HONG KONG
COMMUNITY NURSING SERVICE
Past, Present & Future

May CHAN
Department Operations Manager
Community Nursing Service & Community Health
Princess Margaret Hospital, Kowloon West Cluster

醫院管理局
HOSPITAL AUTHORITY

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- Susanna LEE, HAHO M(N)/CNO
- Queenie LEUNG, POH GM(N)

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Hong Kong West Cluster

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- Catherine WONG, NC(CCS)

Kowloon Central Cluster

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- LEUNG siu-hung, NC(Community)

Kowloon West Cluster

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- Lorraine KONG, CMC WM(CNS)
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- HO Kim-lai, TMH WM(CNS)

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HA Community Specialty Advisory Group (SAG)

Community Nursing was introduced in 1967, first through the Yang Memorial Social Services Centre…

Community Nursing was recognized to be an integral part of the medical & health services from 1979…

CNS under HA after 1991

- Decentralised the management to hospitals
- Practice of nursing in patients' homes
- Continuing care for discharged patients
- Referrals typically for wound care or procedures

Decades' Changes

- Declining fertility rates
- Increasing longevity
- Ageing Hong Kong population
- High density of living environment
- The hospitalization rate per 1,000 population almost doubles with each 10 years after age 65

Key Challenge

"Enhanced Roles of Community Nursing and Effective Mode of Service Delivery in face of Growing Service Demand?"

Principles of Action

1. Engaging consumers & community as partners
2. Helping people stay healthy & out of hospital
3. Advocating hospital without walls
4. Enabling transformation & improving care

Modernization of Community Nursing

1. Hospital-at-home: Virtual Ward
2. Enhanced CNS Program
3. Estate-based Community Nursing Centres

Since October 2011

1. Hospital-at-home: Virtual Ward 虛擬病房

Hospital-at-home: Virtual Ward

Aims:

1. To reduce avoidable hospitalization
2. To improve care

Targets:

- Patients living with family or carer at home
- High readmission risk (*HARRPE $\geqq$0.4)
- Moderate to end stage chronic illnesses
- Complex care and/or end-of-life care

*HARRPE: High Admission Risk Reduction Program for the Elderly to screen for unplanned admission. The score is 0-1, 0.4 = 40% readmission risk.

