Improving Standards and Quality in Palliative Care: Engaging the Professionals

Dr Angel Lee

Senior Consultant
Director of Palliative Care
St Andrew’s Community Hospital

Chairperson
Singapore Hospice Council
The First Prototype

“I didn’t set out to change the world; I set out to do something about pain.”

Cicely Saunders
(1918 – 2014)
QI tradition in Palliative Care

Concept of “Total Pain”

“I realized that we needed not only better pain control but better overall care. People needed the space to be themselves. I coined the term ‘total pain,’ from my understanding that dying people have physical, spiritual, psychological, and social pain that must be treated. I have been working on that ever since.”

- Dame Cicely Saunders
Level of Palliative Care Development (2012)
Twin pillars of organizational change

PROCESS

HUMAN
David Clark’s comments

On Dame Cicely Saunders:

“...A dynamic, highly effective leader.

Her legendary determination and vision, her warmth and enthusiasm, confident humility, sense of humour, curiosity and attention to detail shout from every page (of letter)...”
Engaging the professionals

Is there hope if you are not like “that”?  
The experience from 3 different settings...
Project Omega $\Omega$

“Where does one start?”
Before

The Illusive Ideal

- Correct Medical Treatment
- Symptoms
- Gaps
- Assistance as needed to live fully
- Customize
- Surprise
- Family Role

Frustration

Living Well at the End of Life

Adapting Health Care to Serious Chronic Illness in Old Age
Joanne Lynn, David M. Adamson

Hospital Staff
Palliative Care Service
Patients and Caregivers
# Initial Steps

## EOL Taskforce
- Dr Angel Lee (Chair)
- Dr Wu Huei Yaw
- Dr Tai Hwei Yee
- Dr Chin Jing Jih
- Dr Jackie Tan
- Dr Benjamin Ho
- Ms Susan Chan
- Dr Ho Choon Kiat
- Dr Daniel Kwek
- Mrs Lee Lay Beng
- Ms Lee Leng Noey

## Analysis

### #1 COMMUNICATION

![Bar chart: What ails EOL care?](chart.png)

Main Concerns:
- Communication
- Missed /
  delayed intakes
- Patient / family
  non-cooperation
- Inadequate
  follow-up
- Fear of
  revealing facts
- Incorrect
  diagnosis
- Unable to
  contact
- Inadequate
  skill
- Inadequate
  management
- No support

### #2 TRAINING

## Interventions

- Communication Courses
- “Heartware” Talks
- EOL care training
- Checklists
- Bereavement Programme
- Policies
“Would you be surprised if your patient died within the next 6 months?”

Care Processes
Goals and Extent of Care Conversations
Pre-emptive prescribing
Psychosocial/Spiritual Needs Assessment
Bereavement Risk Assessment
etc
Initial Results

Adoption Rate

8%

Care Processes
Solution

Establishing the Anchors (Nodal Points)

DIL → “DNR” → Discharge

Death → Bereavement

Task

- Discuss Goals of Care
- Focus on EOL symptoms (anticipatory prescribing)
- Identify Psychosocial needs
- Caregiver Training & Education
- Risk Identification
- Caregiver Training & Education

Process

‘EOL BUNDLE’
Handling Grief and Loss

(a) Provide information (issuance of pamphlet) on "Dealing with Grief and Loss"

(b) Notify MSW if bereavement support is required

10 Contact Organ Transplant Coordinator
“Heartware Talks”
Roadshows
Departmental Briefing
A Community Service of St. Andrew's Mission Hospital

Movie screening

Exhibition/Quiz

Communication Cue cards
Results (1)

Adoption Rate

92%

Care Processes
Results (2)

Nursing Perceptions

Nursing Confidence

“We have good processes to care for patients at the end of life.”

“I feel confident caring for patients near the end of life.”
Results (3)

Patient and Caregiver Assessment

Bereaved Family Satisfaction Survey

<table>
<thead>
<tr>
<th>How well did those who care (scale of 0 – 10)</th>
<th>Pre (N=71)</th>
<th>Post (N=71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMUNICATE with you about illness and likely outcomes</td>
<td>5.8</td>
<td>6.3</td>
</tr>
<tr>
<td>Make sure SYMPTOMS were controlled to a degree that was acceptable</td>
<td>6.0</td>
<td>6.3</td>
</tr>
<tr>
<td>Provide EMOTIONAL support for patient and family</td>
<td>3.5</td>
<td>4.7*</td>
</tr>
<tr>
<td>Do in terms of OVERALL CARE</td>
<td>6.3</td>
<td>6.8</td>
</tr>
</tbody>
</table>
Today

