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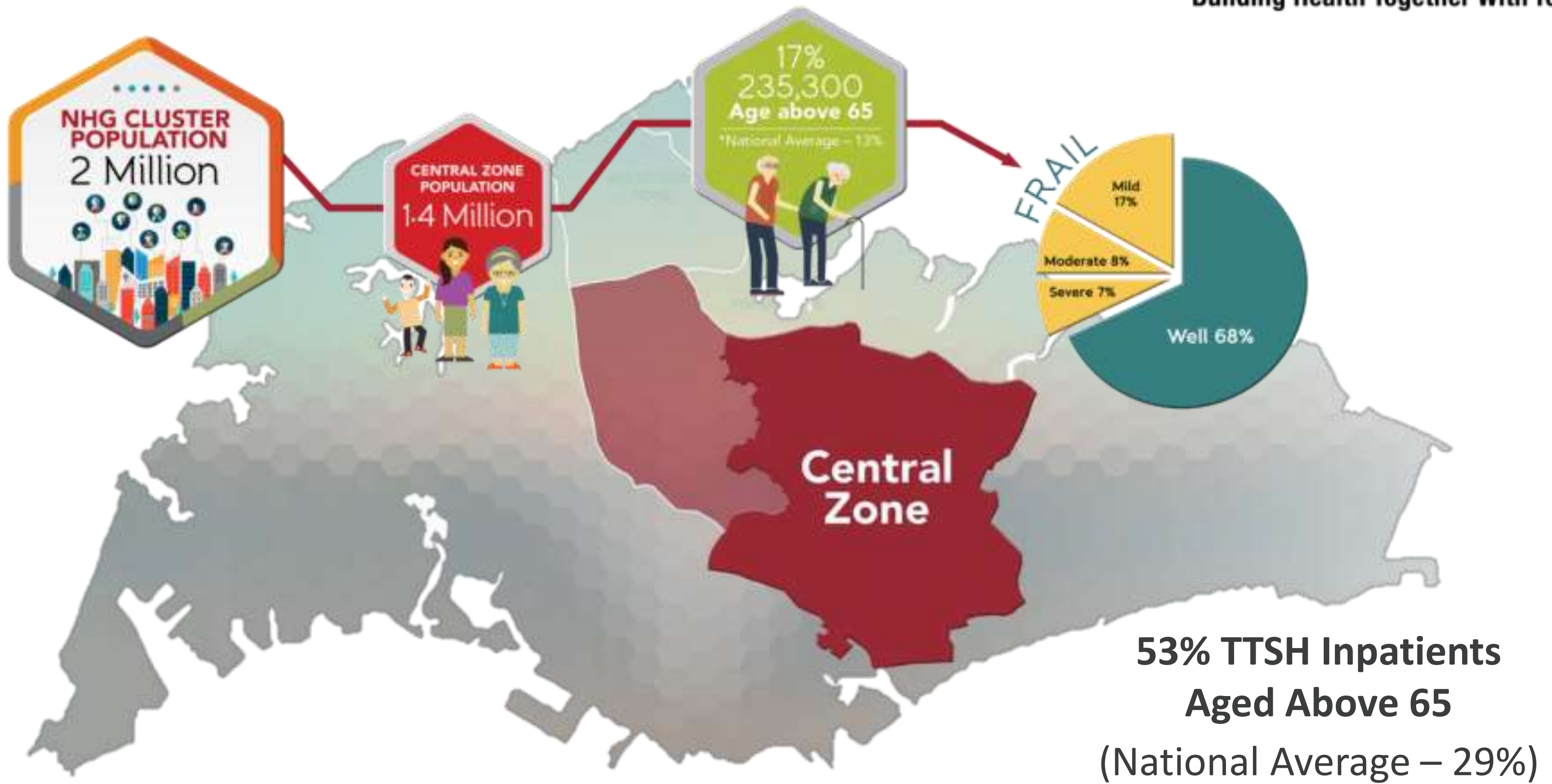
Community Nursing Issues in caring for renal patients – Hospital to Home Programme (H2H)

