New Community Care Model for End-of-life with Organ Failure: Hospital @ Home

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Background

An innovative community care in Kowloon East Cluster (KEC)

- Funded by HKSAR Hospital Authority

- To provide "Hospital @ Home" end-of-life service to the patients with organ failure at home with medical on site support

- Led by experienced Community Nurses (CNs) through intensive clinical support

Objectives

- Enhance patient / caregiver empowerment in symptom management & reduction of disease exacerbation
- Engage patient/caregiver’s psychological support & reduction of caregiver’s stress
- Promote “Ageing in place”
- Support patient / caregiver to have choice for preference home care in pre-terminal stage

Methodology

- Retrospective descriptive study
- 1st October, 2011 – 31st March, 2013
- Target group : - advanced organ failures / frailty from Kwun Tong area
  - cared by committed caregiver(s) at home
- Experienced community nurses (CNs) as case managers

Model of Care

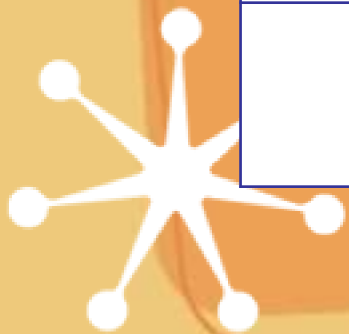
" RETREATS" care model

Phase One	Focus of Care
Reverse unstable condition	Prompt response Timely consultation
Eliminate distressing symptoms	Intensive monitoring
Transit to Rehab / Terminal phase	Advance Care Planning discussion

Phase Two	Focus of Care
Revitalize patient	Rehabilitation training
Empower family / caregiver	Training caring skill & technique
Activate social resource	Caregiver endurance enhancement
Transit to parent team	Sharing information
Sustain efficacy	Reinforcing empowerment

Result - Patient’s data

Number of patients	155
Age (mean)	**84** years old
Sex (Male : Female)	3:7
Living with (Family : Friend / Maid)	7:3
Home visit per each patient (mean)	4.8 times per week
Duration of care (average day)	**38.7**



Result - Patient Characteristics

Clinical Frailty Scale (median)	**6** (SD+/- 1; Range 1-9)
Palliative Performance Scale (median)	**55%** (Range 10 - 60%)
HARRPE Score (mean) (Hospital Admission Risk Reduction Program for Elderly Score)	**0.4** (SD+/- 0.2; Range 0 - 0.8)

Result - Disease Categories

Category	Number of patients (n = 155)	%
Advanced cancer	81	52
Advanced organ failure (Renal, Respiratory, Cardiac failure, Dementia)	74	48

