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From Hospital to Community - Technology-Assisted Care Model for Pre-Discharge Assessment in Tuen Mun Hospital

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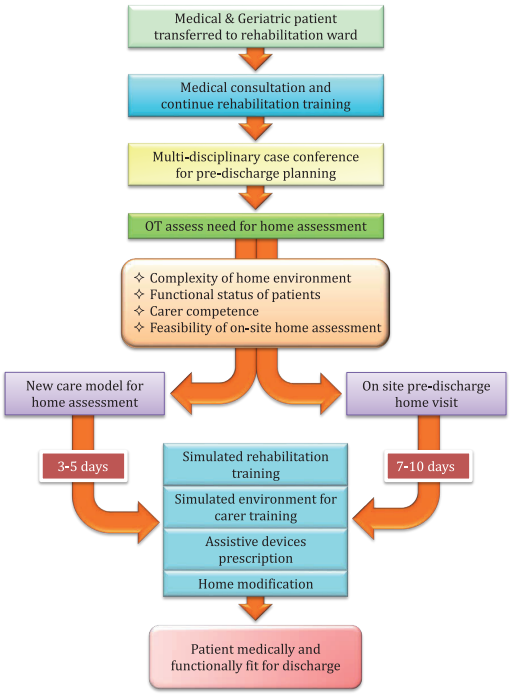
Occupational therapist (OT) facilitates patients' discharge and reintegration into their home through environmental assessment and interventions. To cater for the high patient volume and improve the timeliness of home assessment, a technology-assisted care model on pre-discharge home assessment was developed.



Patients were stratified by four factors, including (1) complexity of home environment (e.g. village cottage vs. public housing estate); (2) functional status of patients; (3) carer competence; and (4) feasibility of on-site home assessment (e.g. availability of family members, location). Complicated cases with potential need for major constructional environmental intervention would be referred for on-site home visit. For cases stratified to technology-assisted fast-track care, carers would be given a standardised assessment form and instructed to reply with the measurement through a designated email. After interpretation, home environment could be simulated with specially designed devices to facilitate practice of activities of daily living and carer training. Prescription of assistive devices, minor home modifications, furniture re-arrangement and advice on home safety would also be provided.

From January 2018 to November 2019, 927 and 169 medical rehabilitation patients were referred to technology-assisted care model and on-site home visit respectively. Comparing with conventional on-site visit, this new care model took shorter waiting time from referral to completion of assessment (3-5 days vs. 7-10 days) and lower average time cost (10 minutes vs. 120 minutes). This care model stratified our patients to appropriate level of care, enabling occupational therapist to increase capacity for environmental screening and interventions for pre-discharge planning, and facilitating safe and timely discharge.

Fast-track pre-discharge home assessment through digital technology

With information from home assessment, occupational therapist provides training in simulated environment

In This Issue:

Editorial Comments

The Technology-Assisted Care Model on Pre-Discharge Home Assessment in Tuen Mun Hospital (TMH) makes excellent use of technology to manage an ever-increasing workload. It managed to dramatically cut the time from referral to assessment completion by half, thereby facilitating a timely discharge and freeing hospital beds. The team should be commended for not applying the model indiscriminately across the spectrum of cases, such that complicated cases still get due attention and home visits. A very successful model indeed!

