



Hua Mei Centre  
for Successful Ageing

*A Tsao Foundation Initiative*

A EVALUATION OF  
**A END-OF-LIFE PROGRAMME**  
EMBEDDED WITHIN A COMMUNITY  
**LONG TERM CARE MODEL**  
IN SINGAPORE



**PILOT STUDY of  
COMMUNITY END-OF-LIFE CARE  
for older non-cancer patients**









**1 October 2010 – 30 Sept 2012**



## Singapore ranks world No. 4 for life expectancy

IN A RECENT WHO RESEARCH PAPER ON LONGEVITY, SINGAPORE IS RANKED THE 4<sup>TH</sup> IN THE WORLD. AND BY 2020, 20% OF THE SINGAPOREAN POPULATION WILL BE AGED 65 AND ABOVE.

List by the World Health Organization (2011) [\[edit\]](#)

Overall rank <sup>[4]</sup> ↕	Country ↕	Overall life expectancy ↕	Male life expectancy ↕	Male rank ↕	Female life expectancy ↕	Female rank ↕
1	 Japan	83	79	12	89	1
1	 Switzerland	83	80	4	85	2
1	 San Marino	83	82	2	83	20
4	 Italy	82	80	4	85	2
4	 Singapore	82	80	4	85	2
4	 Iceland	82	81	3	84	9
4	 Andorra	82	79	12	85	2
4	 Australia	82	80	4	84	9

# HUA MEI MOBILE CLINIC

Since its inception in 1993, HMMC has been delivering

## **Team-Managed Primary Health Care**

to **homebound and frail** older persons at their home.

# GOAL

- To support the frail elder persons to live in their homes among family (until their deaths if dying at home were their wish)
- Provide accessible health care regardless of their mobility status
- To respect and honor their preferences
- To instill a sense of **peace and comfort** in the older person's lives

