
Meals preparation	NA	NA
Get in and out bed	**2**	**1**
Answer door	1	1
Getting and out of chair	1	1
Dressing	1	1
Grooming	1	1
Toileting	1	1
Total	**14**	**10** ↓ 28.6%

Conclusion and Future Plans

Through our trial, there are positive outcomes to suggest that video calls may be an effective and cost-saving alternative to actual home-visits.
Possible future plans:

- Streamline video call process
- Conduct more trials to obtain feedback and data on the effectiveness and receptiveness of technology
- Calculate manpower hours/costs required to conduct video call consultation versus actual therapist home-visit, to understand feasibility of intervention in the long-run

ESTHER Projects 2019-2020

Experience of Care

15. Improving Patient Wayfinding in the Geriatric and Special Care Dentistry Clinic at National Dental Centre Singapore

Team members

Dr Lui Jeen Nee, Dr See Toh Yong Liang, Dr Kong Rui Ling, Nur Liyani Binte Noordin, Fauziah Bte Mohamad Nasir, Selina Chia, Willie Woo, Shemin Ong

National Dental Centre Singapore
SingHealth

Singapore Healthcare Management 2019

Background

The Geriatric and Special Care Dentistry Clinic (GSDC) in National Dental Centre Singapore (NDCS) was set up in 2016. Due to the new clinic layout, patients were often not able to find their assigned treatment rooms. Staff had to spend more time catering to lost patients. As the patients in GSDC are usually elderly and frail, the risk of falls was also increased within the clinic.

Aim

The aim of this project was to improve wayfinding in the clinics for such patients.

Methodology

A pre-intervention survey on 60 patients was done to obtain baseline data of the percentage of patients getting lost within the clinic. Using the **ESTHER** concept, 13 Esthers were interviewed to investigate reasons why patients found it difficult to locate their treatment rooms. Two causes were found:

- Inability to distinguish the queue number from the room number on the display panel.
- Poor signage leading to confusion as to which passageway to enter when going to their treatment room.

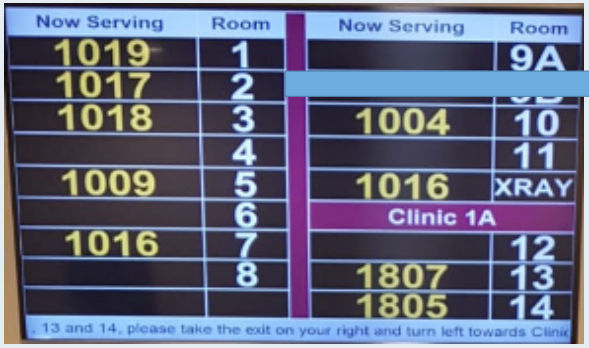
Pre-intervention Queue Display Panel

Interventions

Interventions done to address these causes were:

- Changes to the display panel to better distinguish queue number and room number
- New signage to improve the wayfinding to their treatment rooms.

A post-intervention survey was done after 6 months to determine the results of these interventions.



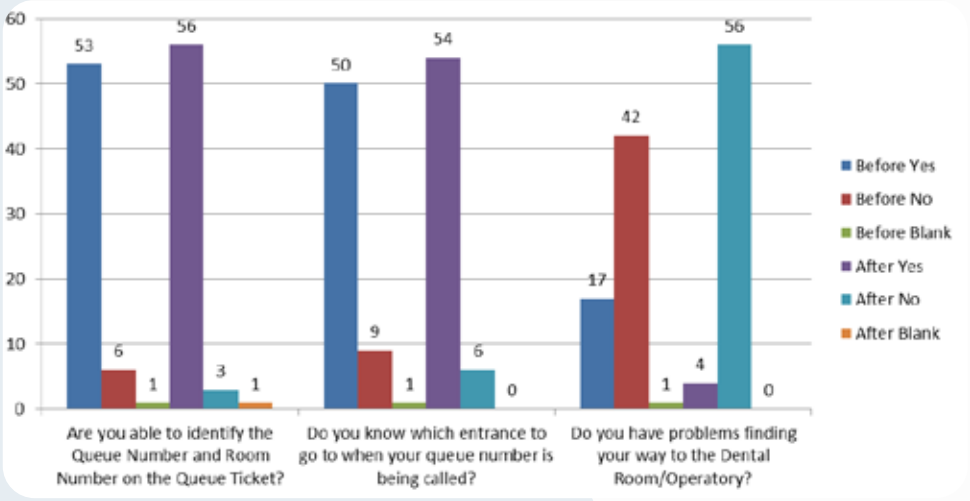
Post-intervention Queue Display Panel

Pre-intervention Signage leading to treatment rooms

Post-intervention Signage

Results

The pre-intervention survey found that 29% (17/59) of patients agreed to the question "Do you have problems finding your way to the Dental Room/Operatory?". This decreased to 7% (4/60) after interventions.