Rujia Ali Shahul Hameed

CENTRAL HEALTH

Building Health Together With You



53% TTSH Inpatients Aged Above 65

(National Average – 29%)

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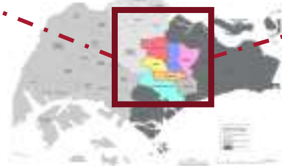
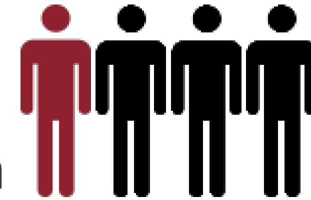
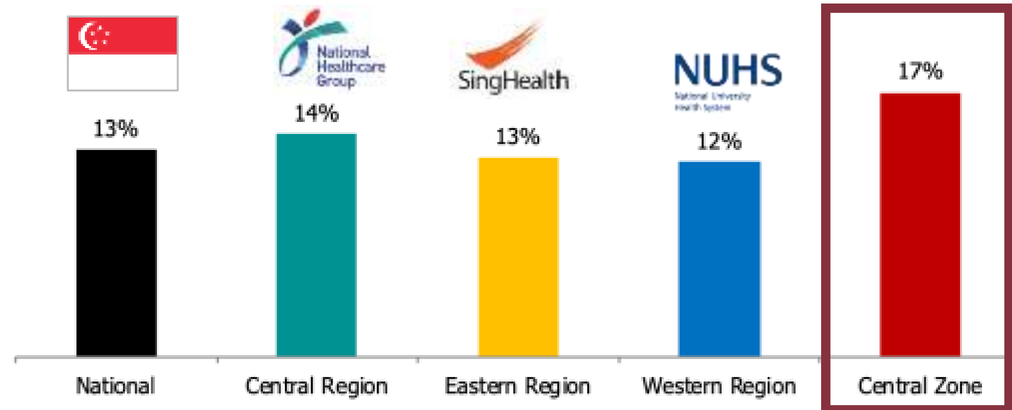
THE CENTRAL POPULATION WE SERVE



Makes up **26%** of Singapore's Population



Zone with the **Highest** Proportion of Residents **Aged >65***



1 IN 3 Central Zone Elderly lives with Frailty

*Singapore Department of Statistics, Population Trends, June 2017

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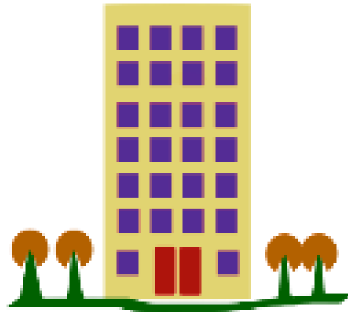
Care Delivery in the Present State



Meet Uncle Lim

- 68 years old
- Single, lives alone
- Has high cholesterol and high blood pressure; on 3 chronic medications
- Ambulates with an umbrella as walking aid

Since retirement…

- Loves to go to the coffee shop near his block for breakfast and catching up with neighbours on local news
- Frequents the Senior Activity Center (SAC) at his block where he enjoys playing mahjong with some *kakis*

Recently…

- Feels tired more easily and seldom visits the SAC or his favourite coffee shop
- Staff and his *kakis* notice he has been losing weight when he does go to the SAC
- Mentions that he sometimes skips his meals as he is lazy to go out and buy food
- SAC staff arranges for Meals-on-Wheels to deliver food to Uncle Lim

3 months later…

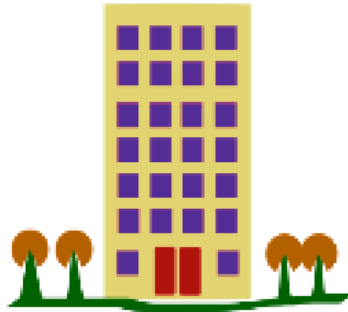
- Uncle Lim does not appear to have gained back the weight he lost; he prefers his favourite *char kway teow* to the meals delivered to his home
- He appears more frail, experiences pain in his leg and does not go out anymore

How might Uncle Lim's needs be addressed?