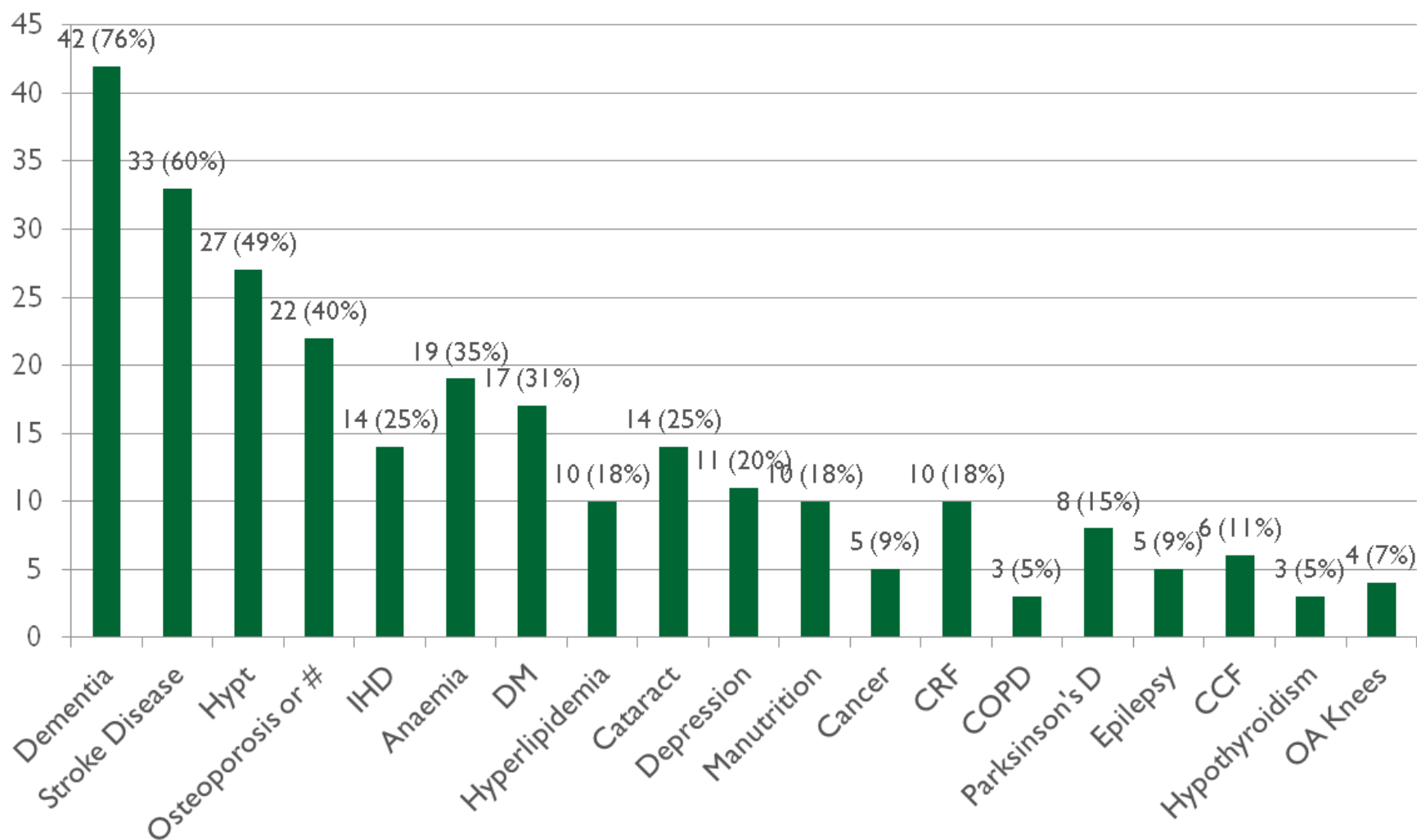
# HMMC'S TARGET POPULATION



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- Very frail, nursing home eligible older persons
- Elders with difficulties accessing community resources due to :-
  - a) Physical disabilities
  - b) Environment
  - c) Psychological factors
  - d) Financial difficulties
  - e) Social

# MEDICAL PROFILES OF OUR CLIENTS





# ASSIMILATING END OF LIFE CARE INTO HUA MEI MOBILE CLINIC SINCE OCTOBER 2009

## Components

1. End of Life Care Training for Team
2. Person-centred Care & Advance Care Planning for All Elders under our care.
3. Increased Resourcing based on Estimated Prognosis

# SNAPSHOT OF OUR PRESENT COHORT

No. of clients served from 1 Oct 2012 till 16 Sep 2013 = 143

No of death occurs = 33

No. of discharges = 11

# CASE PRESENTATION

## Mdm Tan

- Home Maker
- Mother of 3 daughters and 1 son
- Diagnosed with:-
  - Stroke,
  - Vascular Dementia,
  - Hypertension,
  - Diabetes Milletus.
- After a fall she became Wheelchair-bound.



Family Caregivers

A photograph showing a close-up of several hands of different ages and skin tones, some resting on top of others, symbolizing care and support. A red curved arrow points from this image towards the 'Cluttered Home Environment' image.

Cluttered Home Environment

Two photographs showing a very cluttered home environment. The top photo shows a room filled with cardboard boxes, papers, and other household items. The bottom photo shows a similar scene with a person sitting amidst the clutter. A red arrow points from the cluttered home towards the 'Admission into HMMC' text.

**Admission  
into HMMC  
8th Sept 2008.**

# Patient Centred Care

## Other Intangibles

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HMMC Care Model

Initial Goal of Care was Maintenance

Main issue presented then include:

1) Caregiver Stress

-Mdm Tan's sleep-wake reversal

-Knowledge deficit

- Pneumonia
- Mdm Tan refused hospitalization
- Family not ready for Mdm Tan's possible passing on



