Project Title

Project COMFORT – Supporting the Frail in the Community

Project Lead and Members

Project lead: Hong Liyue

Project members: Tan Li Feng, Jeremy Teng, Tan Poh Hoon, Myint Myint Than, Radin Nur Faridah Binte Ali, Nur Sa'idah Binti Jalani, Siti Raihana Binte Mohamed Sharriff, Heng Lee Ling, Tan Li Ping, Kelly Lai, Santhosh Kumar Seetharaman

Organisation(s) Involved

Alexandra Hospital, National University Health System

Healthcare Family Group(s) Involved in this Project

Medical, Nursing

Applicable Specialty or Discipline

Geriatric, Palliative Care

Project Period

Start date: Not Available

Completed date: Not Available

Aims

Project COMFORT is a collaboration between the geriatric and palliative care departments in Alexandra Hospital to support patients with advanced frailty and their caregivers in their own homes, with the goal of reducing the unnecessary hospital admissions and outpatient clinic visits, and providing holistic care that is aligned to with their goals of care.

Background

Patients with advanced frailty face a gradual but progressive and inevitable declining trajectory. During their prolonged course of decline, patients may be burdened with multiple admissions whilst maintaining asymptomatic between exacerbations. Whilst some of them have expressed their preference to be cared for at home, most are not confident in being cared for at home because of the lack of support services in the community for patients with advanced frailty.

Methods

See poster appended/below

Results

- Reduced hospital admissions within the past year from 2 (range 0 to 6) to 0 (range 0 to 10).
- Of the 62 patients, 25 (40.3%) patients had their ACP completed and 6 (9.7%) patients are still in the progress of completing their ACP
- Of the remaining 31 (50%) patients, 18 have demised before their ACP could be completed.
- Of the 25 patients who have completed their ACP, 10 have already demised, of which most of them (90%) had their ACP honoured.

Conclusion

See poster appended/below

Project Category

Care & Process Redesign, Value Based Care, Patient Satisfaction

Care Continuum, End-of-Life Care, Palliative Care

Keywords

Nurse-Led, Frailty, Healthy Ageing Programme, Hospital Admissions, Advance Care Planning

Name and Email of Project Contact Person(s)

Name: Dr Hong Liyue

Email: liyue_hong@nuhs.edu.sg

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NUHS National University Health System