Go to the *Hospital?*

- Would Uncle Lim understand his care plan and be able to follow it post-discharge?
- Who could follow-up with Uncle Lim on his chronic conditions?
- Who could monitor his care plan and coping in the community??
- Could Uncle Lim's admission be avoided with earlier reporting and interventions in lifestyle changes?

Care Delivery in the Present State



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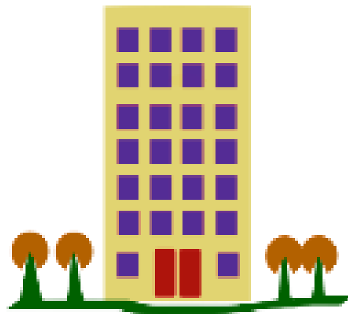
How might Uncle Lim's needs be addressed?

Go to a *GP/ FMC?*

- Would Uncle Lim be able to explain what was happening?
- Could the GP/ FMC assess his need and prescribe any required walking aids, home modification or exercise?
- Who could reinforce the required lifestyle changes and proper use of walking aid?

Care Delivery in the Present State



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How might Uncle Lim's needs be addressed?

Approach *SAC staff* for help?

- Do they have the knowledge and skills required formulate a management plan that addresses the weight loss issues and pain he is facing?
- Could the SAC have been able to identify his issues earlier and provided the relevant advice on lifestyle changes?
- Could Uncle Lim be empowered with the skills and knowledge to report his own issues?

Community Health

ROLE OF COMMUNITY HEALTH

To ensure and maintain the ***well-being*** of the ***Central Health resident population***, keeping them well in the community and minimizing healthcare resource utilization.