**CRISIS I** – 15<sup>th</sup> Nov 2011



Reverted back to Maintenance Care



**CRISIS 2 – 30/7/13**

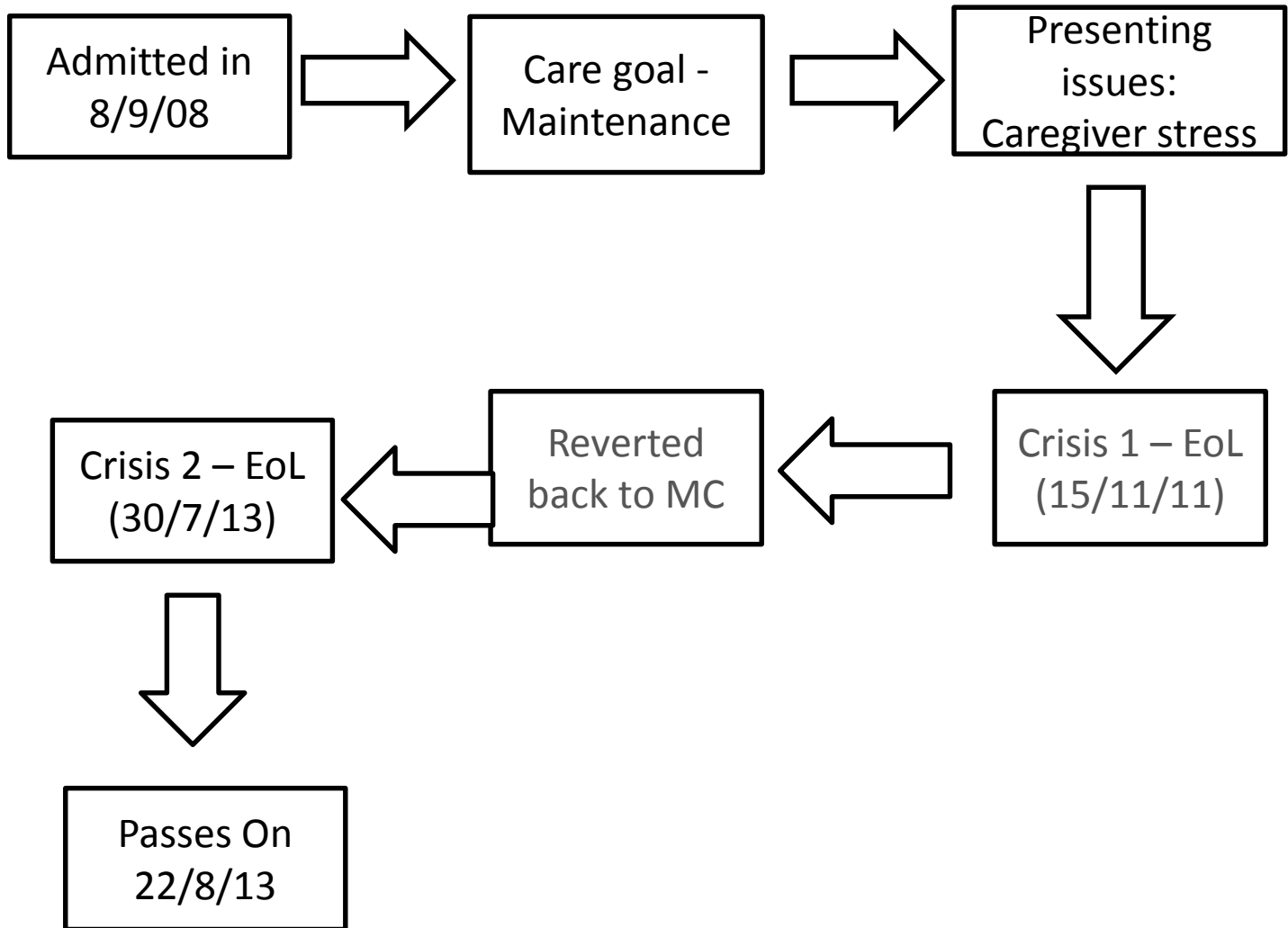


24 Hrs Symptoms Management



**Eventual Peaceful Passing  
22 Aug 2013**

# Summary of Mdm Tan's Journey with us



# CHALLENGES

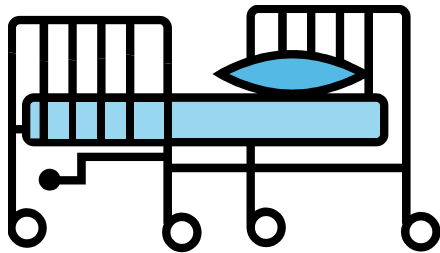
- Prognostication (3 illness trajectories)
  - a. Short period of evidence decline
  - b. Chronic illness with intermittent exacerbations and sudden dying*
  - c. Slow dwindling**