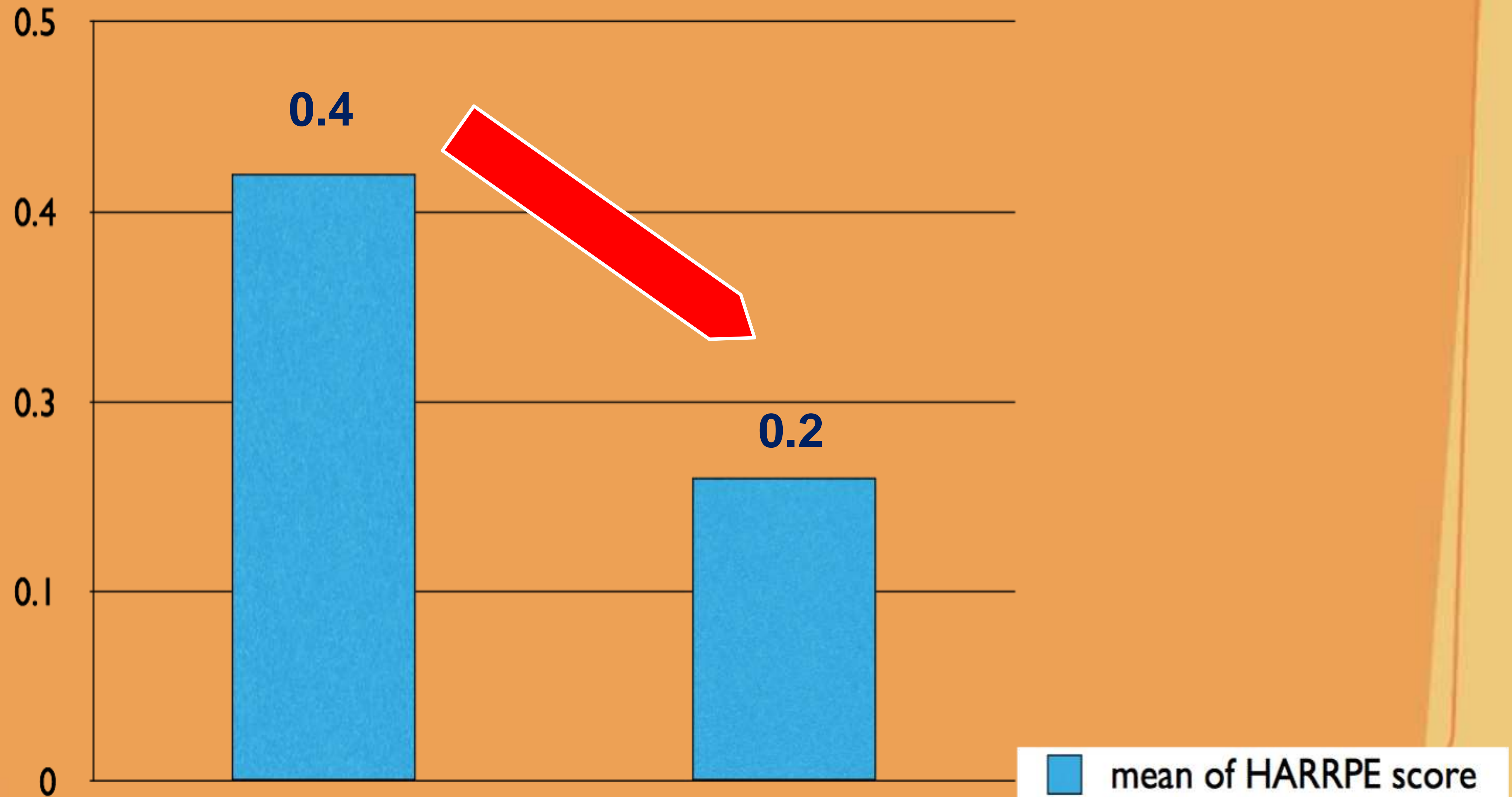
Result - outcome measures

Advance Care Planning	**60%** (93 out of 155)
Choice for preference care in pre-terminal stage (home / hospital / hospice) preference place of care in pre -terminal stage at home	**100%** (n=93) **16%** (n=15)

Result - outcome measures

Reduction of HARRPE score	**0.4 to 0.2**
Reduction of pre and post 90-day hospitalization	**73.7**%
Relative Stress Scale (RSS)	**55%** (EOL cases) of 155 patients' caregiver scored reduction from **moderate to low level** of stress
Patient Care Empowerment	**97%** improvement of care empowerment