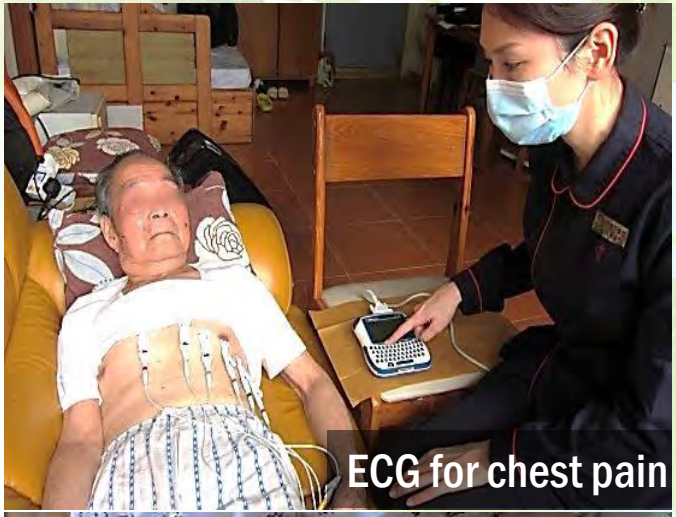
39 Virtual Ward beds in HK

240 Patients per year

8,400 Home Visits per year

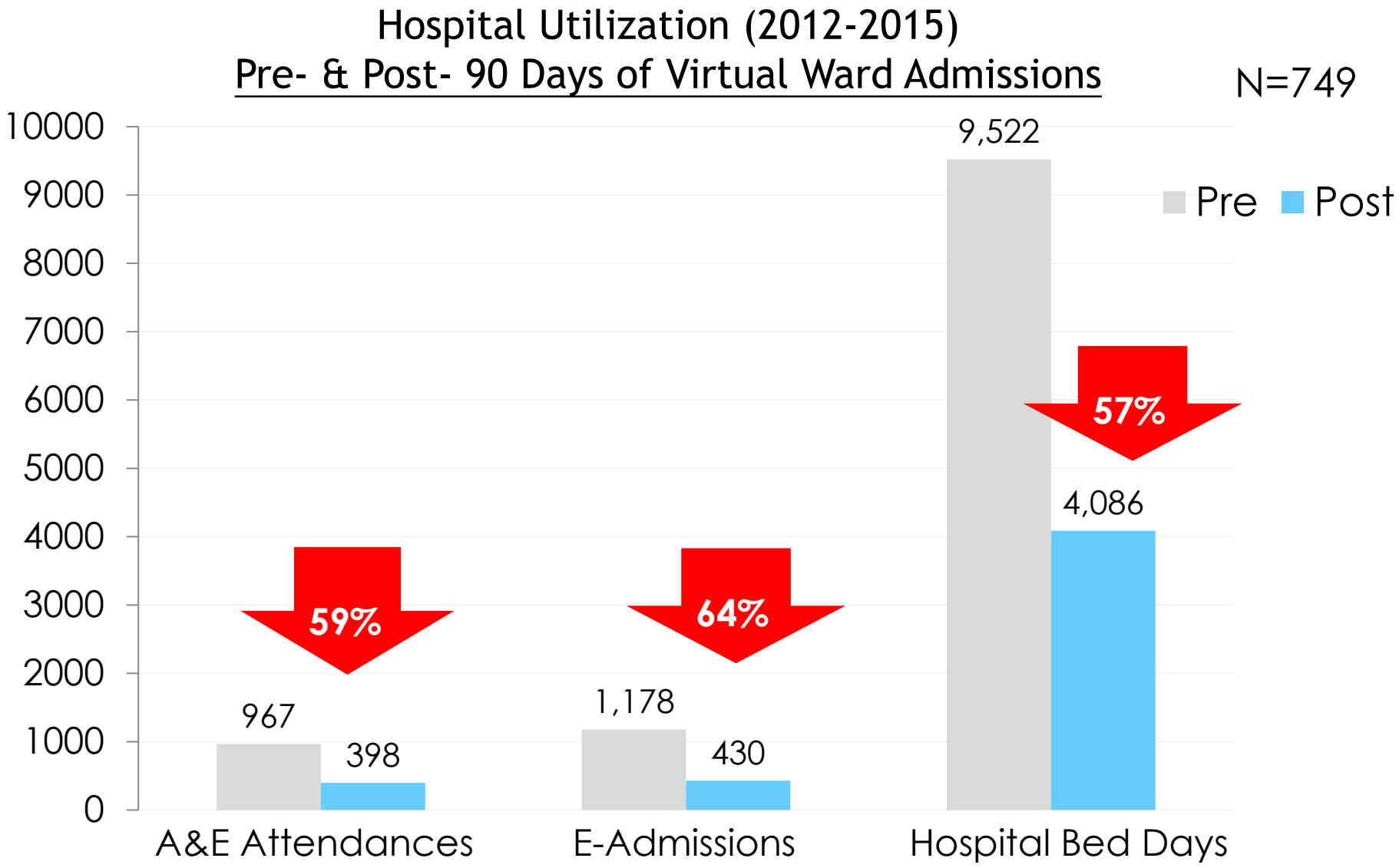
Characteristics

- Multidisciplinary team care
- Extended service hours till 20:00
- Protocol-driven investigations
- Substitutive hospital-at-home interventions
- Regular ward round & case conference


ECG for chest pain


Subcutaneous infusion

Virtual Ward was Effective



Consumer Testimonial

Female, aged 65, Motor Neuron Disease
Home ventilator, Tracheostomy & PEG care

"This year was the first birthday I could celebrate, share the joy & happiness with my family at home instead of lying on a bed of the Hospital in the past 3 years. Thank you Virtual Ward."

