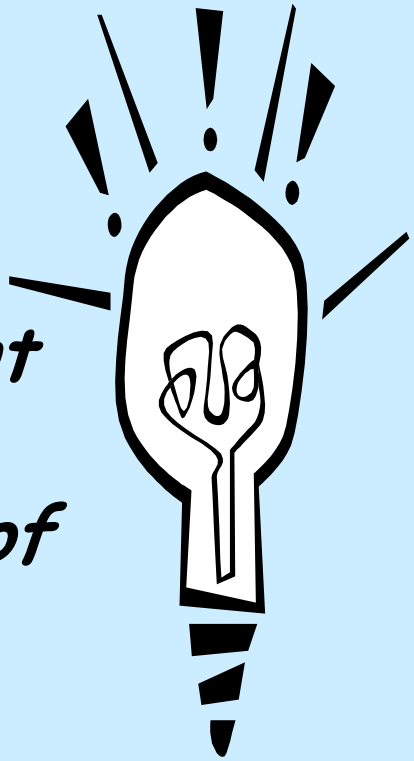
# HKW Cluster

# Community Nursing Service

# (CNS)

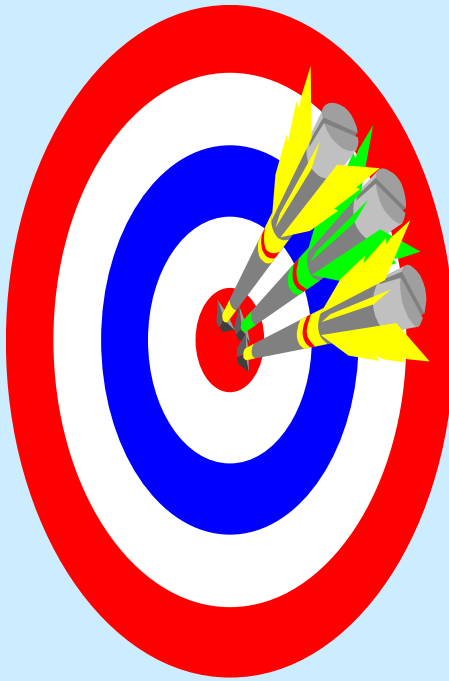
# Mission

As an integral part of the *total health care delivery system*, Community Nursing Service provides *comprehensive and individualised nursing care* to patients in their *own environment* with a view to maximizing or maintaining their *optimum level of self-care* and functioning.

