National
Quality Improvement
Conference

Improving the Rate of Advance Care Plan Completion Among Palliative Medicine Inpatients

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Problem Statement

- Advance care planning (ACP) offers a comprehensive discussion about goals-of-care preferences at the end of life, and can be conveyed longitudinally across time and healthcare settings.
- In TTSH, the new ACP completion rate of Palliative Medicine inpatients by the time of discharge or death was only 4.9%.
- Local evidence of a problem worth solving:

Most patients do not express care preferences.	Discrepancies in end-of-life decisions between patients and surrogates in a third of cases.	Low awareness about ACP, but 60% were willing to do ACP after education.	Caregivers feel that ACP is important – respects autonomy, reduces burden in decision-making.	After ACP, >95% felt it was helpful and felt more prepared to make healthcare decisions.

References:
- Phua J et al. End-of-life care in the general wards of a Singaporean hospital: an Asian perspective. J Palliat Med. 2011 Dec; 14(12):1296-301
- Foo AS et al. Discrepancies in end-of-life decisions between elderly patients and their named surrogates. Ann Acad Med Singap. 2012 Apr;41(4):141-53
- Ng R et al. An exploratory study of the knowledge, attitudes and perceptions of advance care planning in family caregivers of patients with advanced illness in Singapore. BMJ Support Palliat Care. 2013 Sep;3(3):343-8
- Ng QX et al. Awareness and Attitudes of Community-Dwelling Individuals in Singapore towards Participating in Advance Care Planning. Ann Acad Med Singap. 2017 Mar;46(3):84-90
- Post-ACP Discussion Satisfaction Survey, TTSH, 2014

Project Aim

To improve the rate of new Advance Care Plan completion among Palliative Medicine inpatients from 4.9% to 40% (stretch goal: 50%) over 6 months

Eligibility criteria:
- Inpatients under Department of Palliative Medicine
- No prior ACP done

Exclusion criteria:
- Patients under Department of Palliative Medicine for 3 days or less

Lessons Learnt

- Involving all stakeholders on various levels helps to identify potential causes and solutions of a problem more comprehensively.
- Changing mindsets and practice culture is challenging but possible with support on all levels.
- Regular sharing of project results with the department is important to motivate staff and continue the culture shift.

Potential Solutions

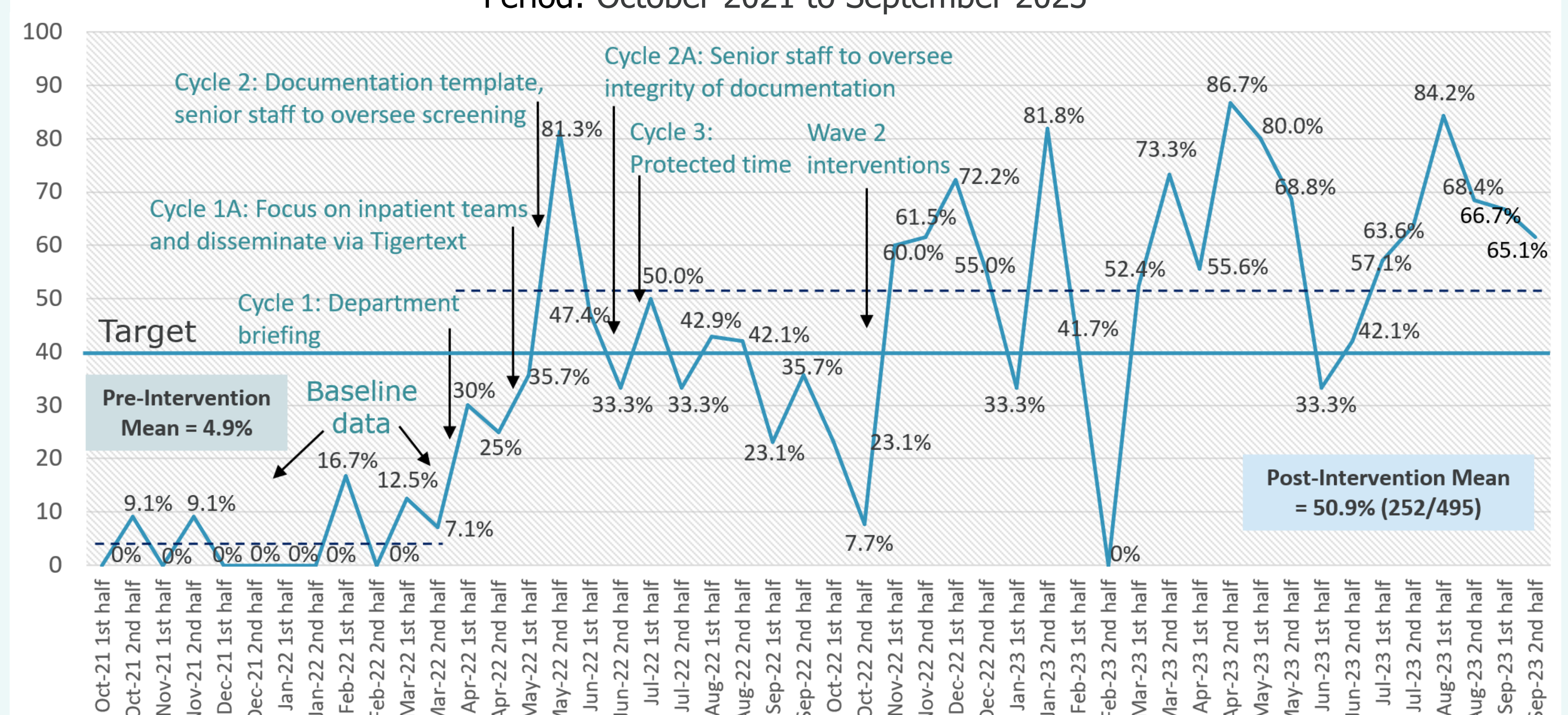
Root Cause	Intervention	Implementation Date
Goals of care discussion deemed sufficient / Inadequate staff knowledge about ACP	Staff education - briefing to clarify work processes, correct misperceptions, encourage staff to build ACP upon goals of care discussion	Cycle 1: Week 1, Apr '22 Cycle 1A: Week 1, May '22
No organized system to initiate ACP	Introduce ward round / discharge summary templates documenting whether ACP is done or offered, and reasons if not done. Senior staff to oversee screening.	Cycle 2: Week 3, May '22 Cycle 2A: Week 3, Jun '22
No protected time	Introduce periods of protected time for staff to conduct ACP discussions	Cycle 3: Week 1, Jul '22

In October 2022 following a dip in ACP rates, a review to fine-tune processes was undertaken, resulting in the following interventions:
(1) Ensuring timely access to the AIC-ACP portal for new staff
(2) Aligning ACP discussion worksheet fields in EPIC with AIC-ACP portal
(3) Department updates of ACP rates every 3 months
(4) TigerConnect reminders when rates are low
(5) Placing a reminder poster in the Palliative ward

Outcomes & Impacts

Percentage of New ACP Completion Among Palliative Medicine Inpatients

Period: October 2021 to September 2023



Note: Excluding patients who had prior ACP done and under Department of Palliative Medicine ≤3 days

- The mean percentage of new ACP completion improved from 4.9% to 44.4% over 4 months. This was sustained at 50.9% up to September 2023, more than one year later.
- GOOD OUTCOME: (i) Patients and families feel heard and valued; (ii) More appropriate level of care aligned with patients' preferences; (iii) Staff are empowered to provide good care.
- COORDINATED CARE: Allows downstream care providers to provide patient-centred, goal-concordant care, in line with the National Strategy for Palliative Care.