- Primary Care* - Community Partners* - Activated Residents*

*Note: Locality-Based

3 Aspects of Well-Being

- Health
- Social
- Mental

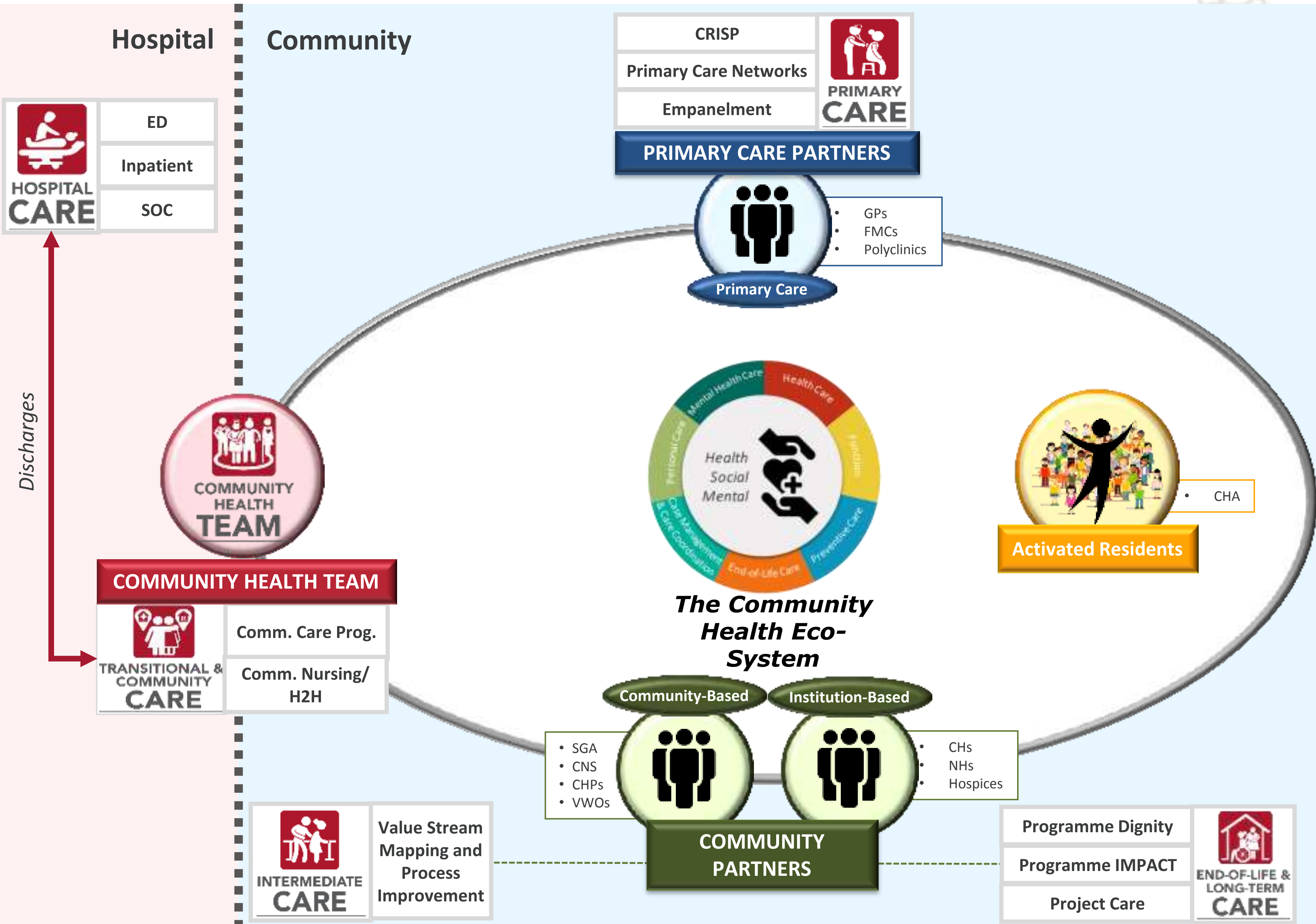
Central Health Population

- ≥65 years old