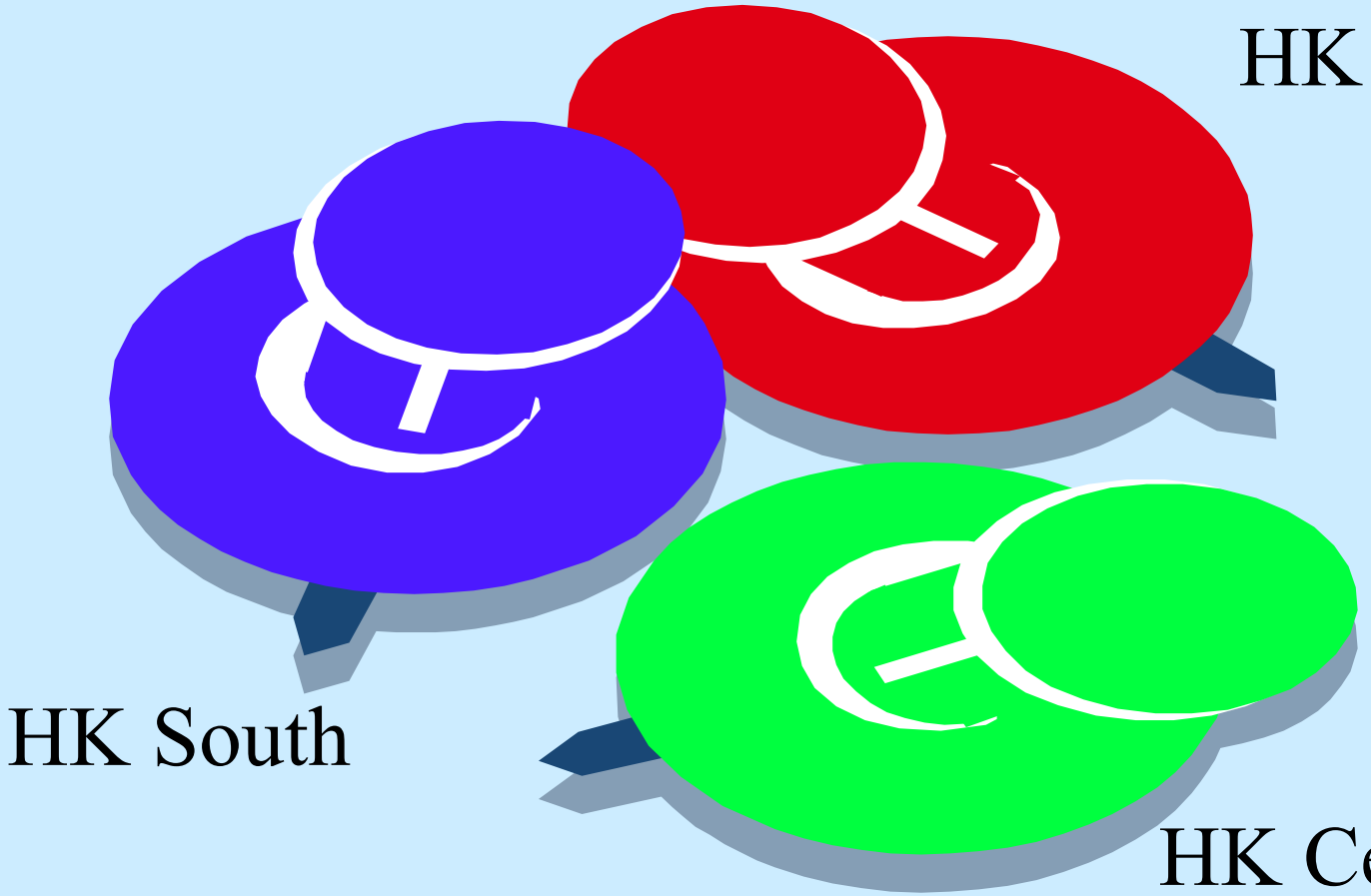


# Objectives

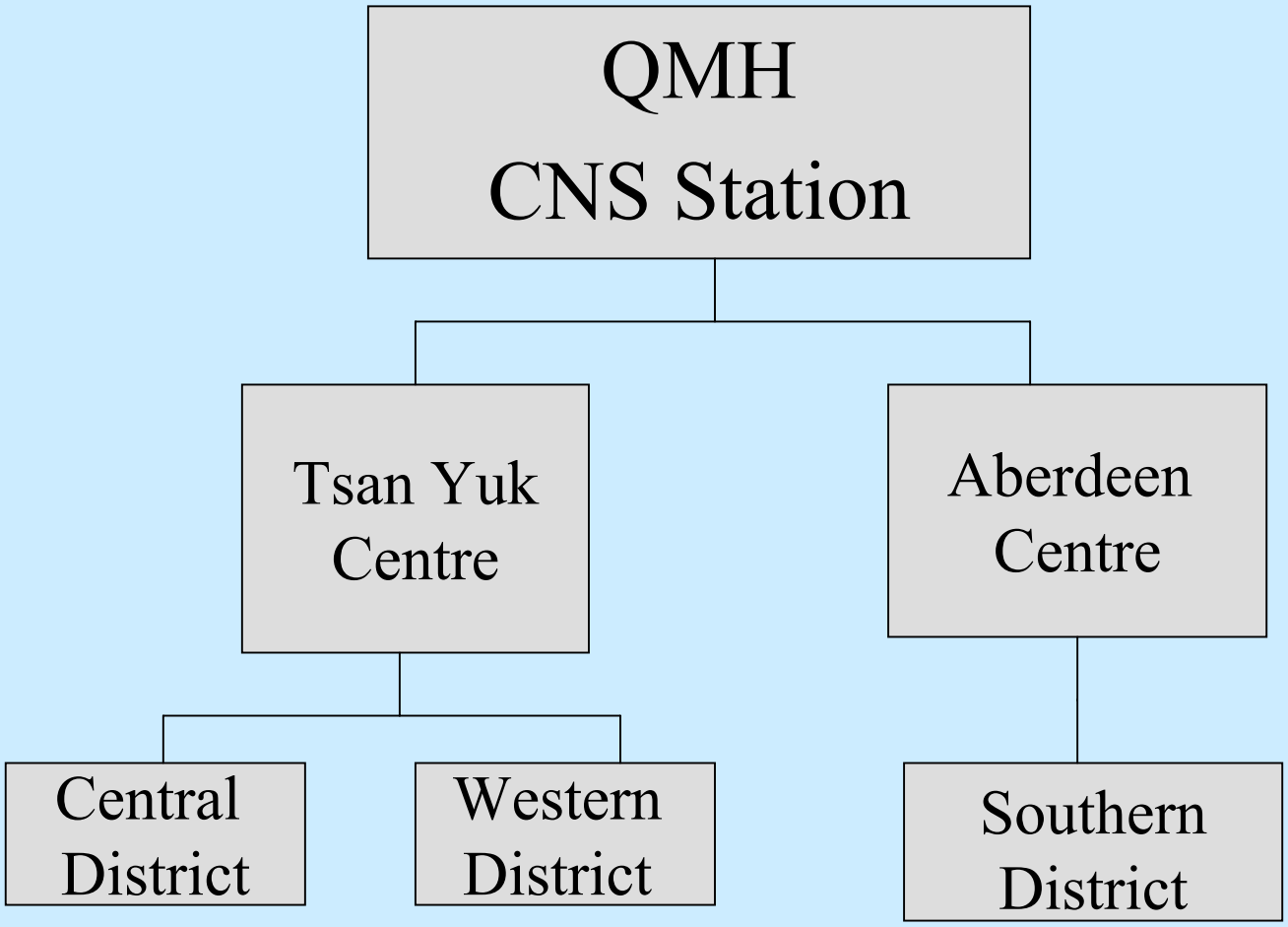
- To provide comprehensive and continuing home care nursing to clients according to their individual needs.
- To optimize self-care and positive resolution of clients' health care problems.
- To promote active participation of clients and their families in the treatment and rehabilitation process through education.



# Service Area



# Structure of HKW CNS



# Scope of Services

- General Nursing Care
- Specific Nursing Care
- Community Rehabilitative Care
- Community Health Promotion and Education
- Co-ordination with Various Community Health Care Partners for the provision of comprehensive care to the patients

# Nursing Service Provision (1)

- Comprehensive assessment
- Drug administration and supervision
- Nutritional care - Ryle's tube/ PEG care
- Central/Peripheral line care
- Ostomy care
- Wound/drain care
- Catheterization care
- Mobilisation exercises