• Gone upstream ... not just DIL
• Discussion of Extent of Care
  • Widely accepted in many hospitals (though can still be improved upon !)
• Acceptance of importance of EOL care
  • Dedicated single rooms for those reaching EOL
  • “Terminal discharges” accepted
  • Better coordination with home hospice teams for discharged patients
  • Greater appreciation of importance of identifying needs and good communications
ENGAGING THE PROFESSIONALS

COMMUNICATION

Pilot group
- Implement and evaluate pilot
- Disseminate change
- Anchor change; create culture shift

Organization

Leader
- Assess readiness for change
- Establish a sense of urgency
- Assemble steering team

Steering team
- Develop implementation plan

Feedback

ST. ANDREW’S COMMUNITY HOSPITAL
(A Community Service of St. Andrew’s Mission Hospital)
Strengthening the Foundation... a Brick at a Time

When the odds are overwhelming
Background

2009
40 bedded in-patient hospice

• Rising demand – call to increase capacity
• Resource limitation – concerns of viability
• Restrictive admission guidelines
Focus Group Discussion
Drivers of Family/Patient Experience

- **1° Drivers**
  - Discharge Planning / Engaging with Dignity Projects
    - Project Pallium
    - Kaizen-TTSH
  - Referral / Admission
    - In-patient Care Experience
    - PCOC Caregiver Experience Survey
    - Post Bereavement Mortality Follow-back Survey
    - Patient Safety Survey
    - Improvement Family / Patient Experience
  - Discharge / Death / Bereavement Experience
  - Clinical Staff Experience
    - $\$

- **2° Drivers**
  - Information
    - Wait Time
  - Access
    - Increase Skills
    - Chart Review
  - Symptom Mx
    - PCOC
    - % covered
  - Communication
    - PCOC
  - ACP
  - Volunteers
  - Psychosocial / Spiritual Care
  - NH / ILTC Options
    - Home Care
  - Equipment / Stores / Medication
    - Start Home Care
  - Safety
    - Falls / Pressure Sores / Outbreaks (MOH Indicators)
  - Staffing
    - Admin Support / IT Support
    - Training / Development
  - Staffing / Skill Mix
    - RUG-ADL / PCOC
  - Funding / Fund raising
    - Review of Charging
  - **3° Drivers**
    - IT Referral / Fax System
    - Communication Problems
    - Suicide Precaution Policy
    - Caregiver Support Programme
    - Medication / Surgical Kanban
    - "6s" Pharmacy / Kanban
    - HR Review
    - Incidents Reports
    - Performance Appraisal
    - ESTAB
Approach

• Prioritization
  • Feasibility
  • Importance
  • Urgency

• Planning
• Policies/Processes
**RUG-ADL Computerised Dashboard**

**Timeline**

- **MRO System**
  - 1stQ 2010
  - Jenny Discharge Planning Start by Jan

- **Serene Training System**
  - On-going
  - Wai Chee /Joyce Referral System (Fax & Electronic)
  - Oct 27 Trial

- **Angel/Jenny ACP Home Care**
  - End Jun
  - Wah Ying/Sylvia/Caroline PCOC Satisfaction Survey Nov
  - Der Tuen & staff Med/Surg Stores, Pharmacy Store Nov – Par Value Feb – GS Completed

- **Susan/Angel Suicide Prevention**
  - End Mar
  - Der Tuen/Sylvia/Maureen Staffing On-going

- **Jenny Suicide Precaution**
  - End Mar
  - Wah Ying/Sylvia/Narin Blood Transfusion Capability End Nov

- **Maureen Caregiver Support Programme**
  - Jan
  - Maureen Pastoral Care End Mar

**Home Care**
- * Nov - Documentation
- * Equipment
- * Budget
- Dec - Numbers
- * Call System
- Nursing Doctors

**Home Care - Innovation**
- IT / Technology → Skype
  - - GPs ← Hotline? Email? Focus Group?

**Home Care - Innovation**
- IT / Technology → Skype
  - - GPs ← Hotline? Email? Focus Group?

**COC / Form Mx**
- * By Nov 2010 (2nd week) – Trial Satisfaction Survey
- By Dec 2010 - Trial New Forms
  - - Forms Reorganised (WIP, Published)
### Planning