- 40 – 64 years old
- <40 years old

Our Three-Pronged Strategy

- Service provision
- Collaboration
- Activation

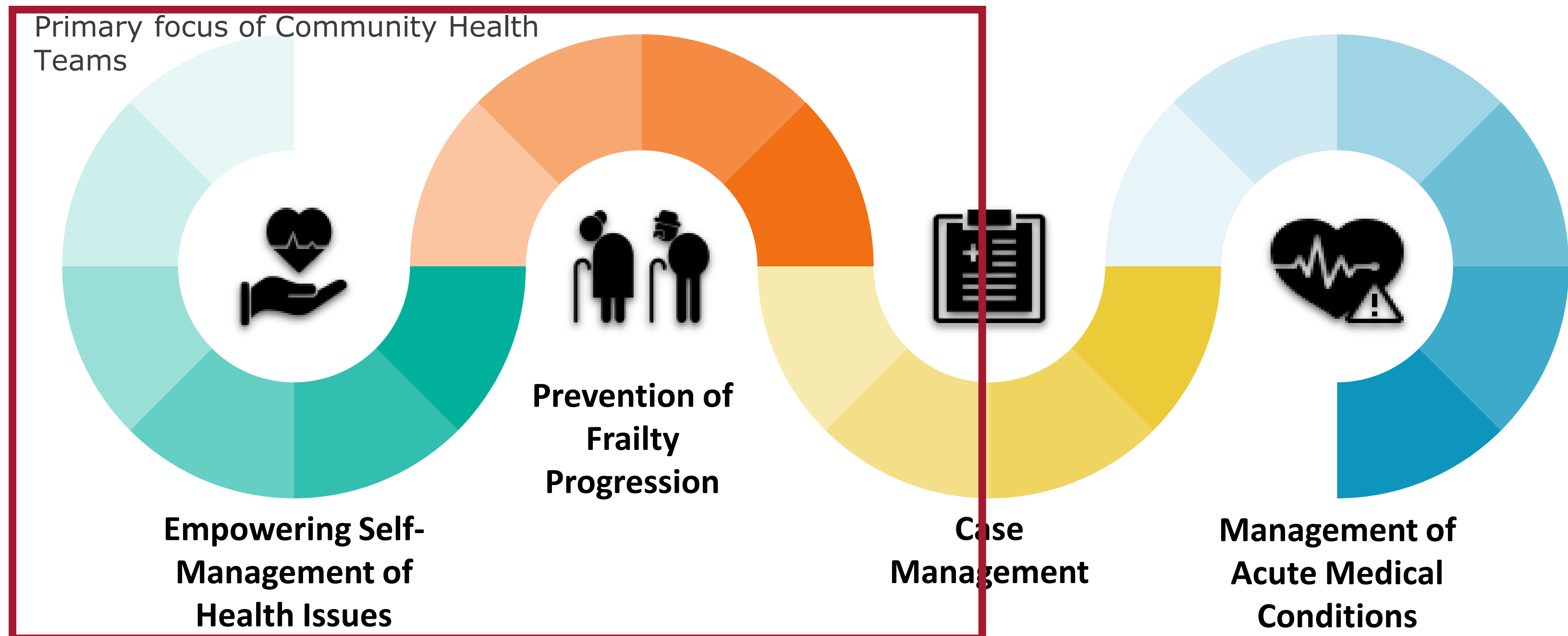
The Community Health Framework *(within Sub-Zones)*