Virtual Ward was effective reducing unplanned readmissions and improving patients' quality of life…

(Leung et al., 2015)

Clinical Interventions in Aging

Dovepress

ORIGINAL RESEARCH

The effect of a virtual ward program on emergency services utilization and quality of life in frail elderly patients after discharge: a pilot study

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Doris Y P Leung[1]
Diana Tze-Fan Lee[1]
Iris F K Lee[1]
Lai-Wah Lam[1]
Susanna W Y Lee[2]
May W M Chan[3]
Yin-Ming Lam[4]
Siu-Hung Leung[5]
Pui-Chi Chiu[6]
Nelly K F Ho[7]
Ming-Fai Ip[8]
May MY Hui[9]

[1]The Nethersole School of Nursing, The Chinese University of Hong Kong, Shatin, Hong Kong; [2]Hospital Authority Head Office, [3]Kowloon West Cluster, [4]New Territories West Cluster, [5]Kowloon East Cluster, [6]United Christian Hospital, [7]Kowloon Hospital, [8]Tuen Mun Hospital, Hong Kong Hospital Authority, Kowloon, Hong Kong

Introduction: Attendance at emergency departments and unplanned hospital readmissions are common for frail older patients after discharge from hospitals. A virtual ward service was piloted to deliver "hospital-at-home" services by community nurses and geriatricians to frail older patients immediately after their discharge from hospital to reduce emergency services utilization.

Objectives: This study examined the impacts of the virtual ward service on changes in the patients' emergency attendance and medical readmissions, and their quality of life (QOL).

Methods: A matched-control quasi-experimental study was conducted at four hospitals, with three providing the virtual ward service (intervention) and one providing the usual community nursing care (control). Subjects in the intervention group were those who are at high risk of readmission and who are supported by home carers recruited from the three hospitals providing the virtual ward service. Matched control patients were those recruited from the hospital providing usual care. Outcome measures include emergency attendance and medical readmission in the past 90 days as identified from medical records, and patient-reported QOL as measured by the modified Quality-of-Life Concerns in the End of Life Questionnaire (Chinese version). Wilcoxon signed-rank tests compared the changes in the outcome variables between groups.

Results: A total of 39 patients in each of the two groups were recruited. The virtual ward group showed a greater significant reduction in the number of unplanned emergency hospital readmissions (−1.43±1.23 versus −0.77±1.31; $P=0.049$) and a significant improvement in their overall QOL ($n=18$; 0.60±0.56 versus 0.07±0.56; $P=0.02$), but there was no significant difference in the number of emergency attendances (−1.51±1.25 versus −1.08±1.48; $P=0.29$).

Conclusion: The study results support the effectiveness of the virtual ward service in reducing unplanned emergency medical readmissions and in improving the QOL in frail older patients after discharge.

Keywords: elderly, emergency attendance, emergency medical readmission, emergency services utilization, quality of life, virtual ward

Introduction

Attendance at emergency departments and unplanned hospital readmissions are common for frail older patients after discharge from the hospital.[1] Patients with chronic illnesses frequently perceived powerlessness in managing their disease after hospital discharge, and they are prompted to seek hospital readmission immediately upon symptom exacerbation.[2] Unplanned readmission is usually defined as readmission to the hospital within 28 days postdischarge.[3,4]

In Hong Kong, it was estimated that the unplanned readmission rate was 16.7% in the general population,[3] and more than 20% in the elderly subpopulation.[4] The Hong Kong

Correspondence: Diana Tze-Fan Lee
The Nethersole School of Nursing, The Chinese University of Hong Kong, 7/F, Esther Lee Building, The Chinese University of Hong Kong, Shatin, Hong Kong
Tel +852 2942 6027
Fax +852 2994 2107
Email tzefanlee@cuhk.edu.hk

「虛擬病房」免病人舟車勞頓

罹患長期疾病的年長患者，不便經常出入醫院。瑪嘉烈醫院——年推出「虛擬病房」服務，護士會定期為患者進行家訪，檢測身體狀況，免卻舟車勞頓之苦。服務推出兩年半以來，共有二百多名病人受惠，醫院的入住率大跌六成八，患者家屬的壓力指數亦減少近四成。