# CASE LOAD AND CAPACITY OF HMMC

1 Oct 10 – 30 Sep 12

– Total number of patients served = 160



Patients never been  
served on EoL  
Programme = 105



Patients served on  
EoL Programme = 55

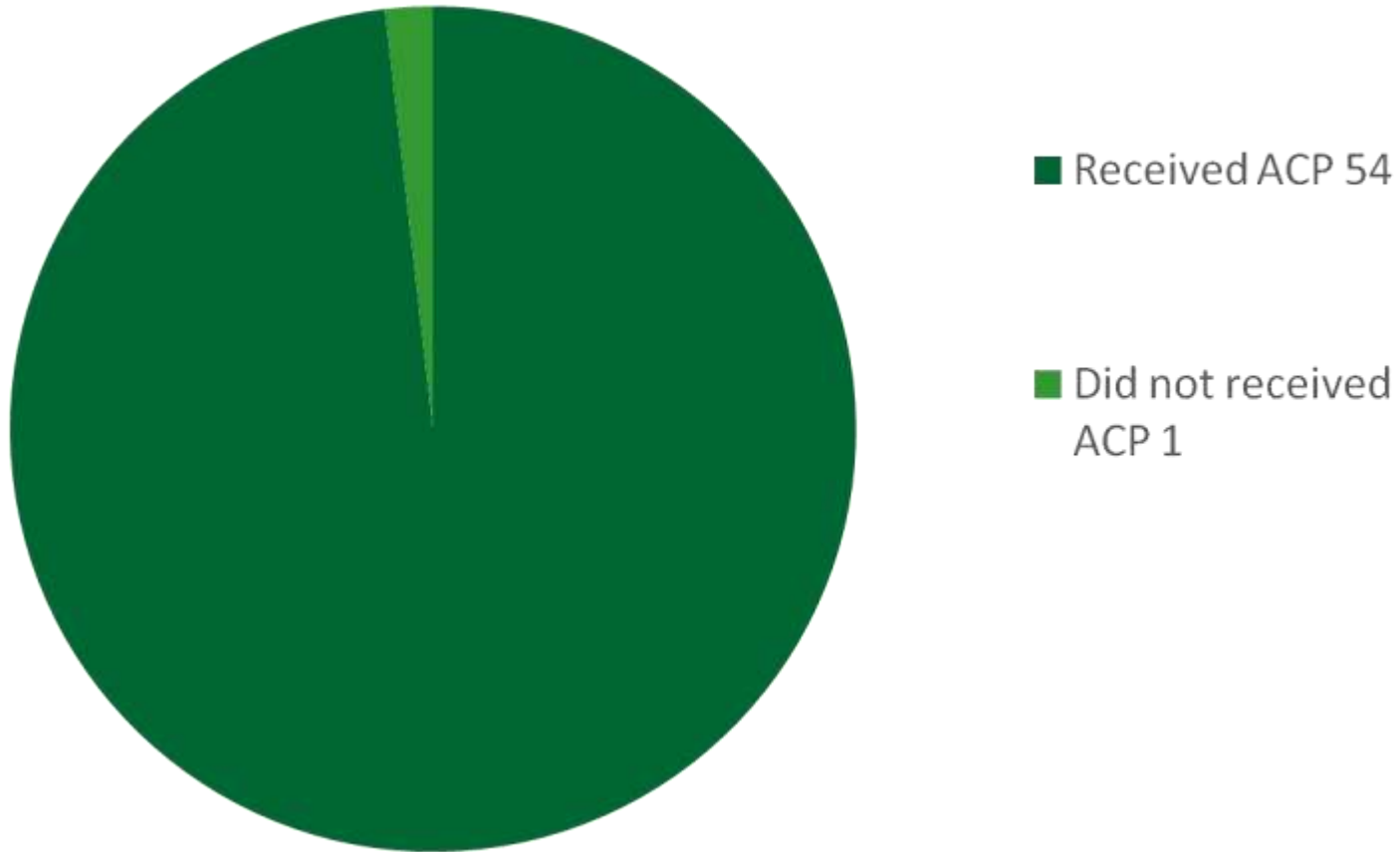
# INTERVENTIONS (EOL PATIENTS)

