## Scope of Service

### Chronic disease management
- Cardiac rehabilitation
- Pulmonary rehabilitation
- Stroke rehabilitation
- Diabetic care
- Renal care

### Specialty nursing service
- Surgical care (e.g. Wound and drain care, Ostomy care)
- Geriatric care
- Postnatal and infant care
- Continence care
- Palliative care/End-of-life care

### Rehabilitation counseling
- Utilization of community resources
- Nutrition counseling and feeding tube care
- Medication management
- Home safety assessment/ Home adaptation and exercise
- Home infection control education
- Community health education

## Application Procedures

- Referral can be made by health care professionals.
- For enquiry, please contact any CNS centers, hospital wards, specialist out-patient clinic or general out-patient clinic for details.

## Service Charges

- Each home visit is charged at a set rate as promulgated by Hospital Authority from time to time. Clients with financial difficulties may apply for waiver through Medical Social Services.

For any queries, please consult medical professionals or access the Hospital Authority website [http://www.ha.org.hk](http://www.ha.org.hk)
**Introduction**

- Community Nursing Service is one of the specialty nursing services within the Hospital Authority of Hong Kong
  - The main aim is to provide holistic care for clients staying in the community
  - Community nurse shall provide the following services at home visitation:
    - Conduct comprehensive health assessment
    - Formulate, implement and evaluate nursing therapeutics according to clients’ needs
  - For clients’ with chronic health condition, case management model of care will be adopted by community nurse to deliver a coordinated healthcare service by networking with other service providers

**Target Group**

- Community Nursing Service provides care for clients of all ages with the following conditions:
  - Unable to attend health care facilities for receiving nursing care because of debilitated health profiles
  - Require nursing support at home for continuous monitoring of treatment regime and compliance
  - Promote self-reliance and empowerment to cope with chronic illness or specific nursing condition at the early stage of discharge from hospitalization
  - Adopt case management model of care while caring at home for complex chronic diseases e.g. Pulmonary, Diabetic, Cardiac or Stroke care

**Objectives**

- To enhance client’s 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 across the hospital and the community
- To promote primary health care
### Scope of Service

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