**Example - Project Pallium**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/24/11</td>
<td>L3 – New Clinical Office</td>
</tr>
<tr>
<td></td>
<td>L3 – T&amp;R Office</td>
</tr>
<tr>
<td></td>
<td>L3 – New Resource Centre</td>
</tr>
<tr>
<td></td>
<td>L2 – Old Clinical Office</td>
</tr>
<tr>
<td></td>
<td>Toilet next to Old Clinical Office</td>
</tr>
<tr>
<td></td>
<td>Old Resource Centre to new MPR</td>
</tr>
<tr>
<td></td>
<td>Staff pantry -&gt; New Quiet Room</td>
</tr>
<tr>
<td></td>
<td>L2 – New Staff Pantry available</td>
</tr>
<tr>
<td></td>
<td>L2 – New Pharmacy</td>
</tr>
<tr>
<td></td>
<td>L1 – New Equipment Room</td>
</tr>
<tr>
<td></td>
<td>L1 – Existing linen and crockery room</td>
</tr>
<tr>
<td></td>
<td>L3 Clin Off - Clin (non-T&amp;R) Moving in</td>
</tr>
<tr>
<td></td>
<td>L3 T&amp;R Office - T&amp;R team Packing/Moving</td>
</tr>
<tr>
<td></td>
<td>L3 RR - Moving Books/equipment in</td>
</tr>
<tr>
<td>4/5/11</td>
<td>L2 - Old Clin Off -Clin (non-T&amp;R) Packing</td>
</tr>
<tr>
<td></td>
<td>L2-Only Handicap Toilet available</td>
</tr>
<tr>
<td></td>
<td>L2-old RR packing</td>
</tr>
<tr>
<td>5/15/11</td>
<td></td>
</tr>
<tr>
<td>6/24/11</td>
<td></td>
</tr>
</tbody>
</table>
Planning

Methodology
- Focus group discussion
- PDSA cycle
Policy and Processes

Example – Project Pallium

• Blood Transfusion Policies and Guidelines
• Training Policies and Guidelines
• Approval for new Staffing Establishment
• Career Progression for Nurses
• OJT on use of syringe drivers and care of infusion lines
It does not always go according to plan …
Results (1)

Increased Capacity
- 40 bedded
  - Admissions from home 7.7%
- 50 bedded
  - (20% increase)
  - Admissions from home 26.9%
  - (250% increase)

Increased Capability
- Oxygen via cylinders
- No emergency power
- Estab and skill-mix only for chronic care
- Infrastructure changes
- Equipment upgrading
- Estab and skill-mix reviewed for more sub-acute/acute care
Results (2)
Today

- Quality Improvement and Assurance culture
- Regular caregiver and bereaved family satisfaction surveys
- Symptom assessment and review with IT support
- Low staff turnover
National Guidelines for Palliative Care

Getting Everyone Involved
Goal 7 - National Strategy for Palliative care

RECOMMENDATIONS

1) Establish local evidence-based standards of care and common outcome indicators.

2) Establish a minimum dataset for collection of quality and service indicators/data to evaluate quality of care and for service planning.

3) Establish accreditation system for palliative care service providers.

JAN 2012
Implementation Process

DRAFTING

JUNE 2014

MANDATE FROM MOH

MANDATE FROM MOH

OCT 2014

STAKEHOLDER ENGAGEMENT

NOV – DEC 2014

Class C
- Main work is in caring for patients with life-limiting illnesses
- Pall Med Departments in RHs
- Hospitals
- Home Hospice Teams

Class B
- Routinely care for a substantive number of patients with life-limiting illness
- ICU
- Chronic Disease Programmes
- Specialist Cancer Centres
- Nursing Homes

Class A
- Substantive work is not in caring for patients with life-limiting illnesses
- Family practitioners
- Community hospitals
- General medical units
CONSULTATION WITH HEALTHCARE WORKERS

Modified RAND Appropriateness and Feasibility Rating of the “Measurables”
Implementation Process

APPOINTMENT OF STEERING COMMITTEE & WORK GROUPS

JAN 2015

JUL 2015
Implementation Process

15 Organizations Invited

11 Organizations Accepted

4 Organizations Declined
Self Assessment Snapshot:

Reflect and rate where your service is at now

Led by implementation representative

MDT Involvement

Feedback

Audit

Overall Improvement Priority

20 casenotes

Review all indicator ratings for the guidelines

Discuss overall priority of the guideline based on ratings and discussions

Rate the guidelines
Guideline 4: Holistic Assessment and On-going Care Planning

Holistic assessment and on-going care planning are implemented in an interdisciplinary manner to meet the changing needs and wishes of patients, caregivers and families.

Rationale: Patients approaching the end of life should receive an initial holistic assessment that covers their physical, psychological, social, spiritual and cultural needs and preferences. Identified needs and preferences can then be supported by members of the interdisciplinary team. Subsequent on-going assessment and care planning should be proactive and responsive to patients’ changing needs.

<table>
<thead>
<tr>
<th>Quality measures</th>
<th>Element Rating</th>
<th>Data Source (To specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 All patients identified as approaching the end of life undergo documented holistic assessments that cover the patient and family’s physical, psychological, social, spiritual and cultural needs and preferences.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.1.1. Percentage (%) of patients screened for pain during first clinical encounter/initial assessment. (Case Notes Audit)

**Numerator:** Number of patients screened for pain during first clinical encounter/initial assessment.

**Denominator:** Total number of patients seen for first clinical encounter/initial assessment.

4.1.2. Percentage (%) of patients screened for dyspnoea, nausea, vomiting, confusion, depression, anxiety and bowel problems during first clinical encounter/initial assessment. (Case Notes Audit)

**Numerator:** Number of patients screened for dyspnoea, nausea, vomiting, confusion, depression, anxiety and bowel problems during first clinical encounter/initial assessment.