- Advanced care plan discussion
- Care-giver support
- Spiritual care

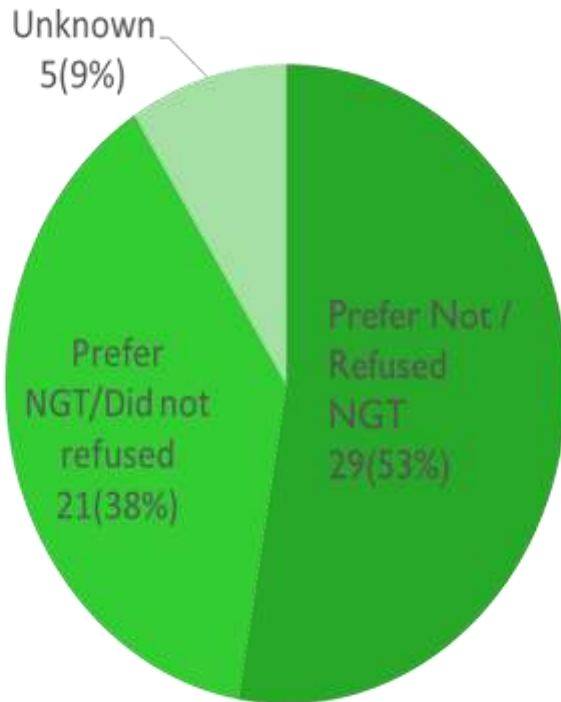
# AVERAGE PROGNOSIS (DAYS)

After admission into EoL Care Programme, death occurred after 173 days (5 months 22 days) on average.