Reduction of HARRPE score



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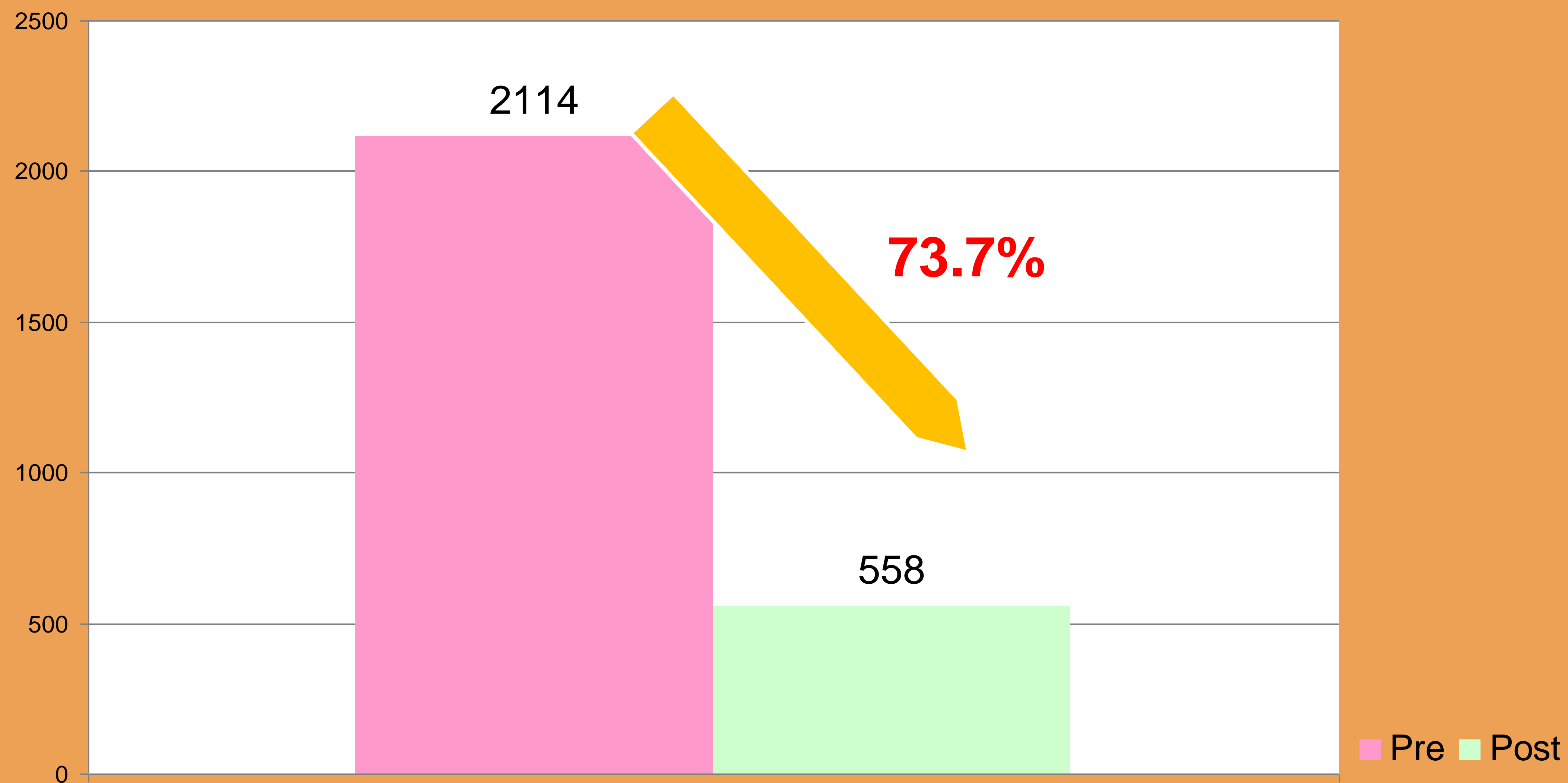
Hospitalization pre & post 90-day



** Remarks : Pre = D1 admitted to Virtual Ward minus 90 days
Post = D1 admitted to Virtual Ward plus 90 days
N = 155 Cases

Result – outcome measures

Reduction of HARRPE score	**0.4** to **0.2**
Reduction of pre and post 90-day hospitalization	**73.7%**
Relative Stress Scale (RSS)	**55%** (EOL cases) of 155 patients' caregiver scored reduction from **moderate to low level** of stress
Patient Care Empowerment	**97%** improvement of care empowerment

Mean RSS Reduction

60
50
40
30
20
10
0

37

13

mean RSS reduction

Pre Post

Result – outcome measures

Reduction of HARRPE score	**0.4** to **0.2**
Reduction of pre and post 90-day hospitalization	**73.7**%
Relative Stress Scale (RSS)	**55**% (EOL cases) of 155 patients' caregiver scored reduction from **moderate to low level** of stress
Patient Care Empowerment	**97**% improvement of care empowerment