Hon. Assoc. Prof. William C M CHUI

Clinical Stream Coordinator (Pharmacy), HKWC

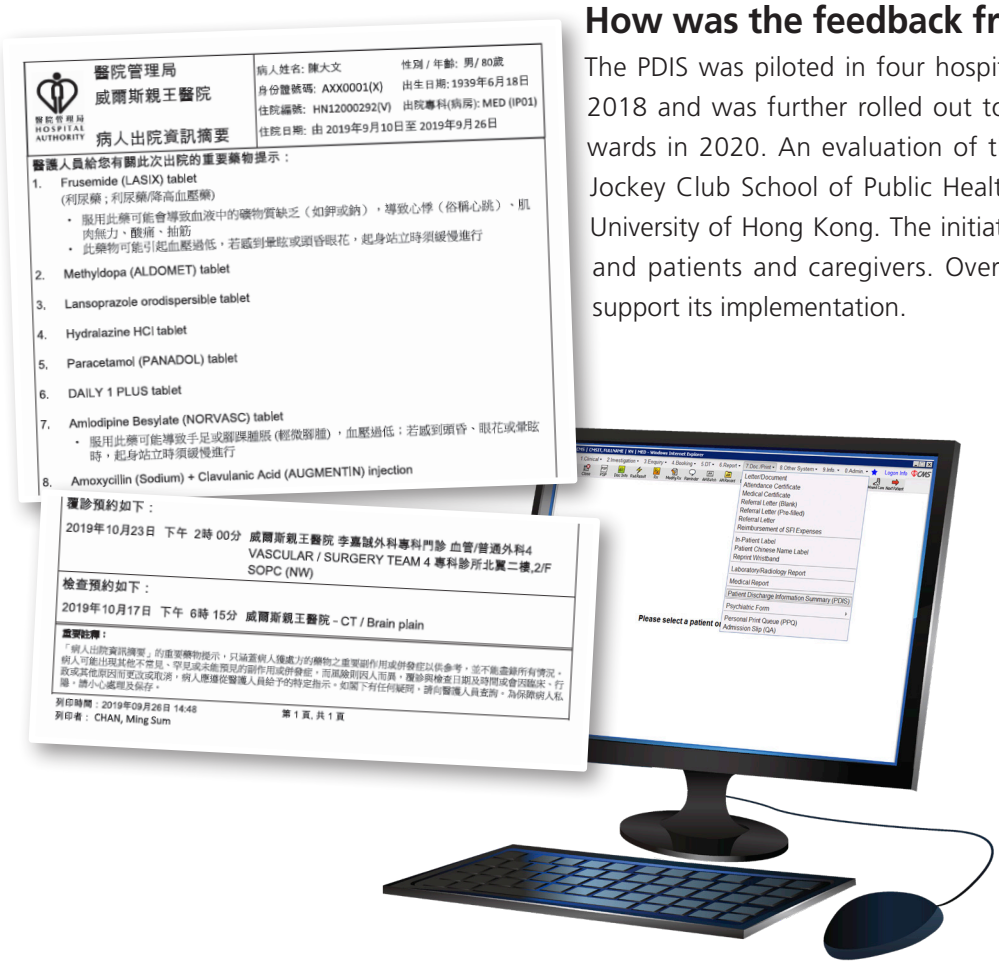
Enhancing Patient Discharge Experience with Patient Discharge Information Summary (PDIS)

*By **Department of Quality and Standards**, Quality and Safety Division, HAHO*

HA strives to provide quality healthcare services to the Hong Kong public and patient experience survey has been conducted on an ongoing basis to facilitate our review on public healthcare services. The survey has consistently shown patients' need for better self-care information upon discharge. To address this gap, Patient Discharge Information Summary (PDIS) was developed to provide a clear and concise summary of important medical advice to patients and their caregivers.

What does PDIS include?

The PDIS consists of two major parts: the Salient Medication Reminders (SMR) and an appointment list. The SMR lists out key information of the patient's prescribed medications including possible side effects. About 58 commonly prescribed drug entities, which include 235 drug items, were identified and the side-effect information for these items were established. The second part of the PDIS is an appointment list that summarises the patient's follow-up and investigation appointments in HA hospitals. The list includes appointment dates, time, and addresses to help patients for a better arrangement.



How was the feedback from various stakeholders?

The PDIS was piloted in four hospitals (PYNEH, RH, PWH and TMH) in 2018 and was further rolled out to all Medicine and Geriatrics (M&G) wards in 2020. An evaluation of this initiative was conducted by The Jockey Club School of Public Health and Primary Care of the Chinese University of Hong Kong. The initiative was welcomed by both our staff and patients and caregivers. Overall, there was positive feedback to support its implementation.