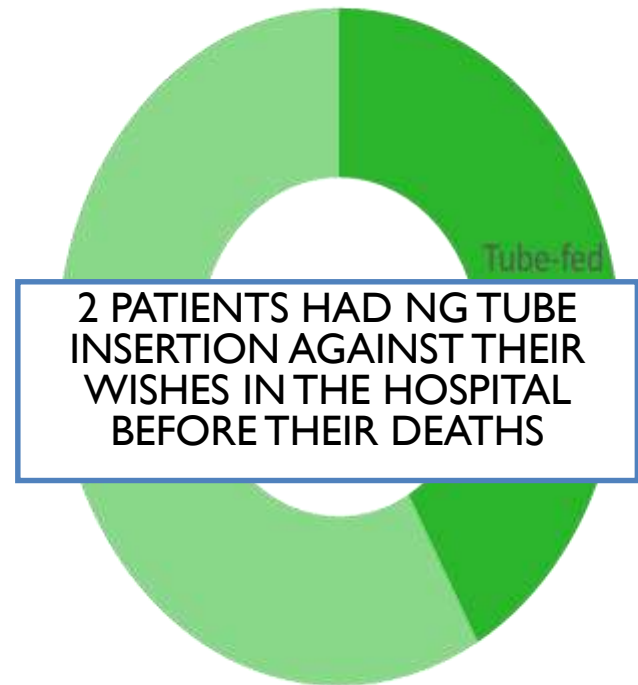
# ADVANCE CARE PLANNING



# TUBE FEEDING (ACP)

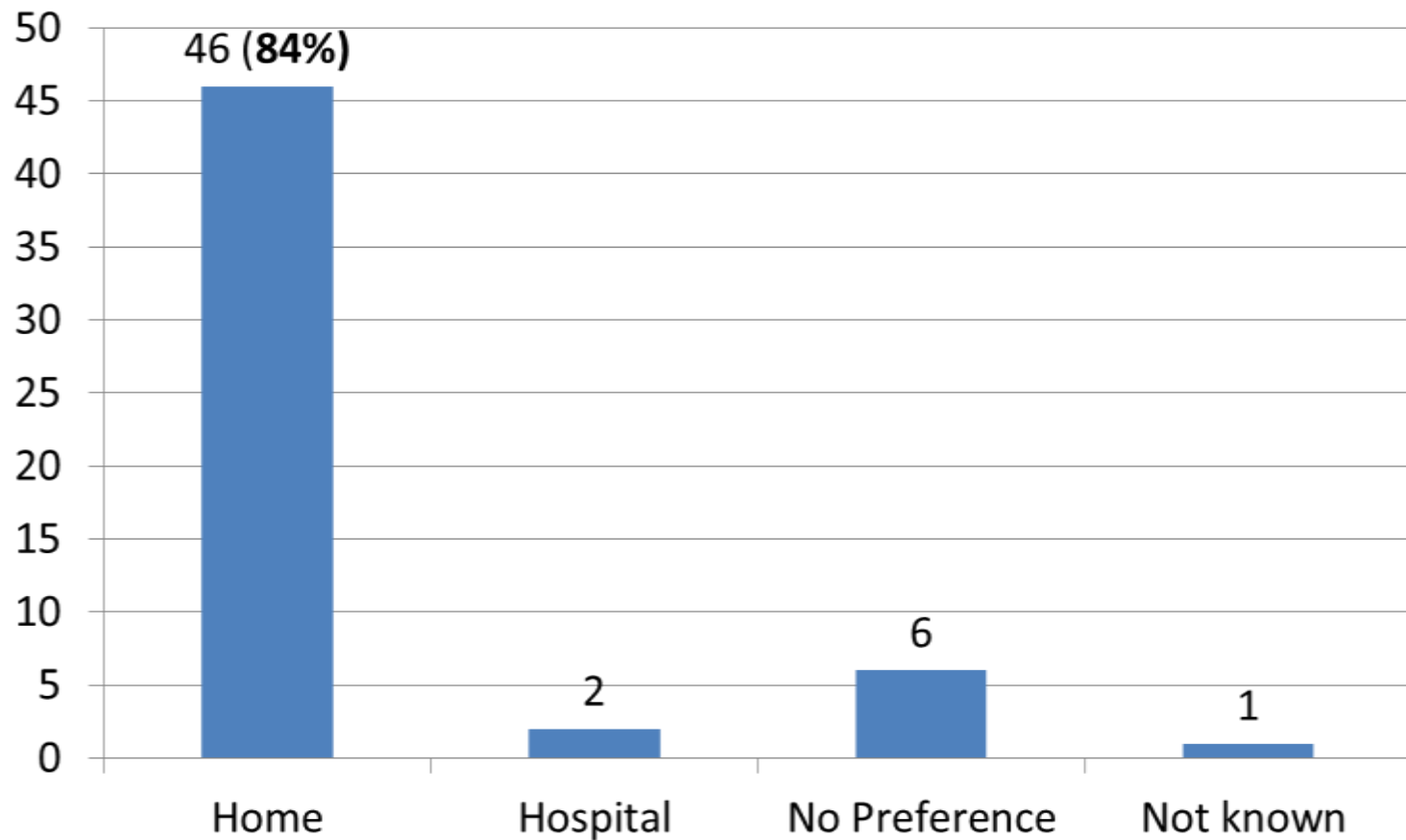


Preferences

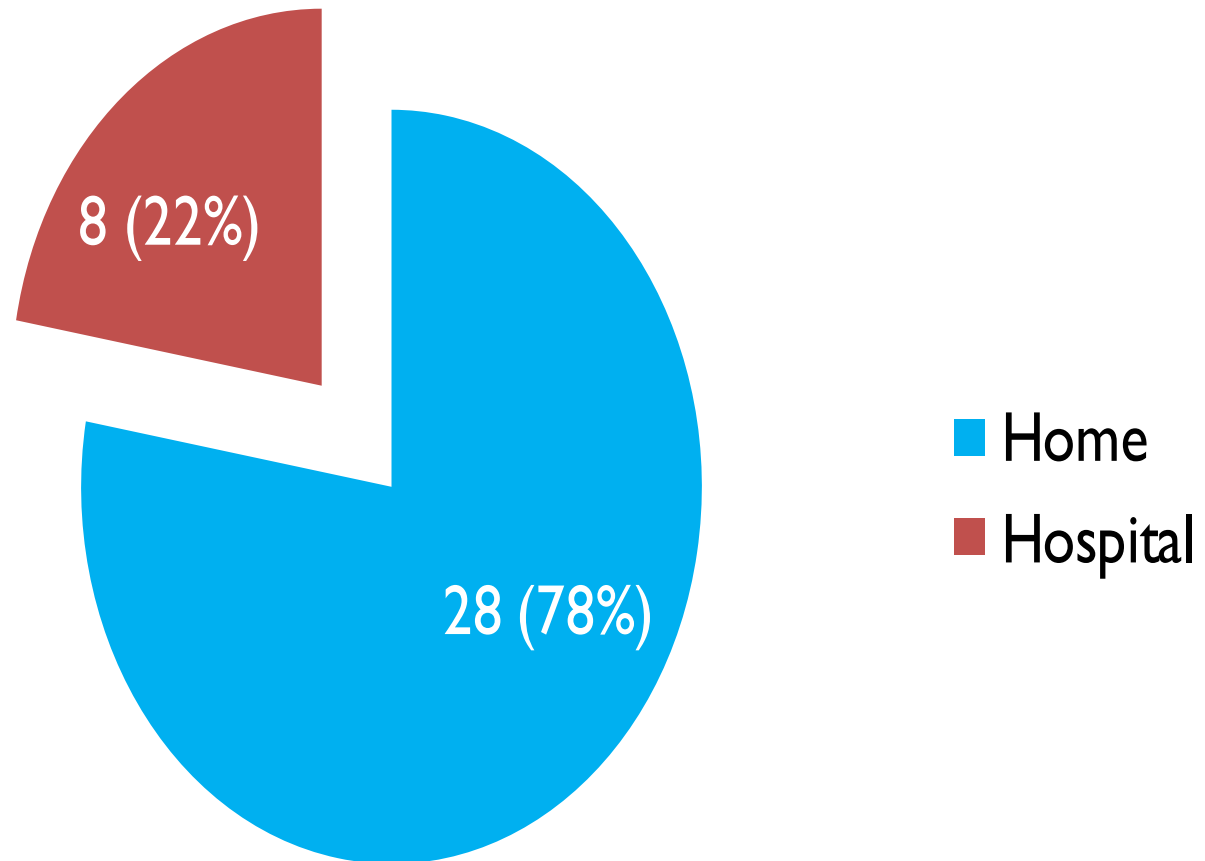


Actual tube feeding

# PREFERENCE FOR PLACE WHERE DEATH OCCUR



# PLACES WHERE DEATHS TOOK PLACE

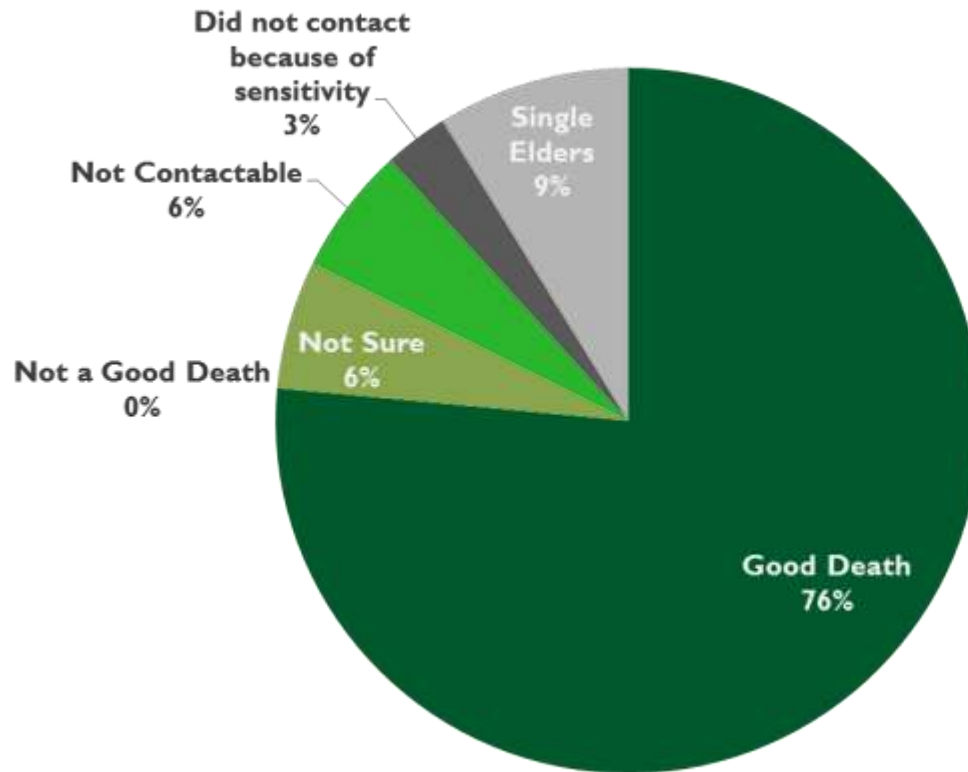


***Number of Deceased who died in a Place against their Wishes = 5***  
***3 were due to care givers' choice***  
***2 lived alone***

# FEEDBACK BY TELEPHONE

“DO YOU FEEL YOUR LOVED ONE HAD A GOOD DEATH?”

Perception of "Good Death" by Primary Care Partner





# REFLECTION

- Most older persons die in a frailty, 'dwindling' trajectory.
- It would be too costly to provide specialist palliative care service for all of them.
- A primary care-LTC empowered and enabled to provide EoL Care may reduce the need for hospitalization
- Minimizes the need for patients to switch between care settings and primary care providers
- Therapeutic rapport between patient/ family/ care teams can be harnessed to improve quality of care

**Thank You!**