為紓緩醫院病牀的壓力，瑪嘉烈醫院的「虛擬病房」服務，主要針對荃灣及葵青區內，罹患中至末期程度慢性疾病的患者，如心臟衰竭。患者出院後，專責的護士團隊會定期家訪，覆檢病情，並與患者及家屬共同制訂長期的療養方法，改善生活習慣。

患有心臟衰竭的岑伯伯，自使用「虛擬病房」服務後，在護士勸喻下，已逐漸戒除不利心臟的重鹽份食品。他感謝護士勞心勞力的照顧，並讓自己及家人進一步認識病情，改善生活習慣。

護士上門 家居變病房

【新報訊】醫院病床時有人滿之患，病人亦厭倦經常出入醫院造成不便，瑪嘉烈醫院推行「虛擬病房」先導計劃，令期望在家中休養的長期病患者，只需安在家中的虛擬病房，也能接受醫院式照顧。計劃實……

情，探訪時更會帶同可攜心電圖機、膀胱超聲波掃描器等，檢查和治理患者症狀，如患者有特別需要，也會將其送院診治；醫生及護士亦每星期開會，商討每位病人病況，如何個別向他們提供適切治……及其家人共同……病者家人如……同時為最少……費全免：計……接收共80個……次，並且安……突發病情共

前3個月內使用急症室的總次數共169次，但參與後3個月內，只有53次，減幅達68.6%，住院日數亦由994日，減少至273日，減少達72.5%。該計劃榮獲2012年亞洲醫院管理顧客服務組別大獎。

壓力大減

……定成效，除……熟悉的地方……

The first ever HK Winner in Asian Hospital Management Award 2012

病人慶幸與紅白藍袋說拜拜

免除勞頓

有參與瑪嘉烈醫院「虛擬病房」先導計劃患者及其家人，指計劃可幫助他們毋須經常進出醫院，大大改善他們的生活質素。有病人本來每星期均需進出醫院，家中常備載滿入院用品的紅白藍袋，參與計劃後，他終於可以和紅白藍袋說「拜拜」。

終可在家慶生日

瑪嘉烈醫院社康護士資深護師孫丹指，患有嚴重慢性阻塞性呼吸病的78歲黃伯，以往經常因呼吸出現困難，需要入醫院接受治療，頻密至每星期入院一次，「醫院好似佢屋企，反而屋企似酒店」。家中常備已放置入院用品的紅白藍袋，隨時取走住院，令他和家人均甚感困擾，甚至過去3年的生日，都要在醫院度過。

不過，自從參與計劃後，有姑娘上門協助照顧，黃伯已毋須經常入院，可與紅白藍袋說「拜拜」，今年更可在家中過生日，他接受錄影訪問時自豪地說：「我已經4個月冇入過醫院！」黃太也說：「家人唔使照顧得咁辛苦，希望計劃可以繼續落去，幫吓其他人！」

新報記者

■黃伯與太太均認為虛擬病房有成效。

「虛擬病房 護養在家」成效顯

瑪嘉烈醫院去年十月全港首推「虛擬病房 護養在家」先導計畫，為居於葵青或荃灣區，入院風險高，患有中度至末期的慢性疾病，並有家人照顧的患者，提供「醫院式」在家醫護照顧，以減低醫院使用率，並讓患者與家人相聚。至今「虛擬病房」服務八十人次，更榮獲今年亞洲醫院管理顧客服務組別大獎。

負責計畫的瑪嘉烈醫院內科及老人科副顧問醫生蘇家駒表示，每名參與患者可接受兩至三個月免費服務，期間專責社康護士將提供約三十七次家訪，有別於傳統社康護士只監察病人服藥情況，或作簡單檢查，專責護士會帶同儀器，為病人作詳細檢查，如為心胸痛患者提供心電圖檢查，或為有尿道問題患者作超聲波檢查等。

瑪嘉烈醫院社康護士資深護師表示，醫生與護士會每周開會，跟進個案，如病人感不適，可提早入院檢查。患者家人得到社康護士協助，懂得如何照顧患者，大大減低他們的壓力。參與計畫的患者平均年……九歲，多患有心臟衰竭、慢性肺……尿病等，當中六成更患有三種或以……疾病。

