



Service Priorities and Programmes Electronic Presentations

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From Curative Treatment to Comfort Care: Hospital @ Home

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Introduction

Reflection key note address on Hospital Authority (HA) Chief Executive told HA Convention 2016, people nearing the end of life (EOL) would be cared in the community with professional support. In fact, majority of patients with life-limiting diseases have frequent hospital admissions for curative care during the last weeks or months of life. At present, the trend is relatively prone to tender loving care at home by their committed family instead of invasive treatment in hospital. Hence, Virtual Ward Program in Kowloon East Cluster as an integral part of the community care services for supporting patients/families taking control of their advanced organ(s) failure has been regulated the magnitude of service direction to support end of life care at their own home.

Objectives

1. To provide coordinated professional care and support for patients/ family at home 2. To reduce family stress for 24 hours personalized care 3. To reduce health care utilization in term of shorten hospital length of stay in a safe manner and unplanned re-admission

Methodology

This was retrospective review study from October 2011 until March 2017. Recruited patients referred from various specialties suffering from advanced cancer and advanced organ(s) failure were screened by Community Nurse (CN) coordinator through the co-joint case conference supported by geriatrician and palliative care physician. The assessments and home care plans were initiated by CN within a tentative period of 4 to 8 weeks. Despite the medical treatment for medication reconciliation, the high-touch nursing interventions including prompt response and timely consultation for unstable condition, motivate patients/families for down-to-earth caring skill, enhance families' endurance with social resources activated, advance care planning (ACP) and EOL care were delivered. Descriptive data were collected

from clinical record for descriptive analysis.

Result

During the period between October 2011 and March 2017, 505 patients with 78% of the age of over 75 years old were recruited. Over 67% of recruited patients had ≥ 2 chronic diseases. Patients were suffered from advanced cancer (10%) and advanced organ(s) failure (90%). The referral sources were mainly from 49% of Department of Medicine and Geriatrics and 32% of Palliative Unit/ Home Care Team. Nearly thirty-two home visits per patient on average or on patient need basis with an average of 48 days of care were provided. All patients/families had fulfilled their preferences to stay at home for as long as possible to receive care at their own home with high adherence on ACP. Advance directive (AD) and non-hospitalized Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) were signed by 19 and 55 patients respectively. The overall 28-day Accidents and Emergency Department (AED) attendance rate was reduced by 55% and reduction in very high-risk frail elderly unplanned hospital admission rate by 64%. After the implementation of high-touch and intensive interventions, the total hospital-bed-days were reduced by nearly 50%. All recruited patients/families were highly appreciated the effort of professional team. As conclusion, Virtual Ward Program revealed that EOL patients were vulnerable with life-limiting diseases able to stay at home for the longest possible duration and reduce the risk of unplanned admissions through intensive hospital @ home service was accomplished.