Project Title

Project New Home: Transforming Nursing Home Care through a Person-centred Care Model

Project Lead and Members

Project Lead: Cheng Siok Khoon

Project Members: Alvina Tan, Sathish Kumar, Niki Goh, Dennis Tong, Crystal Wang, Lim Lay Beng

Organisation(s) Involved

Bright Hill Evergreen Nursing Home

Healthcare Family Group(s) Involved in this Project

Nursing

Applicable Specialty or Discipline

Nursing Home Care

Aim(s)

- To transform nursing home care by redesigning care delivery and processes
- To enable residents to use their remaining abilities, promote continuous activity engagement and socialisation to enhance their well-being through interdisciplinary collaboration approach and redesigned processes to optimise resources

Background

See poster appended/ below

Methods

See poster appended/ below

Results

See poster appended/ below

Lessons Learnt

See poster appended/ below

Conclusion

See poster appended/ below

Additional Information

- It is critical for community care organisations to have a model of care to guide and deliver its processes, practices and interventions.
- The needs of clients are changing, and community care organisations need to adapt to remain sustainable. True change will help us optimise our resources. It is practical and effective.
- The change allows BHEH to move away from the traditional medical approach to person-centred approach to address the holistic needs of older clients.

Project Category

Care & Process Redesign

Clinical Practice Improvement

Keywords

Nursing Home, Person-Centred Care

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Bright Hill Evergreen Home

Background:
With Singapore's rapidly aging population and its accompanying changing care needs, the traditional medicalised and dormitory-style nursing homes has evolved to person-centric design nursing homes characterised with smaller homelike and household units that aim to deliver care services that promote autonomy, privacy and dignity. However, the physical design and layout of segregated household units coupled with strained manpower within a floor pose potential care challenges such as limited line of vision that can hinder prompt responses to residents as well as limited socialisation.

Bright Hill Evergreen Home (BHEH), in anticipation of such operational challenges with the new building design and layout in the extension block, proactively developed a person-centred care model to transform nursing home care by redesigning care delivery and processes. This transformative care approach aims to enable residents to use their remaining abilities, promote continuous activity engagement and socialisation to enhance their well-being through interdisciplinary collaboration approach and redesigned processes to optimise resources.

The project started in September 2020 in anticipation of the new building extension that was targeted to complete in June 2021. The project phases included the following:
Phase 1: (Oct 2020 – June 2021) Design and development of the transformative care model, new staffing model and redesigned care processes that will optimise the workflow and resources in the new layout.
New Home started gradual operations from Jul 2021.
Phase 2: (Jan-Feb 2022) Current state assessment and analysis for 2 fully operational wards of 70 new residents with varied conditions including dementia, neurological and high care needs to identify key care issues and challenges.
Phase 3: (Feb-Jul 2022) Implementation and evaluation of care model including redesigned processes, job roles and care interventions.

With the help of a consulting team, a project team comprising management, clinical and operations personnel was set up to design and develop a BHEH model of care to articulate the transformative care delivery that will augment the new home design and layout. The consultants supported the project team to operationalise the care model and implement solutions to address the identified gaps and challenges to successful impact care delivery and outcomes.

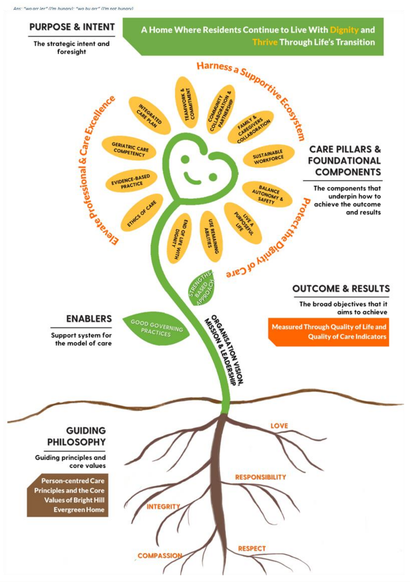
Analysis:
Baseline assessment of current state was conducted and the key issues identified are as follows:
1. Need to reduce the high number of call bells due to residents waiting time between care routine and dependence on staff for care activities.
2. Need to standardise and streamline care processes to optimise resources and minimise re-work.
3. Need to build geriatric care competencies to address holistic care needs.

Strategy:

Focus Area 1: Reduce Residents Waiting
- Provide more appropriate activities and encourage residents to engage in them.
- Promote and support residents to use their remaining abilities.

Focus Area 2: Streamline Care Processes to Optimise Resources
- Reduce the need for staff to re-work.
- Identify residents' needs to utilise resources effectively.
- Standardise care procedures.

Focus Area 3: Build Staff Competency
- Align staff to BHEH model of
- care and person-centred care principles
- and practices.
- Develop geriatric care
- competencies including medical,
- psychosocial and functional needs.



Results & Conclusion:
The implementation of the person-centred care (PCC) model was successful in the following outcomes:
i) increased in residents' functional abilities and well-being;
ii) improved productivity with reviewed processes reducing the number of call bells
iii) increased staff gerontology care competencies resulting in care efficiencies.

Focus Area 1: Reduce Resident Waiting

S/N	Area	Baseline	Post Implementation	Changes from Baseline
1.	**OUTCOME INDICATOR:** Number of activities[1] that residents are engaged in (A4 and A5)	88[2]	130	↑ 48% ← Exceeded desired outcomes
2.	Total number of unique residents participating in activities in A4	31 out of 34 residents (91%)	29 out of 32 residents (91%)	(=)
3.	Total number of unique residents participating in activities in A5	20 out of 37 residents (54%)	25 out of 37 residents (67%)	↑ 13%
4.	Number of residents that are given roles or assist in ward tasks (e.g. dry cups, fold plastic bags, fold and match laundry, mop floor) in A4	4	7	↑ 75%
5.	Number of residents that are given roles or assist in ward tasks (e.g. fold apron, push trolley, clear food) in A5	2	5	↑ 150%
6.	Variety of activities in A4	11	14	↑ 27%
7.	Variety of activities in A5	7	11	↑ 57%

Focus Area 2: Streamline Care Processes to Optimize Resources

S/N	Area	Baseline	Post Implementation	Changes from Baseline
1.	**OUTCOME INDICATOR:** Average number of call bells raised in A4[1]	121 PER DAY	71 PER DAY	↓ 41% ← Exceeded desired outcomes
2	Average number of call bells raised in A5	72 PER DAY	63 PER DAY	↓ 13%

Focus Area 3: Build Staff Competency

S/N	Area	Results
1.	**OUTCOME INDICATOR:** Average rating[1] on understanding of BHEH Model of Care	2.9 out of 3 ← Exceeded desired outcomes
2	Average rating on effectiveness of training (for 4 modules)	3.6 out of 4
3	Average rating on effectiveness of trainer (for 4 modules)	3.6 out of 4
4	Total number of new staff that attended Alignment Workshops	81
5	Total number of staff that attended Dementia Care Training	18
6	Total residents impacted through Dementia Care Training	15

What we learnt:
- The success starts with designing the model of care that represents BHEH.
- Staff need guidance and coaching to implement the changes.
- Organisations must believe that residents of nursing homes can improve with person centred interventions.

Our Sustainability Plans:
- Extending dementia training to more staff.
- Incorporating the dementia care management into the individual care planning.
- Building a dementia specialist team within BHEH.
- Sustain the dignity of care culture through continued model of care and dignity of care training to on-board new staff.