已故，享年八十四歲的梁婆婆……有嚴重慢阻性呼吸道疾病及心力衰……

虛擬病房家中療養

▲護士上門護理用的心電圖儀器。

長期病患長者，經常因疾病復發而需要進出醫院，對病人家屬都構成照顧壓力，亦增加對醫療資源的依賴。

▲蘇家駒(左)表示，希望虛擬病房計劃可以擴展。右為孫丹。

虛擬病房護士到會監控病情

【本報訊】瑪嘉烈醫院去年 10 月起推出全港首個虛擬病房，透過專責護士以家訪和電話監控病情，以及「到會式」家居檢查，讓病情屬中度至末期的慢性病患者在家中獲得醫院式照顧。

截至今年 9 月為止，有 80 名患者透過虛擬病房方式回家休養，其中以心臟病患者、呼吸衰竭及癌症病人佔多。醫護人員家訪時可向相關病人提供心電圖、膀胱超聲波等檢查，若發現症狀不受控，會安排回院治療。

研究顯示患者住院時間及使用急症室使用次數均大減七成。

VIRTUAL WARD

Pioneered a new service model “Hospital-at-home” for better care in Hong Kong

2. Enhanced CNS Program

Support for Patients with Chronic Disease & Early Discharge from Hospital

Modernization of Community Nursing

Enhanced CNS Program *includes*

1. Case management approach
2. Case identification & risk stratification
3. Partnership working with patients and carers
4. Empowerment on chronic disease management
5. Interface with inpatient services

CNS Liaison Nurse conducting pre-discharge patient assessment in ward

Target Patients

- Newly diagnosed chronic disease(s)
- Unstable health conditions e.g. COPD exacerbations
- Moderate readmission risk (*HARRPE $\geqq$0.2)
- Emergency admissions $\geqq$2 times in 3 months
- Require advanced nursing interventions
- Program based protocol-driven care

