Post-discharged Patient Care Project for Kwun Tong Community

Presented by:
Vikie Wong, Social Worker
Community Involvement & Volunteer Service Department
Background

• High percentage of older people in Kwun Tong

• High percentage of older people living alone or with their spouse only

• In 2003 / 2004, over 3000 discharged patients from UCH required community support services

• It was noted by community nurses that a significant number of patients known to them did not receive timely and essential support exposing risk to these patients especially those older patients living alone
The Development of ‘Post-discharge patient care project for Kwun Tong Community’

• At the end of 2004, the UCH Community Involvement Volunteer Service Department, Community Nursing Service and Medical Social Service jointly proposed this new project to set up a coordinated support network in mobilizing a team of visiting support volunteers, district social services agencies and local organizations in the district to satisfy the needs of high risk discharge patients
Objectives

• To fill the service gap by providing appropriate and immediate support or assistance for discharged patients

• To assist and empower discharged patients to face the reality of sickness, to enhance their ability of self help, to get accustomed to the new life after discharge from hospital, and to learn to know the ways and means to make use of community resources to obtain support
Objectives (Con’t)

- To strengthen co-operation with social service agencies in the community for establishment of a powerful community support network

- To encourage local community organization to participate and support the needs of discharged patients, in order to build up a caring and harmonious community
Community Partners of the Program

- District Elderly Community Centers – 4
- Other Elderly Centers – 7
- Volunteers from church and local community organizations – more than 10
Training of Volunteers

- 7 classes training has been provided to 370 volunteers with information on common illnesses of older people, infection control knowledge, observation skills for older patients, home visiting skills and communication skills

- Emergency supporting volunteers - 64
- Community support volunteers - 306
# Age Distribution of patients served

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below 50</td>
<td>8</td>
<td>1.43%</td>
</tr>
<tr>
<td>51-60</td>
<td>22</td>
<td>3.92%</td>
</tr>
<tr>
<td>61-70</td>
<td>39</td>
<td>6.95%</td>
</tr>
<tr>
<td>71-80</td>
<td>211</td>
<td>37.61%</td>
</tr>
<tr>
<td>81-90</td>
<td>254</td>
<td>45.28%</td>
</tr>
<tr>
<td>Above 91</td>
<td>27</td>
<td>4.81%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>561</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

90% of cases aged 71 or above
## Living Status

<table>
<thead>
<tr>
<th>Living Status</th>
<th>No of case</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live alone</td>
<td>406</td>
<td>72.4%</td>
</tr>
<tr>
<td>Live with spouse</td>
<td>92</td>
<td>16.4%</td>
</tr>
<tr>
<td>Live with children (daytime alone)</td>
<td>63</td>
<td>11.2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>561</strong></td>
<td><strong>100%</strong></td>
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90% of cases lived alone or lived with spouse
Service Achievement

• From 1/2005 to 10/2006 a total of 561 patients were referred to the program

• All 561 patients have been visited by emergency support volunteers within 2 days of hospital discharge

• 240 patients were referred to community support services within 6 weeks

• Self care ability improved from 16.5% to 62.3%

• 95.7% of patients greatly appreciate the caring support provided by volunteer

• 60% of cases have reduction in unplanned readmission
Service Achievement (Con’t)

- Positive feedback and appreciations from the community

- Strong community support network was established which effectively enhance quality of life of older patients discharged back home, promote community partnership and caring community for older people

- Enhances the community relationship between hospital with other community organizations
Service Sharing

- 7 / 6 / 06
  7 clusters’ representatives of Hospital Authority

- 22 / 9 / 06
  Principal Assistant Secretary (Elderly Services and Social Security) – Health Welfare and Food Bureau Government Secretariat

- 25 / 11 / 06
  14th Annual Congress of Gerontology, Hong Kong Association of Gerontology

- 11 / 12 / 06
  53rd Kowloon Region Advisory Committee Meeting
Critical success factors

1. Support from Hospital Administration and various wards/Departments is essential

2. A well established volunteer program within the hospital

3. Training and support of volunteers are important

4. Need for a coordinator in hospital to build network with community partners
Conclusion

The project actualized hospital community cooperation, filled the service gap and empowered patients effectively, and also reducing the utilization of health service as a result.

~ Thank You ~