Alexandra Hospital

BACKGROUND

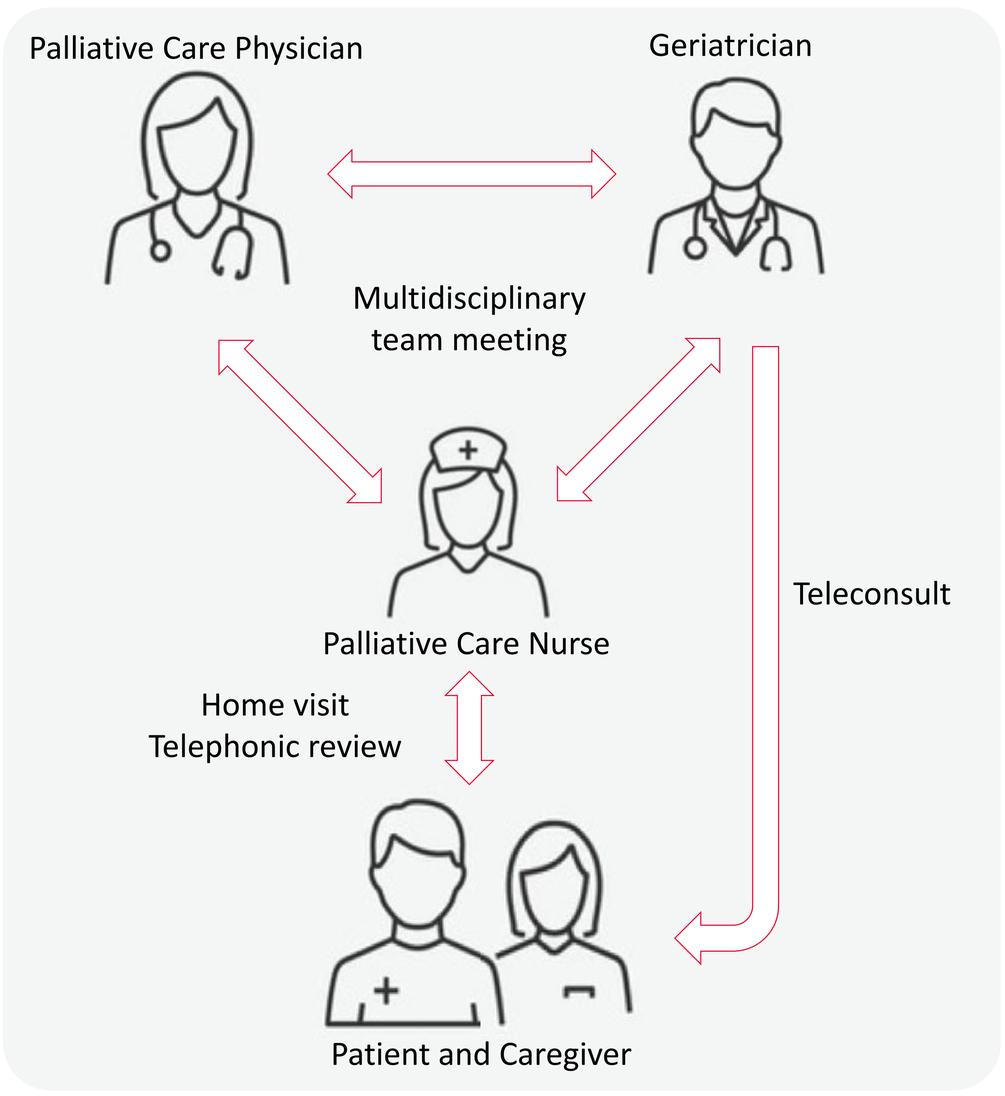
Patients with advanced frailty face a gradual but progressive and inevitable declining trajectory. During their prolonged course of decline, patients may be burdened with multiple admissions whilst maintaining asymptomatic between exacerbations. Whilst some of them have expressed their preference to be cared for at home, most are not confident in being cared for at home because of the lack of support services in the community for patients with advanced frailty.

PROJECT AIM

Project COMFORT is a collaboration between the geriatric and palliative care departments in Alexandra Hospital to support patients with advanced frailty and their caregivers in their own homes, with the goal of reducing the unnecessary hospital admissions and outpatient clinic visits, and providing holistic care that is aligned to with their goals of care

SOLUTION

The COMFORT team compromises mainly of palliative care nurses, supported by geriatricians and palliative care physicians. Patients are referred to the programme by the primary geriatricians. The intervention is mainly nurse-led.



SOLUTION

Intervention includes

- Converting appointments into teleconsultations and consolidation of care as appropriate
- Close communications between palliative care nurse and caregivers via home visits and telephonic reviews
  - Psychoemotional counselling
  - Education on advanced frailty
  - Medication reconciliation
  - ACP/ PPC
  - EOL care
  - Liaise with primary geriatrician
  - Transition to other existing community services as appropriate

Tier	Status	Activity description
L1	Stable with no symptoms	• 1-monthly telephonic/video review by nurse • 3 monthly video teleconsultation with primary geriatrician • Ad hoc home visits by nurse • Quarterly MDT
L2	Stable but some nursing or family concerns	• 2 weekly to 1-monthly telephonic/video review by nurse • 1 – 3 monthly video teleconsultation with primary geriatrician • Monthly home visits by nurse • Monthly MDT
L3	Recent admission or new symptoms	• Post discharge follow up and assessment by nurse • Weekly telephonic/video review by nurse • Frequency adjusted to needs • Video teleconsultation with primary geriatrician as necessary
L4	Actively dying/ symptom crisis	• Work closely with hospital palliative care team • Facilitate compassionate discharge after admission if appropriate • Transition to home hospice team if appropriate

OUTCOMES

- Reduced hospital admissions within the past year from 2 (range 0 to 6) to 0 (range 0 to 10)
- Of the 62 patients, 25 (40.3%) patients had their ACP completed and 6 (9.7%) patients are still in the progress of completing their ACP
  - Of the remaining 31 (50%) patients, 18 have demised before their ACP could be completed
  - Of the 25 patients who have completed their ACP, 10 have already demised, of which most of them (90%) had their ACP honoured

Lessons Learnt

- Important to speak to patients and caregivers to understand what are some of the gaps in our healthcare system and how they feel we can support them better in caring for their loved ones