Conclusion

Understanding patients' needs is important in determining the root causes and solutions to problems they face when seeking treatment. Wayfinding in the GSDC was improved after interventions based on patient surveys and interviews.

16. Empowering Improvement in Patient's Participation Collectively

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Facilitators

Dr Luke Low, William Ng

Background and Methodology

Prior to intervention, patients had limited participation at the wards due to various barriers. Activities were mostly held in activity rooms at pre-arranged time with fixed number of attendees and help from a facilitator (e.g. weekly mahjong on Wed afternoon). While patients appreciated and benefitted from these activities, they expressed desire for improvements. This project aims to empower patients at Sengkang Community Hospital (SCH) to engage in more activities independently by the end of 2020. We aim to do so by discussing and co-creating solutions with our community partner (i.e. Sunlove), patients (i.e. Esthers) and ward staff. We collected primary data from patients' attendance list, measured their well-being with a modified scale (adapted from the Health Promotion Board) and conducted interviews with 31 patients during the Plan-Do-Study-Act phases.

Results and Suggested Solutions

Three themes emerged prior to our intervention: Autonomy, Independence and Inclusion. Based on these themes, we found that a variety of interactive, flexible and accessible activities that were mobile, were most helpful for patients to achieve autonomy (choices available), independence (did not need help to facilitate) and Inclusion (should be interactive in nature). A box of games and activity materials was (e.g. snake and ladder) placed in the ward based on the preferences and practice wisdom of patients, practitioners and partners.




Outcomes and Learning Points

We saw 50% increase in attendance of ward activities and an improvement in patients' social well-being. More patients were able to make friends (18% increase) and ask for help (25% increase). The intervention certainly met our intended goals. The ward staff were creative to suggest that these activities could be conducted in tandem with OT interventions and would be particularly helpful on weekends when activities were limited. We also found that the ward staff organically improvised our intervention by adding games into the activity box.

Future Plans

Given the positive results of this intervention, the activity box has been adopted by wards in Outram Community Hospital.

17. Empowering Esthers in the Community Hospital – Patient Goal Card

Team members

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Sponsor

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Facilitator

Dr Luke Low Sher Guan

Background

Esthers (patients) in Sengkang Community Hospital (SKCH) are admitted for rehabilitation, sub-acute care or palliative care. To determine "What matters most" to our Esthers, several interviews were conducted.

Problems Identified

Our Esthers responses revolved around a common theme, being independent when they return home matters most to them. However, as we explored further, the definition of "being independent" varied from patient to patient.

Care team assigned health goals may not be meaningful to Esthers if it is not aligned to Esthers personal health goals. Thus, having a one-size-fits-all or universal program that caters to every Esthers individual needs is challenging.

Objectives and Proposed Solution

Create a tool which:

- Can be administered to cover a range of goals
- Allows care team to better understand Esthers personal health goals
- Assist Esthers with goal-setting
- Is simple and effective to be used by Esthers or care team

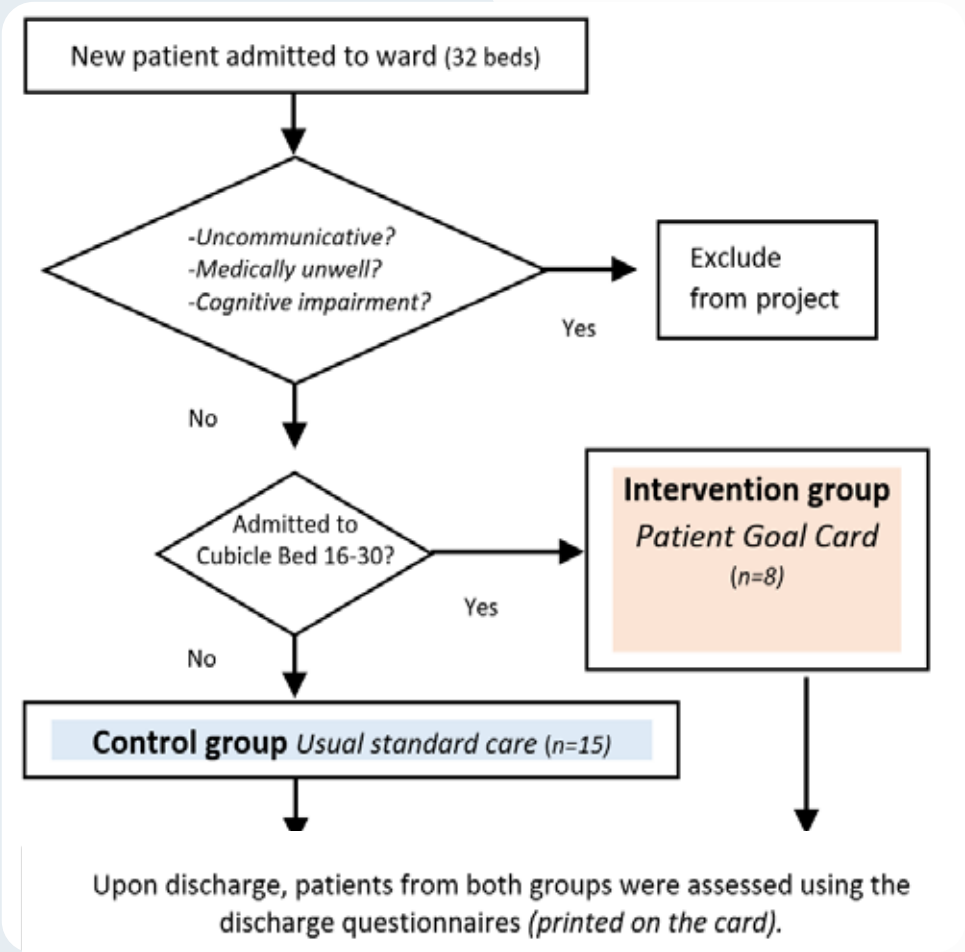
We aim to implement the Patient Goal Card to assist patients with meaningful personal goal setting and align our multidisciplinary team's efforts to help patient achieve their personal health goals.