Scope of Community Health Teams

OBJECTIVE OF THE COMMUNITY HEALTH TEAMS

To ***build relationships*** and ***work with local partners*** across health care and social care domains to enable ***health engagement***, ***care coordination*** and ***ageing-in-place***.



Service Provision

- Risk assessments
- Case management
- Coaching, counselling
- self-empowerment
- Bridging interventions

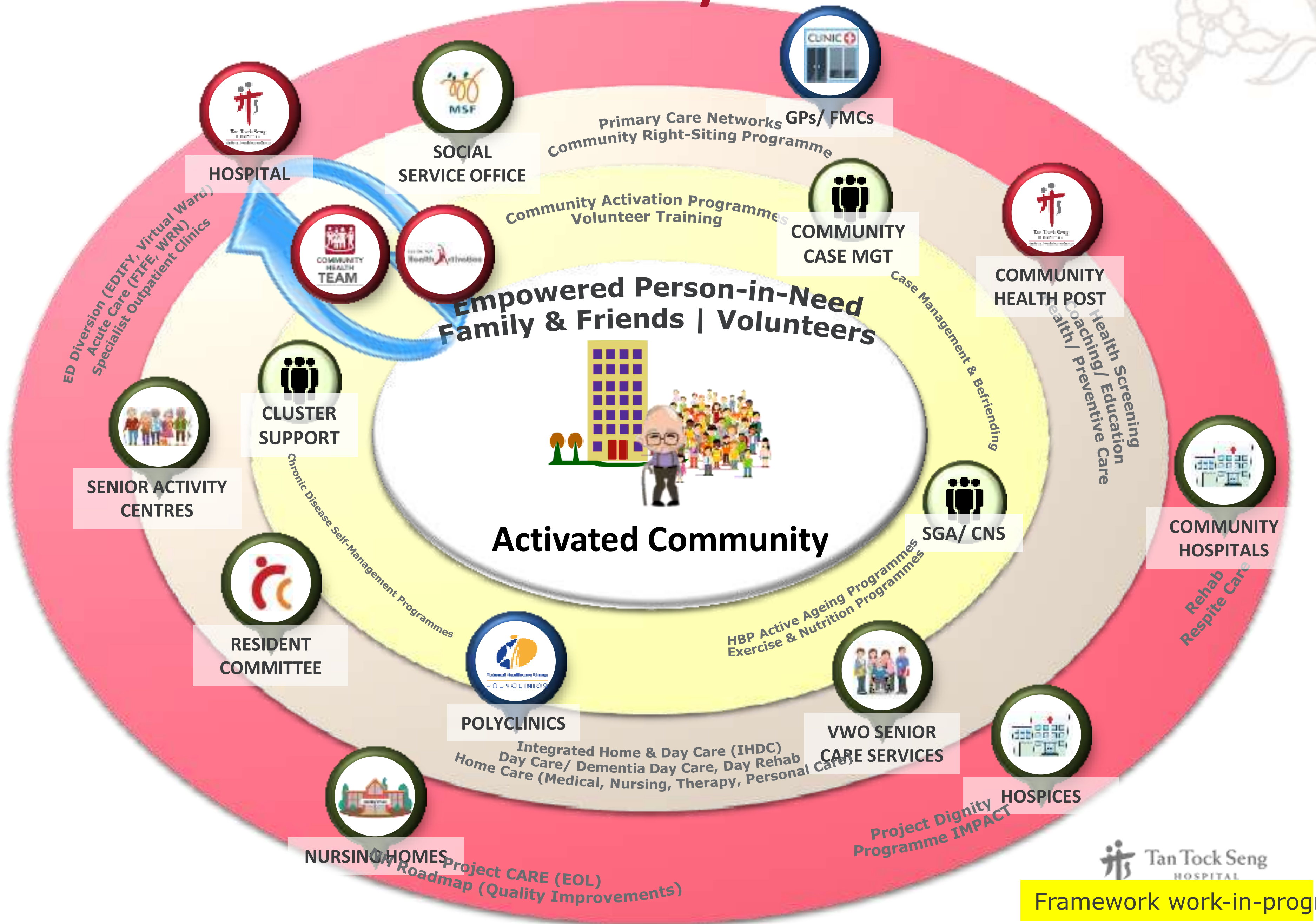
Collaboration

- Case discussions
- Co-management
- Care transitions

Activation

- Co-creation of programmes
- Co-learning of best practices
- Create activate communities

Future State: A Community of Providers



Challenges in community

2 Persona

- Mdm M
- Ms V

Mdm M- Profile

- 64 yrs old/M/F
- Retired Cleaner

- Stays alone in rental flat
- ADL independent, wheel chair in community
- No social support, financially depends on her $180 monthly pay out
- Has son* and a daughter (daughter not in good terms with her)
- She had frequent admission for fluid overload and poorly controlled DM
- Frequently defaults NKF dialysis sessions
- Defaults appointments in hospital (renal and endocrine)

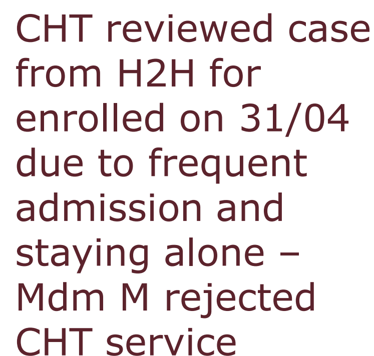
ORIGINAL TASTE - LESS
Coca-Cola

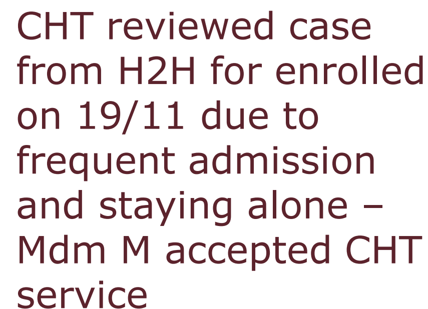
Mdm M – Past Medical History

- DM complicated by renal failure
- Hypertension
- Hyperlipidaemia
- Right OA knee
- Status post appendectomy done in 2002

Mdm M – Referral to community health team (CHT)

- 28/04 - 11/05:TTSH GM admission for Fluid overload
- 11/07 - 17/07: TTSH GM admission for Fluid overload and poorly controlled DM
- 19/09 - 24/09: Raffles Medical admission for fluid overload
- 14/11 – 22/11: TTSH GM admission for Fluid overload and poorly controlled DM