**Denominator:** Total number of patients seen for first clinical encounter/initial assessment.

4.1.3. Percentage (%) of patients with documented psychological, social, spiritual and cultural screening by third clinical encounter. (Case Notes Audit)

**Numerator:** Number of patients with documented psychological, social, spiritual and cultural screening.

**Denominator:** Total number of patients seen by third clinical encounter.

---

Courtesy of Dr Patricia Neo
# Key Improvement Areas identified in the Self-Assessment snapshot

<table>
<thead>
<tr>
<th>What Guideline/s is this strategy relevant to?</th>
<th>What is the key improvement area?</th>
<th>What is the Priority for this improvement?</th>
<th>Proposed Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. 5 and 8 or just 5</td>
<td><strong>What is your service planning to do to improve care?</strong></td>
<td>High, medium, or low</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>• To develop response guidelines for palliative care emergencies</td>
<td>Medium</td>
<td></td>
</tr>
<tr>
<td>4.5.2</td>
<td>• To develop suicide protocol</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td>• To include psychosocial screening into existing assessment form</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>
| 7                                             | • To develop care of dying pathway  
• To include secretions/death rattle into existing assessment form | High |                  |
| 7.3.5, 8.1.2, 8.1, 9.1                        | • To develop caregiver survey | Low |                  |
### Guideline 4: Holistic Assessment and On-going Care Planning (cont’d)

<table>
<thead>
<tr>
<th>Percentage (%) of patients with improvement in moderate or severe pain within 24 hours or by next visit. Moderate or severe pain is defined as pain score of 4 and above. (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients assessed for pain and/or physical symptoms (every visit or at least every three days). (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients and/or families assessed for psychosocial/spiritual needs (every visit or at least once a week). (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients assessed for suicide in patients who are assessed to be depressed or at risk of self-harm. (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>No data</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing data</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients assessed by clinicians to be at high risk of suicide who have been referred to and assessed within 24 hours by an MSW or Psychiatrist or admitted to an inpatient facility. (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>No data</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit using the amended measure</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Courtesy of Dr Patricia Neo**
### Guideline 7: Care in the Last Days of Life (cont’d)

<table>
<thead>
<tr>
<th>Percentage (%) of patients whose pain at the end of life is controlled at the last clinical encounter. Control is defined as mild or nil pain. (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients whose dyspnoea at the end of life is controlled at the last clinical encounter. Control is defined as mild or nil dyspnoea. (Case Notes Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients for whom anticipatory prescribing is done. (Medication Chart Audit)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage (%) of patients whose bereaved families/caregivers report that physical symptoms were well-controlled in the last days of life. (Caregiver Survey)</th>
<th>Never (0%)</th>
<th>Rarely (&lt;25%)</th>
<th>Sometimes (25%-75%)</th>
<th>Often (&gt;75%)</th>
<th>Always (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

Courtesy of Dr Patricia Neo
## National Level Improvement (example)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage (%) of patients whose families are given information or directed to resources regarding the signs and symptoms of imminent death. (Case Notes Audit)</td>
<td>❖ To develop and further enhance education materials from SHC</td>
</tr>
<tr>
<td>Percentage (%) of patients and/or caregivers who are given information on the safe use of opioids upon commencement of opioids by way of written or verbal communication. (Case Notes Audit)</td>
<td></td>
</tr>
</tbody>
</table>

Courtesy of Dr Patricia Neo
## National Level Improvement (example)

<table>
<thead>
<tr>
<th>Measures</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage (%) of patients screened for pain during first clinical encounter/initial assessment. (Case Notes Audit)</td>
<td>To develop IT platform to improve patient assessment and track outcomes</td>
</tr>
<tr>
<td>Percentage (%) of patients screened for dyspnoea, nausea, vomiting, confusion, depression, anxiety and bowel problems during first clinical encounter/initial assessment. (Case Notes Audit)</td>
<td></td>
</tr>
<tr>
<td>Percentage (%) of patients with documented psychological, social, spiritual and cultural screening by third clinical encounter. (Case Notes Audit)</td>
<td></td>
</tr>
<tr>
<td>Percentage (%) of patients with individualized documented care plans at the end of first clinical encounter/initial assessment. (Case Notes Audit)</td>
<td></td>
</tr>
</tbody>
</table>

*Courtesy of Dr Patricia Neo*
Next Phase

• Individual organizational changes
• National Collaborative Efforts
• National Minimum Data Set
Summary – Engaging the professionals

Training is not sufficient
Neither are more policies, checklists and forms
Thank you