Way forward

In the way forward, it will be explored for PDIS to expand to other specialties. We also hope PDIS can be integrated into HA Go in the future to further enhance information sharing and facilitate clinical workflow. We will continue to make our efforts to improve quality of our services.

Editorial Comments

Patient is usually given numerous information sheets before discharge. The PDIS is able to provide a clear and concise summary of the essential information which effectively fosters communication and facilitates self-care upon discharge. The future plan to expand to other specialties and integrate into HA Go is encouraging and can further extend the benefits of PDIS.

Dr Joanna PANG
Chief Manager (Health Informatics), HAHO

Improvement of Advance Care Decision through Advance Care Planning (ACP) Clinic

By PMH M&G Discharge Planning Coordinator ***Jessica YIK[1], WY KAN[2], Cathy CHEUNG[2], Monica POON[2]***

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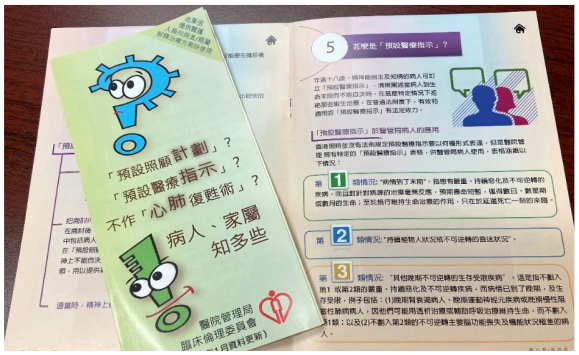
Advance care planning (ACP) is a proactive communication process to guide patients with advanced progressive disease on expressing their wish and preference regarding the end-of-life (EOL).

In collaboration with geriatricians, ACP clinic has been piloted in Medicine and Geriatrics Department at PMH to facilitate and improve the advance care decision making for patients since April 2019. At the ACP clinic, all discharge planning coordinators (DPC) have been trained on EOL/ palliative care and communication skills.

With an out-patient setting at ACP clinic, patients and family members are interviewed by DPC. In addition to introducing the concept of ACP including patient's prognosis and treatment options, DPC facilitate the discussion and understanding on patient and family's preferences and values. Eventually, DPC summarise the discussion and the patient is able to reach a decision.

Medical and nursing interview with family members

Details of the discussion are documented on the ACP form and signed with confirmation by doctor and patient or family members. An advance directive and/or Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR) form may also be used if deemed appropriate.



Advance directive information pamphlet and booklet

Short video time before interview

By December 2019, thirteen patient and family groups were interviewed in ACP clinic. 85% of them had signed the ACP forms to indicate patient's advance care plan. The healthcare team was appreciated for providing effective patient-centerd care and formulating patient's ACP to achieve a 'good death' in patient's last journey of life as well as establishing a professional nursing image in EOL care.

Editorial Comments

Advance care planning (ACP) might not be widely practised in Hong Kong because of the traditional cultural values of Chinese society. However, the need to improve end-of-life care with ACP is enormous and ever increasing. The ACP clinic demonstrates an excellent example to achieve patient-centered care by taking into account the best interest of patients and family members at the end-of-life journey. With the improvement of advance care decision, scarce healthcare resources could be better utilised in delivering quality healthcare services to the patients and their families.

Dr Osburga CHAN
Service Director (Quality & Safety), KCC

CLUSTER SHARING

Hong Kong East Cluster

HKEC Sharing: Patient and Nurse Empowerment Program to Strengthen the Discharge Information and Communication

By ***MC Chow[1], TL Choi[1], Angel KM Wong[1], Geoffrey TM Chan[2], Quinton CK LAM[3], Alex HF SHE[3],***