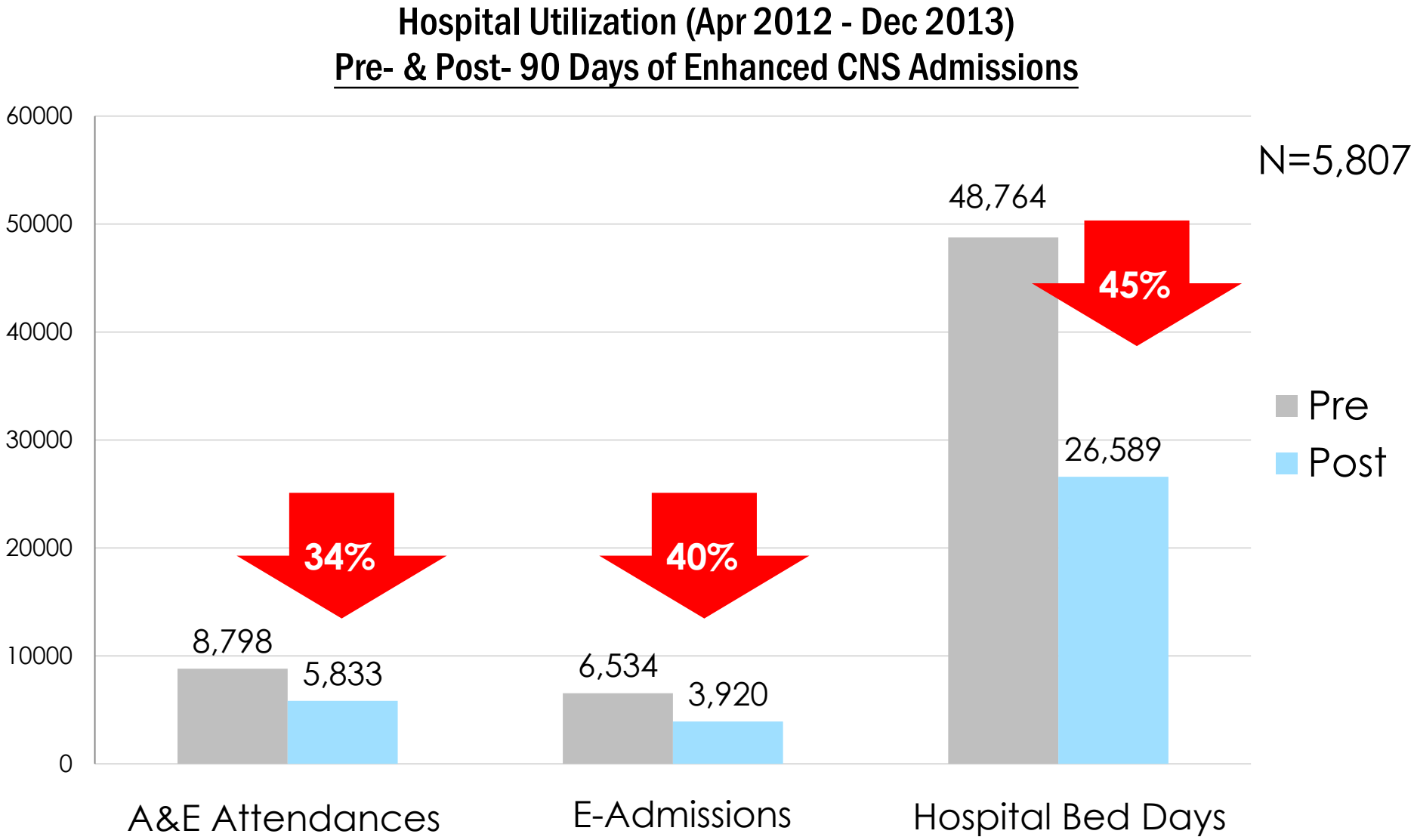
*HARRPE: High Admission Risk Reduction Program for the Elderly to screen for unplanned admission. The score is 0-1, 0.2 = 20% readmission risk.