Our Patient Goal Card would incorporate the Goal Attainment Scaling (GAS). GAS is an individualised measure in which assessment areas and scale items are selected based on the specific issues of concern for a particular patient.

Our Esthers defined "being independent" as:

- *To be able to walk again (ambulation goals)*
- *To be able to enjoy my hobby (functional goals)*
- *To take care of my health (self-care goals)*

Project workflow



Patient Goal Card

PATIENT GOAL CARD

Bed number: _____
Admission date: ___/___/____
Patient agrees to place patient goals at bedside? ☐ Yes ☐ No

Patient Stated Goal	Details	Baseline	At outcome: Was the goal achieved?		
			Yes	☐ Much better	+2
				☐ A little better	+1
				☐ As expected	0
			No	☐ Partially achieved	-1
				☐ Same as baseline	-2

Discharge date: ___/___/____

Questions to ask upon discharge	Strongly Agree	Agree	Disagree	Strongly Disagree
Q1: My goals were discussed during my stay in SKCH	☐	☐	☐	☐
Q2: The goals set were meaningful to me	☐	☐	☐	☐
Q3: The activities/therapies were effective in helping me achieve my goal	☐	☐	☐	☐
Q4: I have achieved my goal	☐	☐	☐	☐

Please return this Card to the "Project ESTHER" drawer at the ward 70 PSA counter after patient is discharged. Thank you.

Placing the Patient Goal Cards inside the nursing counter providers the care team with an overview of all patients' goals for a particular cubicle.
If the patient consents, their goal will also be written at their bedside.

Results

Prior to discharge from the community hospital, patients from both the baseline and intervention group were assessed using questionnaires printed at the bottom of the Patient Goal Card.

The percentage of patients who agreed that their Health goals were discussed during their stay in the community hospital was noticeably higher in the intervention group. (87.5% vs 13.4%). The percentage of patients who find that the goals set were meaningful to them were also higher in intervention group.

All patients (100%) in the intervention group achieved their goals. In contrast, only half (53.3%) of patients in the baseline group achieved their goals at the end of their stay in the community hospital.

Conclusion

The Patient Goal Card is an effective instrument for the care team to set goals and deliver personalised care with patients.

This pilot project shows that Patient Goal Card is a feasible tool to empower patients through meaningful personal goal setting and helps align the care team's efforts to assist patient achieve their personal health goals.

Future Plans

- To scale up this project in other wards in SKCH.
- To enhance the Patient Goal Card to involve and empower family members.
- The total number of Esthers achieving their goals since the start of this project will be updated weekly/monthly in the ward notice board to keep the care team motivated.

ESTHER Projects 2019-2020

Living in the Community

18. Giving OTAGO a GO

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Background

Falls are a major public health problem because they are common in people aged 65 and older. Falls among the elderly are the leading cause of injury in this age group. Falls can have serious consequences such as trauma, pain, impaired function, loss of confidence in carrying out everyday activities, loss of independence and autonomy, and even death.

