Hand in Hand Program with Community Volunteer Services to Support the Post-Discharged Patients in the Community - A Collaborative Pilot Project

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Introduction
Post discharged frail patients requiring maintenance nursing care in term of health condition monitoring occupied high demand but low care capacity in the Community Nursing Service (CNS). Apart from the provision of maintenance care, Community Nurses (CNs) may not be attentive enough on social concern and emotional support to the patients. Hence, community volunteers from Health Resource Centre (HRC), working hands in hands with CNs and Social Worker of HRC provided support for the target patients. Thus, the Collaborative Pilot Project was launched to establish a platform for enhancing high touch home care service to post discharged patients in the community

Objectives
1. To early detect the potential health problem
2. To facilitate the social concerns and provide emotional support
3. To empower discharged patients for better community re-integration
4. To reduce the hospital re-admission rate of the patients

Methodology
The pilot program was implemented from May 2013 till October 2014. Patients with weak social support, living alone or in elderly couple were recruited. A series of volunteer intensive training workshops focusing on alertness of elderly emotional and physical issue was conducted. Volunteers, matching their place of residence, were provided basic health monitoring, good neighbor and psychosocial support training for supporting the target patients. Each recruited case would be visited two months by CNs and three months by volunteers. A structured “My-Health Passport” was designed for recording mutual communication between the stakeholders. The
volunteers would consult HRC Social Worker and CNs on the social and health problems of the target patients respectively for timely interventions and appropriate follow up action.

**Result**
Over forty trained volunteers and twenty-five patients cases were matched. The mean age of the service recipients was 85.3 years old and 92% of them were living alone. In regarding the type of diseases, the majority were suffering from Diabetic Mellitus, Cardiovascular and Respiratory disease. The average number of home visit provided by CNs and volunteers were 6.28 and 5.56 respectively. The burden of home visits by CNs was reduced by 21.5%. The reduction of A&E attendance and hospital admission were 20% and 50% respectively. Around 28% of the health problems were successfully early detected by the trained volunteers with timely nursing interventions by CNs accordingly. Moreover, the level of feeling being concerned and cared as well as self-care ability and understanding of the community had been increased by 75% and 37% respectively. Among the recruited patients, 20% of them were referred to Non-Government Organization for the continuity of community service and care.

**Conclusion**: The pilot project showed the benefit and success of collaborative partnership between Volunteer Services and the health care team in building up a safety community network for the elderly living a healthy life of comfort with assurance in their familiar community.