



Service Priorities and Programmes
Electronic Presentations

Convention ID: 1181

Submitting author: Ms Bonnie WONG

Post title: NULL, Princess Margaret Hospital

The Effect of Community Nurse Led Transitional Care Program to Enhance Patient and Health Service Utilization Outcomes for Older Adults with High Risk Hospital Readmissions

Wong Y F (1), Heung L W (1), Chan WMM (1), Yu SFD (2)

(1)Community Nursing Service, Princess Margaret Hospital,(2)The Nethersole School of Nursing, The Chinese University of Hong Kong

Keywords:

Transitional Care

Older Adults

Hospital Readmission

Community Nursing

Introduction

In order to responding to the ever rising demand of hospital services, the elderly patients with chronic illness and complex needs are being discharged from hospital earlier. Various studies have identified the shortcomings of inadequate discharge management for elderly patients who would eventually lead to high risk hospital readmission. It is crucial to develop effective transitional care to enhance post-discharge outcomes of elderly patients with chronic illness.

In Hong Kong, Community Nursing Services are well developed to provide continuous care for discharged patients. However, there is limited evidence on how to integrate the role of community nurse in developing transitional care to elderly patients with chronic illness. Even less is available about the effects of such program on patient outcomes, satisfaction of care and health care services utilization.

Objectives

To develop community nurse led transitional care program (CNLTCP) and examine its effect on enhancing post discharge outcomes of those elderly patients with chronic illness.

Methodology

The study will adopt randomized controlled trial (RCT) by using blocked randomized method. The intervention group will receive 8 weeks CNLTCP to enhance their self-care in disease management and control group will receive usual care only. The sample size is estimated 198. The community nurse who implements transitional care will screen patients for eligibility and obtain informed consent form for those who meet

the inclusion criteria.

Result

Outcome measures (1) Primary outcomes: the number of hospitalization, emergency room visits, length of hospital stays. (2) Secondary outcomes: psychological status by using the Hospital Anxiety and Depression scale; quality of life by using the Chinese version of the EQ-5D questionnaire; self-efficacy by using the Chinese version of the short form Chronic Disease self-efficacy scale and satisfaction of care questionnaire.

This study can inform whether CNS can play an expanded role to provide comprehensive transitional care in a cross-sectorial environment. If this model and care protocols are found feasible and effective, it can be adopted to our health care context. Corresponding CNS staff training can be conducted to enhance the quality of practice.