Around one-third of generally healthy people aged 65 and older will have at least one fall each year, and a key concern is that the rate of falls and severity of the resulting complications increase dramatically with age. The majority of falls occur because of multiple interacting factors, but leg muscle weakness and impaired balance contribute to most falls. The economic costs of falls increase with fall frequency and falls are an independent predictor for admission to long-term care. Therefore, healthcare cost savings for both acute and long-term care can be expected if falls are reduced.

Many Esthers (residents from Kreta Ayer SAC – Jalan Kukoh) indicated that they are afraid to fall. Majority of the Esthers shared that they wish to have a trained healthcare professional conducting their daily morning exercise. These Esthers are aged 60 years old and majority of them are either staying alone in (i) a rental flat or (ii) sharing a rental unit with a flat mate.

Kreta Ayer SAC – Jalan Kukoh has been conducting regular morning exercise sessions since their establishment. Their regular morning exercise sessions consist of Qigong, Tai Chi and Aerobics. These sessions are normally conducted by the Centre Manager and assigned staffs for the day.

These Esthers wish to improve their strength as a prevention from falling and therefore gaining their confidence to ambulate freely in the community – the team generated ideas to life.

Proposed solutions

The structure physiotherapy exercise programme - OTAGO is an evidenced-based program specially designed to prevent falls. It consists of a set of leg muscle strengthening and balance retraining exercises progressing in difficulty, and a walking plan. The exercises increase in difficulty during a series of sessions. A group-based OTAGO compared with the original home exercise program showed that group training was more effective in improving functional balance, muscle strength and physical health. Overall the exercise programme was effective in reducing both the number of falls and the number of injuries resulting from falls by 35%. It was equally effective in men and women.

Esthers are expected to exercise three times a week and go for a walk at least twice a week. As most Esthers are active members in the SAC and has been attending daily morning exercise sessions, implementing the physiotherapy OTAGO program in the SAC was taken as a positive achievement.

The team conducts 3 outdoor sessions weekly (Monday, Tuesday and Friday). The exercises take about 30 minutes to complete. Two champions were identified among the Esthers to assist in conducting the session.

Research Aim

Reduce the fear of falling by conducting physiotherapy OTAGO exercise for Esther(s) with CFS 3-4 within the duration of 8 weeks.

Methodology

A survey questionnaire with 43 Esthers was conducted in Kreta Ayer SAC – Jalan Kukoh to explore Esthers concerns and willingness to perform a new set of exercise regime.

With collaborative efforts from SGH physiotherapist, a total of three community nurses, two Centre managers and one program executive were given training by OTAGO-trained physiotherapist from SGH. A full set of handout was created to guide the team and healthcare professionals as a form of reference. ESTHER Cafes were subsequently conducted for the staff members from Kreta Ayer SAC – Jalan Kukoh to identify areas of concern and refine the work processes to ensure sustainability of the implementation.

Esther's wish list

- To walk confidently in the community without having the fear of falling
- To better improve their gait strength
- To have a professional healthcare leading the morning exercise sessions

Learning Points

Capability	Centre Managers were willing to try out new implementation. However, they were not confident to carry out the session independently.
Adaptability	Sponsors were very willing to support the Coaches and able to accommodate to the hours needed in order to meet the goal of this project.
Knowledge	Trained physiotherapists were very willing to share and assist the Coaches, and impart their knowledge in other for the team to be able to carry out the implementation successfully.
Flexibility	Coaches were willing to try out and work around Esthers needs/ goal.
Sustainability	Getting a CHAMPION among the Esthers was a challenge as they showed resistance and little confidence. We managed to identify CHAMPIONS and they were able to oversee other Esthers.
Others: Logistics	Esthers wish was to have the exercise done outdoor. Coaches had difficulty with carrying out the chairs every session as there was not much assistance rendered in the beginning. After a few sessions, Esthers and Centre Manager willingly assisted in the setup at the outdoor area.

Future Plans

- ESTHER Project Escalation to other SACs
- To train more community nurses to carry out individually structured physiotherapy exercise programs

Acknowledgement

ESTHER Network Singapore recognises the partnership and contributions of the following community and healthcare institutions, the ESTHER Network Taskforce and Coach Trainers in promoting and co-creating a person-centric ecosystem and approach to provide better care for our clients, patients and residents in the larger community.

Our Partners

Agency for Integrated Care
ABLE – Abilities Beyond Limitations and Expectations
Assisi Hospice
AWWA
Active Gobal Senior Care Centre
Bright Vision Hospital
Care Corner Seniors Services Ltd
Changi General Hospital
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Institute of Advance Nursing
Kandang Kerbau Hospital
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Sunlove Senior Activity Centre
St Luke's ElderCare Ltd
Tan Tock Seng Hospital
The Salvation Army Peacehaven Nursing Home
Thye Hua Kwan Moral Charities
Tsao Foundation
Woodlands Health Campus

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