ENHANCED CNS

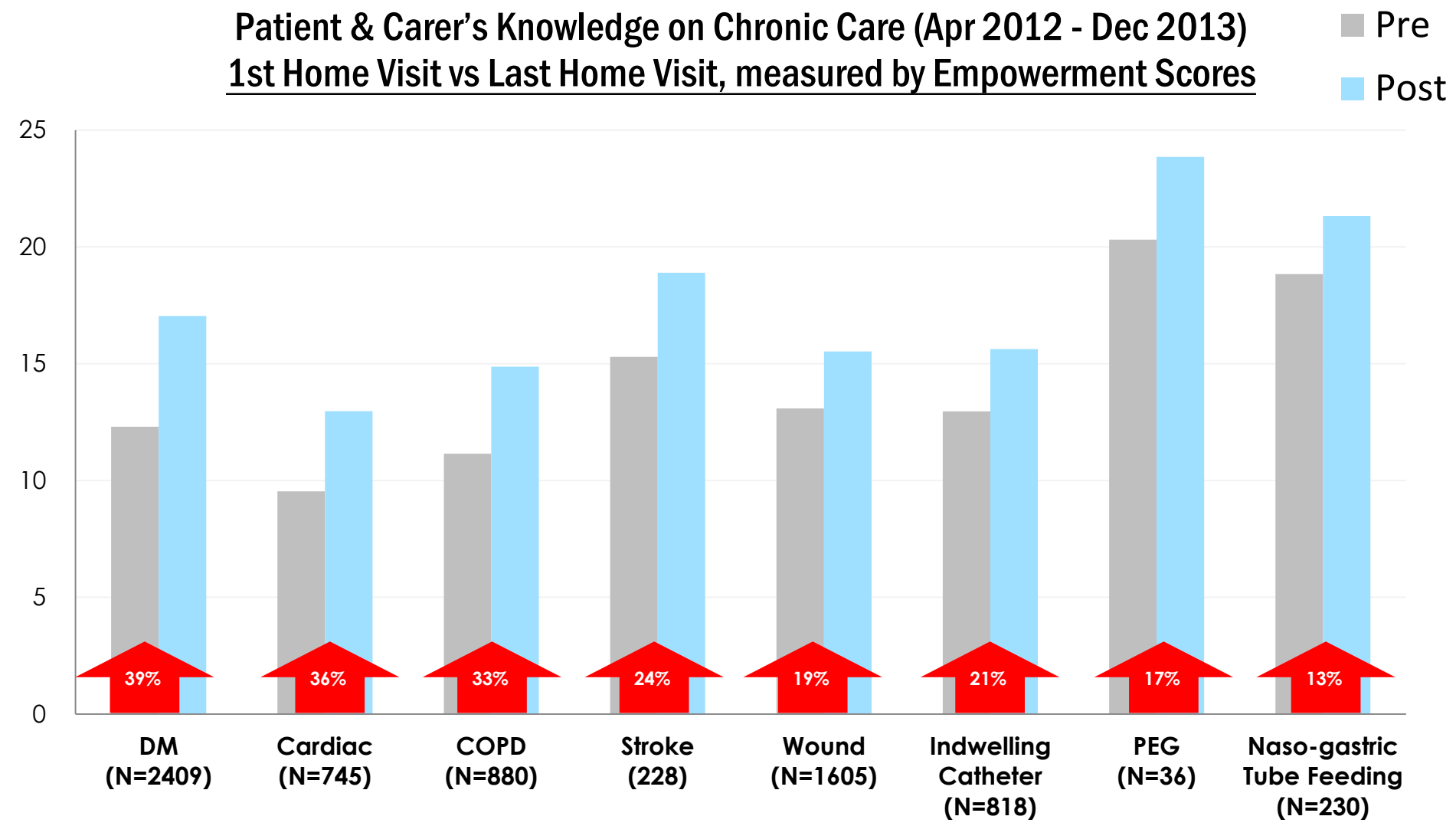
3,700 Patients per year

8 Home Visits per patient

Enhanced CNS reduced Hospitalizations



Enhanced CNS Empowered Chronic Care



ENHANCED CNS

Successfully enabled and empowered patients & family as partners in care

3. Community Nursing Centre

Foster Community Partnership & Promote Ageing in Place

Community Nursing Centres were set up in Estates having >3,500 elders in Hong Kong


Shui Pin Wai Estate, Yuen Long

Yue Wan & Tsui Wan Estate
Chai Wan


Fu Cheong Estate, Shamshuipo


Oi Man Estate, Ho Man Tin

The Centres *provide*

1. Walk-in service for health maintenance
2. Nurse consultation spots for care advice
3. Group therapy for care empowerment

COMMUNITY NURSING CENTRES

60,000 Walk-in attendances per year

769 Customers surveyed, **97%** satisfied with the service

372 Patients consulted community nurses & reduced **41%** A&E attendances (pre- vs post- 90 days)

“east or west, **home** is the best.”

Community Nursing Centres create modified access for elderly people to healthcare services in their home and community.