# Nursing Service Provision (2)

Specimen collection

Renal care - CAPD,IP antibiotics, bladder irrigation

Pulmonary care - $SaO_2$ monitoring, Tracheostomy care, Puff techniques

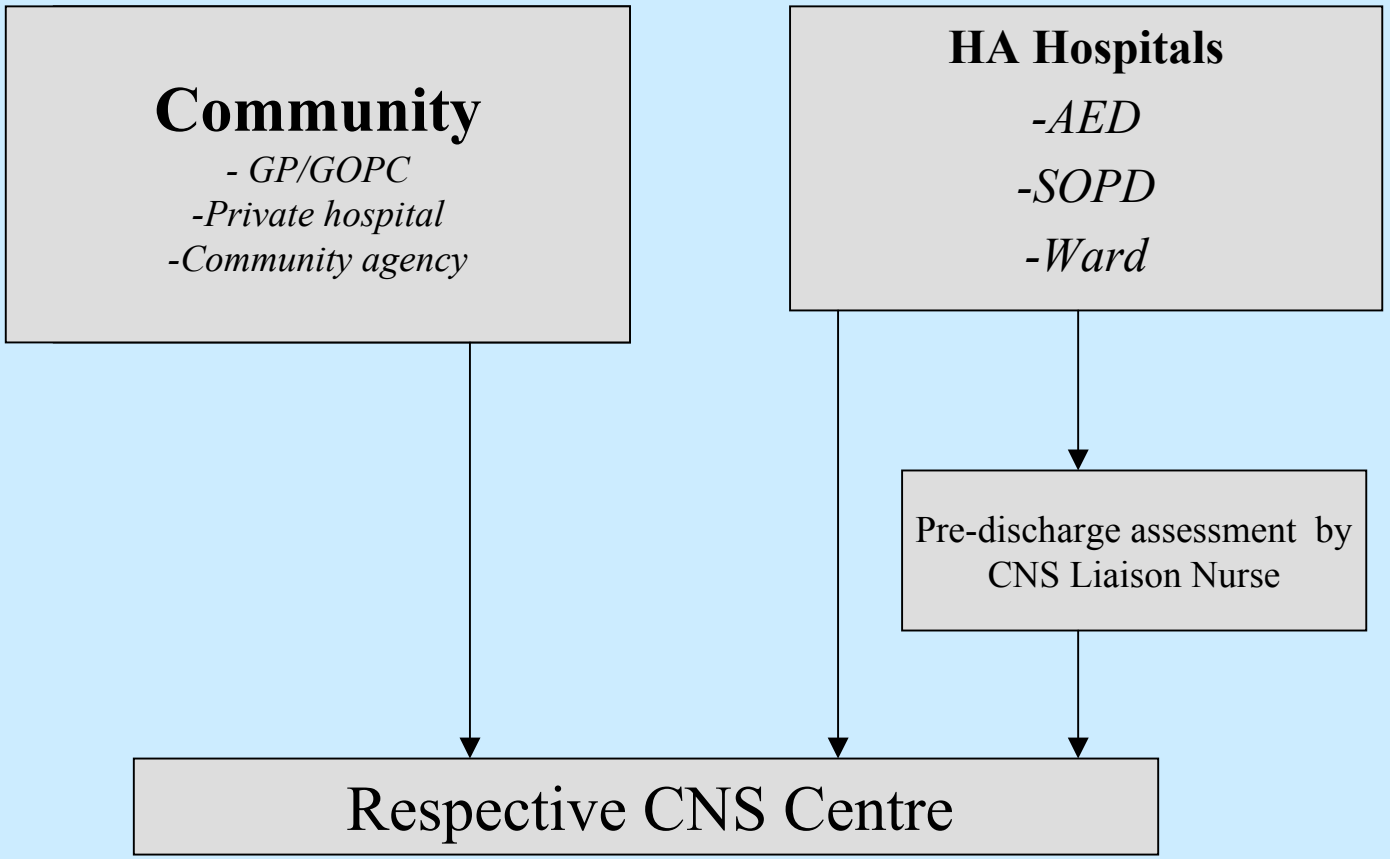
Diabetic care - Insulin injection, H'stix monitoring, DM foot care

Stroke care - Rehabilitation exercise

Hospice care

Postnatal and infant care

# Intake of Clients



# Referral Procedures to CNS

Identification of potential clients

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Completion of HA 1611 CNS referral form

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Notification of CNS station nurse

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Pre-discharge assessment interview by CNS station nurse

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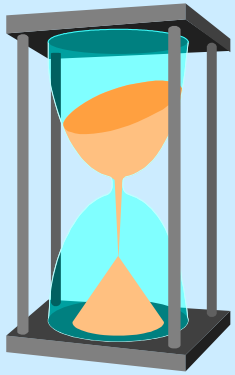
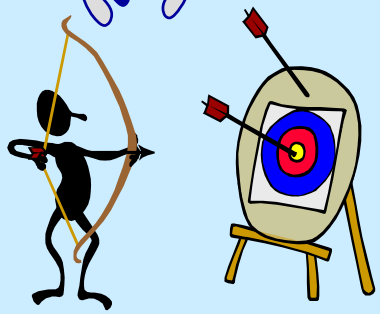
Acceptance of the case and referring client to related CNS centre



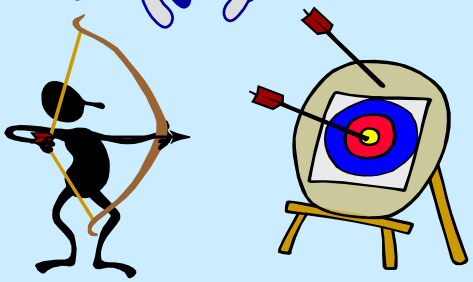
# Pre-discharge Assessment (1)



