Early Post Discharge Support for Chronic Obstructive Pulmonary Disease Patient by Community Nursing Service in Shatin: a Pilot Study

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Introduction

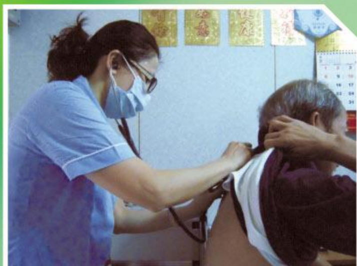
Chronic Obstructive Pulmonary Disease (COPD) is the fifth fatal disease in Hong Kong. It causes heavy burden for healthcare services. According to Hospital Authority, the hospitalization day of COPD patients was the third top in the total utilization of hospital-bed days in 2007. A pilot study focusing on collaboration service between Respiratory Medicine of Prince of Wales Hospital (PWH) and Community Nursing Service (CNS) of Shatin was implemented since August, 2010.

Objectives

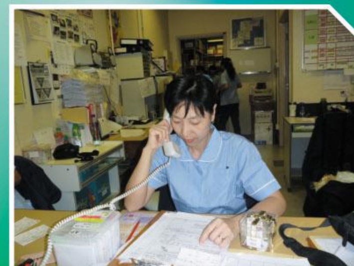
i) To ensure a safe post-discharge support to COPD patients,
ii) To optimize therapeutic treatment by improving the inhaler technique and drug compliance of COPD patients,
iii) To empower clients and caregiver on COPD self-management techniques during COPD exacerbation and
iv) To reduce unplanned readmissions.

Methodology

COPD patients lived in Shatin were recruited from an acute medical ward of PWH. A COPD care booklet and Respiratory hotline were provided to patient upon discharge. Patients were referred to CNS for post discharge support in the community. A liaison nurse of CNS performed pre-discharge screening and assessment to enhance a safe discharge for those patients. Home visits and phone follow-up were arranged by a designated community nurse. Comprehensive health education focused on the explanation of COPD, prevention and management of COPD exacerbation, care and use of inhalation device, maintenance on quality of life was given to those patients by community nurse. Protocol - "Immediate Management for Breathless Patient" was used to solve emergency events. Medical backup to the community nurse was provided by the Respiratory Medicine of PWH. The cases were closed after discharge for 28 days if their condition were stable. Patients were followed up in designated COPD clinic as scheduled at 6 weeks after discharge.



Provide home visit and COPD care by community nurses



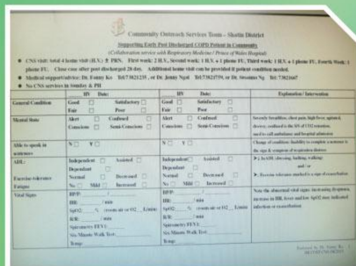
Phone follow-up to COPD patients

Results

During the study period, 31 patients were recruited. 90 % were male and 10% were female. The range of age was between 56 and 92. With community nurse support, 23 (74%) patients were successfully discharged without unplanned admission within 28 days. 6 (75%) patients with unplanned readmission were out of CNS office hour and 2 (25 %) patients needed emergency admission during office hour because of health deterioration.

Conclusion

This pilot programme showed that community nursing service could help to prevent unplanned readmissions of COPD patients by empowering COPD patients on self-management technique.



COPD Assessment Form & Protocol is used for CNS

Empower COPD patients on self-management technique