



Service Priorities and Programmes Electronic Presentations

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Pilot Community Cardiac Rehabilitation Program

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Introduction

Poor control of Congestive Heart Failure (CHF) results in frequent hospital admission and high casualty attendance rate. Fatigue, dizziness, shortness of breath, exercise intolerance and fluid retention strike them in both physical and psychological aspects. Patient and their family members experienced poor quality of life. A clinical pathway was developed by community nurse and medical team to manage CHF patients. Comprehensive disease management including knowledge consolidation and support from the team was provided from hospitalization period to community.

Objectives

1. To establish a guideline based clinical pathway to manage patient with CHF from hospital to community.
2. To reduce hospital stay and unplanned readmission rate with home support.
3. To empower patient and carer knowledge in CHF.

Methodology

1. Recruit suitable cases by Medical team and Community team.
2. Introduce the program by cardiac nurse or community nurse in hospital.
3. Empower knowledge in symptoms management, medication knowledge and facilitate coping and rehabilitation at home from community nurse by providing regular home visit and act as a case manager.
4. Closely monitor patient's condition by community nurse and advocates for patient via case conference.
5. Arrange advance consultation or clinical admission by team if necessary.

Result

1. From February 2017 to January 2018, 8 cases were being recruited.
2. Accident & Emergency Department attendance rate and unplanned admission related to CHF was Zero.
3. Knowledge in CHF was improved, as Cardiac Rehabilitation Care Empowerment

Score was increased for both patient and carer.

4. All results shown the collaboration was successful in promoting patient health in the community.