*Purposes :-*

- To identify high risk case
- To introduce CNS to client and relatives and obtain their consent for the CNS
- To explore client/relatives understanding of the disease process and progress
- To assess the bio-psycho-socio-spiritual needs of the client

# Pre-discharge Assessment (2)

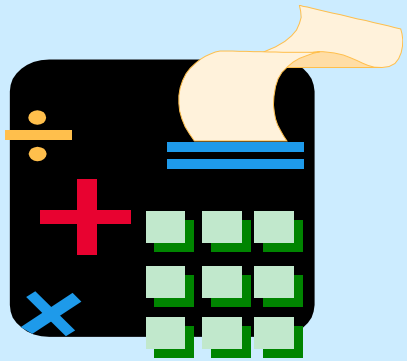


*Purposes :-*

- To advise client/relatives on preparation of necessary resources in their own environment
- To consult/refer to other health care professionals for collaborative community care if deemed necessary
- To refer MSW if service fee pose a problem
- To make arrangement for first home visit

# Service Charges

- HK $80 per visit
- Free service delivery for the following clients :-
  - Government servant and dependent
  - Pensioner and dependent
  - H.A. Staff and dependent
  - Retired H.A. Staff and dependent
  - CSSA recipients and beneficiaries
  - Charges waived by MSW
- Billing procedure is carried out by QMH Finance Department



# Visit Arrangement (1)

## Normal circumstances :-

*First home visit*
- the next working day following referral date

*Subsequent home visits*
- depends on client's condition and be scheduled under mutual agreement

*Working hours* - Monday to Friday 0830-1630
Saturday 0830-1230

# Visit Arrangement (2)

## Special circumstances :-

*First home visit*

- as arranged with the referral source and clients

*Subsequent home visits*

BD visit, Sunday and public holiday visits etc.

*Working hours* - BD visit 0830-1800
Sunday/PH 0730-1130 &
1400-1800

# Case Management Approach

- **NO / NS as Advanced Practice Nurse to**
  - **supervise performance of front line CN**
  - **support CN in making clinical judgement on complicated cases**
- **RN as case manager to**
  - **monitor post-acute and chronically ill patients in the community**
  - **provide direct home rehabilitative care**
  - **work with client / family members to empower them with self-care technique**
  - **co-ordinate services for client to enhance better utilization of community resources**

# Supporting Network (1)

- Good Supporting Network enhances better co-ordination with various community health care partners in order to achieve the following:-
  - Early identification of symptoms on relapse of diseases or emergence of new health problems
  - Timely nursing intervention
  - Appropriate medical referral

  so as to reduce unnecessary utilisation of health care resources

# Supporting Network (2)

- **Medical Supporting Network**
  - **Family Medicine**
  - **VMO**
  - **GP**
  - **CGAT**
- **Allied Health Supporting Network**
- **Social and Community Supporting Network**
  - **Non-government Organisations**

# Medical Supporting Network (1)

- **Family Medicine / GP / VMO**
  - **provide consultation service on episodic basis**
- **CGAT**
  - **provides specialty support to complicated cases.**

# Medical Supporting Network (2)

**Aim at provision of timely intervention**

- **Minor problems** - **nursing intervention**
- **Moderate problems** - **consult GP/VMO/FM**
  - **early special FU Appt in SOPD**
- **Severe problems** - **urgent medical consultation to related specialty**
  **± A & E Department**

# Allied Health Supporting Network

- **Mutual Referral System between CNS and Multi-disciplinary Teams**
  - **Occupational Therapists**
  - **Physiotherapists**
  - **Dietitians**
  - **Speech Therapists**
  - **Medical Social Workers**
  - **Podiatrists**

# Social and Community Supporting Network

- **Non-government Organisations (NGOs)**
  - **Programs**
    - **Enhanced Home & Community Care Scheme**
    - **Integrated Home Care Program**
  - **Mutual Referral System**
    - **Stabled cases to NGOs for continuous care**
    - **High risk cases to CNS for monitoring and early intervention**

# Ultimate Aim

- **To ensure well co-ordinated community services are available for the chronically ill patients in the community.**

# Conclusion

- **Patients**
  - **better quality of life**
- **Hospitals**
  - **better utilization of resources**
- **Community Partners**
  - **better co-ordination**