Service Priorities and Programmes

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Submitting author: Ms S H LEUNG
Post title: Nurse Consultant, United Christian Hospital, KEC

Community Care Empowerment Program for the post-discharged chronic diseases elderly

Leung SH(1),Chan PF(2),Chau YZ(2),Chin CF(2),Chiu LT(2),Karn KY(2),Lam CC(2),Lam SY(2),Lo CW(2),Sze PL(2),Tsang SY(2),Wong YY(2),Yau PS(2),Yu LC(2),Yeung KC(2)
(1)Nursing Services Division, United Christian Hospital (2)Community Nursing Services, Kowloon East Cluster

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Introduction

Nearly 50% of patients aged over 65 having more than one admission in the year and 30% having 3 or more admissions are common in Hong Kong. To avoid the unnecessary hospital re-admissions, the continuity of intensive care would be provided to this specific group of chronic disease elders and caregivers after discharge from hospital by Community Nurses (CNs). In fact, the time investment is needed for patient self -care empowerment and education on chronic disease management. As a result, the Community Care Empowerment Program (CCEP) was launched to provide intensive community nursing care under protocol driven for empowerment of chronic disease elders and caregivers' self-efficacy and prevention of the unplanned readmission. We intended to strengthen nursing care for the patients with chronic diseases, to avert the unplanned re-admission, and to empower the chronic disease patients'/ care-givers' self-efficacy.

Objectives

1.To strengthen nursing care for the patients with chronic diseases 2.To prevent the avoidance unplanned re- admission 3.To empower the chronic disease patients'/ caregivers self-efficacy

Methodology

This was retrospective review study. Three hundred and nine patients had been recruited in six cluster-based community centers. Patients under this program were recruited from 1st October, 2011 to 31st March, 2012. The experienced CNs as case managers were responsible for planning and implementing the quality and needed nursing care with case management model. Descriptive data of patients' demographics, disease and care categories, nursing care time, Empowerment score (a set of Key Performance Indicators for evaluating the effectiveness of community

nurses in chronic disease home care management), hospital readmission rate were looked into for evaluation of outcome within two or three months cared by CNs.

Result

Three hundred and nine cases were recruited. Mean age was 74.7 years old. Majorities were suffering from diabetic mellitus, cardiovascular disease, respiratory disease and renal disease provided protocol driven specific nursing care by designated community case managers under the “Level of Care Triage model”. Mean home care intervention was 7.4 and more than 50 minutes tailor-made care were provided on each care. The overall empowerment score was improved by 96%. For comparison with ordinary care, the episodes of unplanned readmission were reduced by 8.2% and the satisfactory recovery rate was increased by 12.4%. Conclusion This program demonstrated the crucial role of community nurses in enhancing patients’ self-chronic disease empowerment and reducing unplanned readmission in post discharged frail elderly.