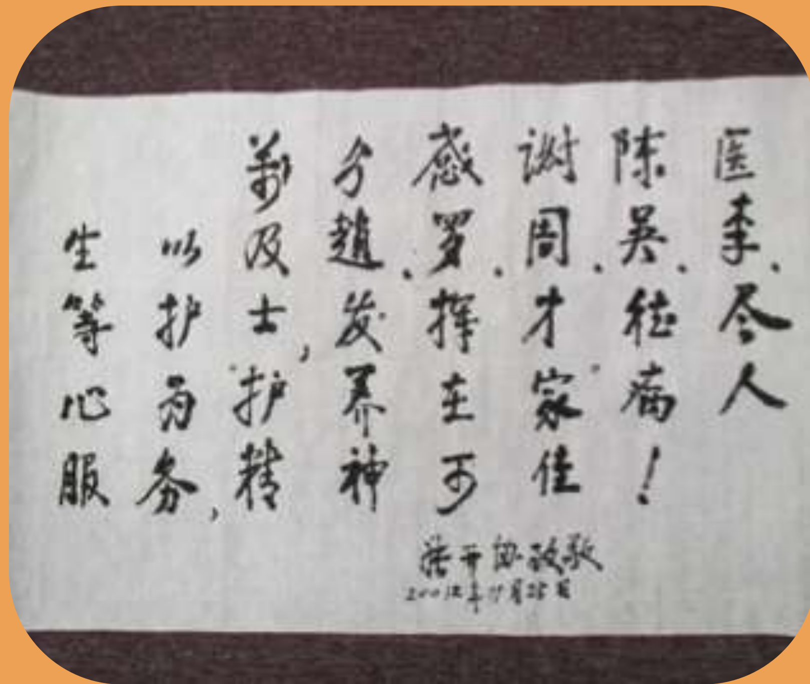
Limitation

- The limited resource constrained the development of the service
  - manpower
  - service loading
  - service hour
- Lack of government policy supporting home death
- The service could not be beneficial to the patients with poor family support and living alone

Conclusion

- Crucial role of Community Nurses in patient / caregiver empowerment & self efficacy
- Sustainable the quality nursing care through “RETREATS” care model which ensure intensive and timely interventions
- Pre-terminal care in preference place was succeeded under this program through collaborating with palliative care teams & emergency department team support
- Aging in place & dying with dignity is successful with a nurse led community based service concerted a cross-specialty multidisciplinary effort

Patient’s & caregiver’s appreciation



Thank You

Hospital Authority Community Nursing Service

Introduction

Community Nursing Service (CNS) is one of the specialty nursing services in the Hospital Authority aiming at providing holistic care in the community. Community nurses conduct comprehensive health assessment, formulate, implement and evaluate nursing therapeutics for the clients during visits according to their unique needs. The service promotes client health through improving self-care ability, knowledge and carer skills. For chronic health conditions requiring case management that the community nurses network with other service providers to deliver a coordinated healthcare service.

Target Group

Community Nursing S[illegible]ice provides care for clie[illegible] of [illegible]ges es[illegible]se wi[illegible] the foll[illegible]ng c[illegible]itions:

- [illegible]able [illegible] attend [illegible]ealth [illegible]ilitie[illegible] or rece[illegible]ng n[illegible]ing [illegible] bec[illegible]se of hea[illegible] pro[illegible]s
- requires nursing support at home through monitoring on treatment regime and compliance, self reliance and empowerment to cope with illness and chronic disability, or during times of stress
- chronic illness that requiring case management in community for betterment of health outcomes e.g. case management on COPD, DM, Cardiac or Stroke care

Objectives

- To enhance client self care ability
- To empower client/carer towards self-reliance on illness management
- To promote client's rehabilitation through active liaison with the supportive network within the hospital and the community
- To promote primary health care

Scope of Service

Community Nursing Service provides a broad range of holistic and specialized care including:

Chronic disease management	Cardiac rehabilitation
	Pulmonary rehabilitation
	Diabetic care
	Stroke rehabilitation
	Renal care
Specialty nursing services	Surgical care (Examples: Post-surgical care, Wound and drain care, Ostomy care)
	Geriatric care
	Postnatal and infant care
	Continence care
	Palliative care / End-of-life care
Nutrition counseling and feeding tube care	
Medication management	
[illegible] education and [illegible]	
[illegible] infection control education	
[illegible] health education	

Application Procedures

- Referral by the health care professionals
- For enquiry, please contact any CNS centers, wards, Specialist Out-patient Clinic, General Out-patient Clinic for details

Service Charges

- Each CNS visit is charged at a rate as set out and promulgated by Hospital Authority from time to time
- Free of charge for CSSA recipients
- Clients with financial difficulties may apply for waiver through Medical Social Services

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