KOWLOON WEST CLUSTER

九龍西醫院聯網

A Collaborative approach in the management of hypertensive patient by a nurse led hypertension clinic in Caritas Medical Centre

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Aim:

To enhance the management of patients with elevated blood pressure and hypertensive patients in low risk

Objectives:

1. To serve the role of primary health care of primary screening and active case finding
2. To facilitate target group patient's attendance and reassessment of blood pressure
3. To improve the assessment and lifestyle advice on target group patients
4. To refer back patients with target organ damage for further management
5. To develop a collaborative approach in the management of chronic diseases

Methodology:

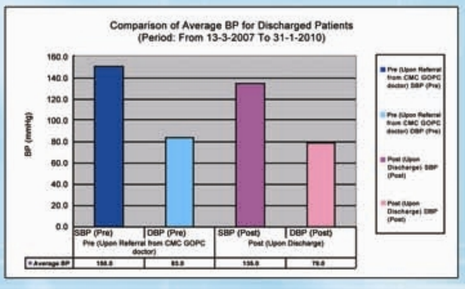
Patient with initial blood pressure > 140/ 90 mmHg but <160 mmHg /< 100 mmHg without history of diagnosis of hypertension were referred to the nurse led HT clinic for further counseling and work up

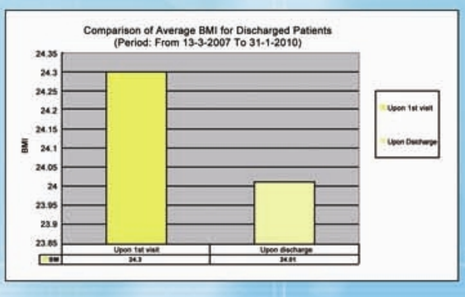
Results:

A total of 149 patients from 3/2007 to 1/2010 were included. Their demographic data were analysed. The average BMI , blood pressure on the referral date and last attendance to the nurse led clinic were compared. Their outcomes and hypertension complication rate were also studied.

Discussion:

For these 149 patients, there are 57 males and 92 females. The average age is 64.9 years old. The average number of consultation was 3.04. Fifty patients were discharged after a follow up period of 6.3 months. Their blood pressure on referral was 150/ 83 mmHg and their BMI is 24.3kg/m2. These findings were decreased to 135/ 79 and 24.01kg/m2 respectively.





Among these patients, 16 patients have normalized blood pressure after the follow up. Their average discharge blood pressure was 128/ 75 mmHg. 10 patients were referred back to doctors for initiation of anti hypertensive drugs. Their average blood pressure was 144/ 86.5mmHg. Among them, 4 have hypertensive complication of left ventricular hypertrophy, 1 has renal impairment, 1 has diabetes mellitus and 1 has proteinuria.

Conclusions:

With the implementation of nurse led clinic, trained nurse can demonstrate the primary care role of education, lifestyle modification (as shown by improving BMI), shared care (as shown by early notification of potential complicated case to doctors) in the course of chronic disease management. This collaborative approach can be rolled out to include other stable chronic diseases with trained nurses and allied health staff.