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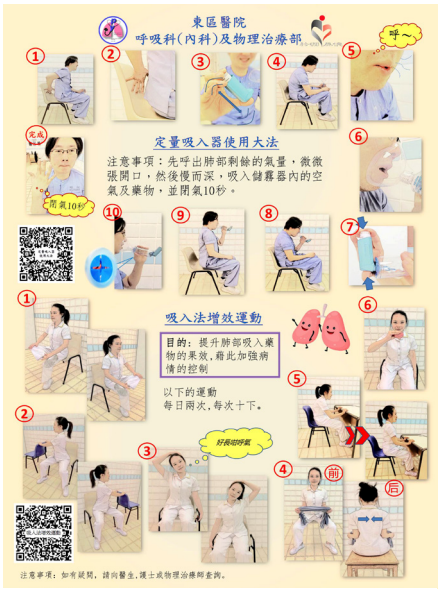
Chronic Obstructive Pulmonary Disease (COPD) Patient Empowerment with Discharge Care Bundles

Since October 2019, COPD discharge care bundles programme in PYNEH has been implemented to empower COPD patients on symptoms control and improve their exercise tolerance for their daily activities.

COPD Helpline

Smoking cessation and pulmonary rehabilitation programme are arranged and reinforced. With telephone helpline and follow-up nurse clinic monitoring support, drug compliance increased by 13.9% (from 81.9% to 95.8%) and inhaler technique score improved from 74.66% to 94.66%. In collaboration with Department of Physiotherapy, video QR code and educational poster were designed to facilitate patients to perform home exercise. After the implementation of the discharge care bundles programme, the readmission rate of COPD patients reduced by 5% and 11% in 1Q2020 and 2Q2020 respectively. In the future, we plan to explore the feasibility of home exercise by video call to monitor the effectiveness through an interactive approach.

Physiotherapy Exercise Video



Puff Education Poster

Pamela Youde Nethersole Eastern Hospital
Department of Surgery
F10 Ward
Early Discharge Planning Program

Background		
Diagnosis : _____		
Date of recruitment: _____		
Date	Patient status	Patient label
	Clinically unfit for discharge	
	Clinically planning to discharge	
	Clinically fit for discharge	

Potential and Active Discharge Problem

- ☐ ADL de-conditioning due to prolonged hospital stay or clinical complications
- ☐ Abrupt changes in anatomy which are affecting daily activities
- ☐ Daytime alone / live alone elderly
- ☐ Financial problem
- ☐ Placement problem
- ☐ Poor family support
- ☐ Others (please specify) : _____

Action Plan

Refer to : ☐ Geriatricians ☐ Integrated care model ☐ Medical social worker
☐ Occupational therapist ☐ Physiotherapist ☐ Others : _____

Date	Action	Progress (please review in 3-5 days)

Early Discharge Planning Program

Patient Post-discharge Empowerment Program in Surgical Department

The early discharge arrangement for patients and communication with involved parties in the Department of Surgery aims to "early detect and early tackle" the barriers, shorten patient's length of stay and reduce the chance of readmission due to the same complaint.

Before discharge, a multi-disciplinary team ensures early mobilisation for post-operation patients, such as regular sit out of bed with cycling and walking exercise by physiotherapist etc. Ward-based early discharge program and intensively case review at weekend, Patient Care Management Round and case conference for discharge problem case act as an effective safety guard as well. When patient is allowed to be discharged, special technical caring skills are demonstrated, such as tube feeding and self-stoma care. Also, respective instruction sheets are provided to improve patient's knowledge and self-care technique in their recovery phase, including corresponding illness and procedure-based information, drain and foley care education pamphlets, follow-up appointment, common medication and diet advice. Hotline is offered to patients for seeking help after discharge. We believe that our discharged patients feel more confident and secure under all these empowerment programs.

Editorial Comments

Good communication between care providers and patients and detailed technique training provided to patients before discharge have shown to improve patients' satisfactory, drug compliance and success in the empowerment programs. Besides, the availability of telephone hotline also plays a part in building up confidence of post discharge patients.

Dr Carmen CHAN, Deputy Service Director (Quality & Standards), HKWC

Comments are welcome

Please email us at address:
HO Quality & Standards Department