CNS 2015

Community Nursing Service

7 Clusters **16** Hospitals **40** CNS Centres

69,552 new patients

861,961 home visits

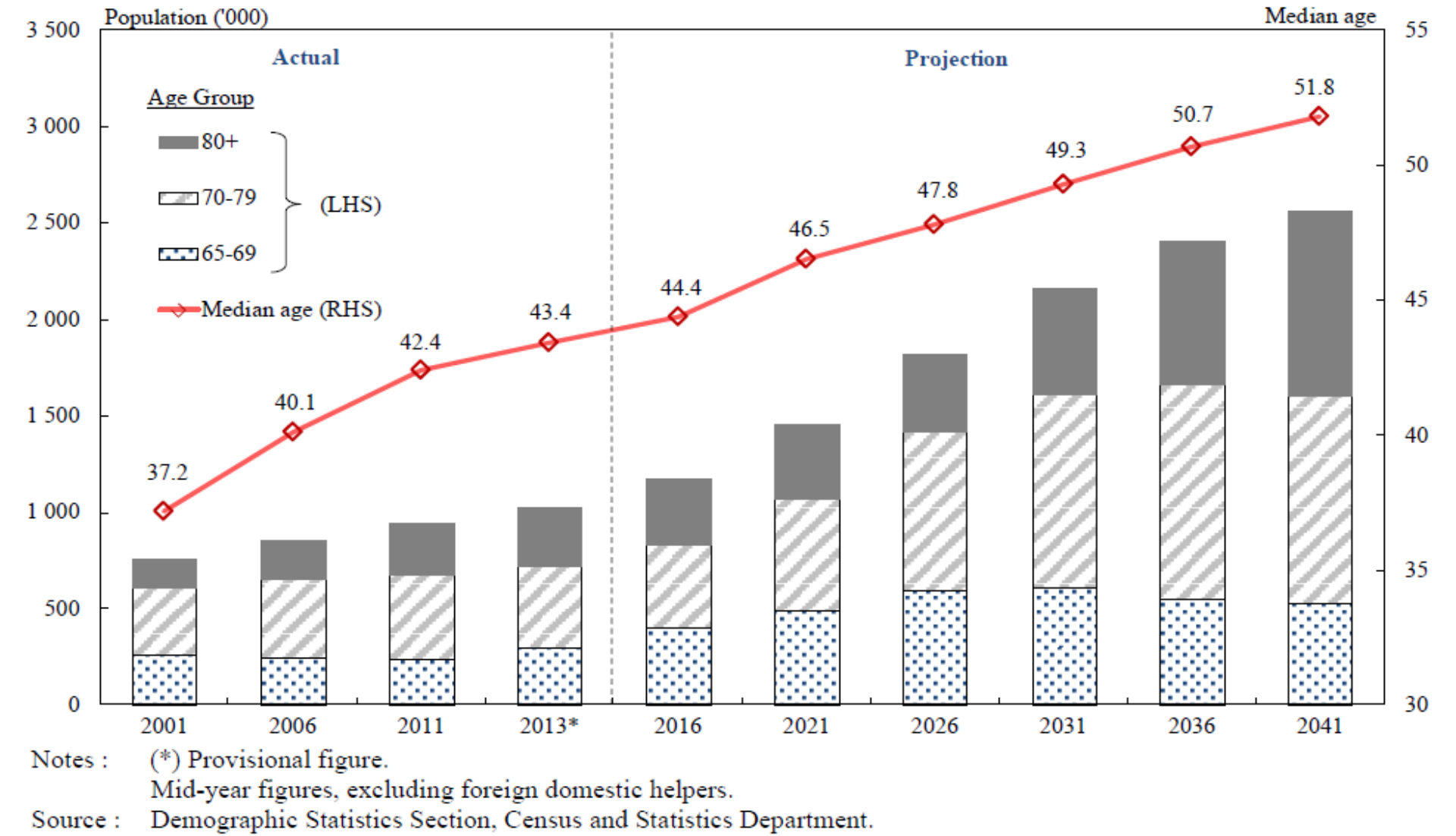
The changing healthcare needs are the drivers for the reform of healthcare delivery...

39 virtual ward beds serving **240** frail elders

3,700 cases under Enhanced CNS Program

4 Estate-based Community Nursing Centres

HK's Population is Ageing Fast



Notes : (*) Provisional figure.
Mid-year figures, excluding foreign domestic helpers.

Source : Demographic Statistics Section, Census and Statistics Department.

Source: http://www.hkeconomy.gov.hk/en/pdf/box-13q3-5-1.pdf

The Way Forward

- **Community Care** is set to take on an even more prominent role in the health care system over the next two decades.
- The challenge is to work across boundaries developing an **integrated, patient-centred service** which will transform care for this growing group of people…

Conclusion

Community Care is an effective alternative to hospital-based care. "Partnership Working" and "Matching Care to Needs" are keys to our long-term success in healthcare.

The Future integrative, cross-specialty…

The Present disease management & transition of care

The Past episodic care, long-term care

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THANK YOU

For more info, please email
chanwmm@ha.org.hk