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Mdm M – CHT home visit

07/12 home visit by CHT Dr & nurse, issues:

1. DM poorly controlled
2. Hypertension
3. Fluid overload
4. Staying alone

a) Medication packing
b) Preloading of insulin
c) introduce diet coke
d) Healthier choice of food

a) Advised to take medication regularly
b) Medication packed

Advised fluid management

a) Referred AMKFSC
b) Referred for MOW, transport and escort service

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Mdm M – Journey with AMKFSC & CHT

- Link with NKF (Cab charge for dialysis session)
- Attends dialysis frequently
- NKF provided flow sheet for renal TCU
- Better management of medication – Medication packing taken over by AMKFSC staff
- Lesser episode of hypoglycemia (blue tab)
- Healthier choice
- Better fluid management

Mdm M

- Son returned to take care of her – cooking and medication packing done by son

- Continuous support from partners – escort, transport, befriending service

- Managed to stay with son and passed on due to disease progression

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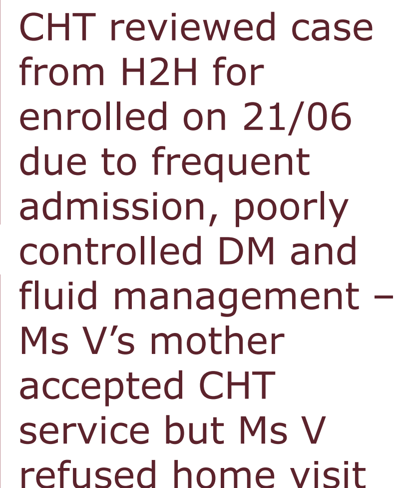
Ms V - Profile

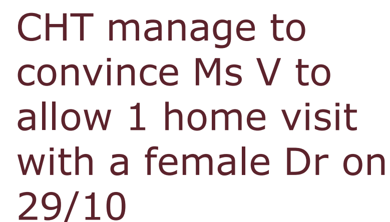
- 30 yrs old/C/F
- Smoker
- Unemployed

- Stays with widowed mother in 5 rooms purchased flat
- ADL independent and community ambulant
- Good financially support, late dad's CPF
- Only child – very grumpy and refused to listen to her mother
- She had frequent admission for fluid overload and poorly controlled DM
- Frequently attend NKF dialysis sessions
- Attend all appointments in hospital

Ms V – Referral to CHT

- 21/06 - 30/06: TTSH Renal admission for Fluid overload
- 11/07 - 15/08: TTSH Renal admission for Fluid overload and poorly controlled DM
- 14/09 - 27/09: TTSH Renal admission for fluid overload
- 18/10 – 24/10: TTSH Renal admission for Fluid overload and poorly controlled DM





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Ms V – Past Medical History

- Type 1 DM complicated by renal failure
- Hypertension
- Hyperlipidaemia

During admission 18/10 to 24/10 for Fluid overload, breathlessness and poorly controlled DM

Family conference done with pt's mother, CHT nurse, APN Renal by Renal team :

- Managing family's expectation towards pt's condition
- Discussion on support from CHT in the community

Care plan

1. DM control
2. Fluid management
3. Smoking cessation
4. Medication management
5. Social support

Ms V – CHT home visit

29/10 home visit by CHT Dr & nurse, issues:

1. DM poorly controlled
2. Hypertension
3. Fluid overload
4. Care giver stress

a) Medication packing – done by mother ex-nurse
b) Healthier choice of food

a) Advised to take medication regularly
b) Cut down on snacks

Advised fluid management - introduce ice chips for thirst

a) Refused referral to community partners
b) Referred smoking cessation – rejected by Ms V

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Ms V – thoughts :

‘I am still young, I want to enjoy life ’

‘My mother loves me, I don’t think she will leave me .’

‘Is there no cure or fast fix for my condition ?’

‘It is better I keep coming to hospital, they will know my condition better !”

`when time is right I will change?’

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CHT's actions taken to assist Ms V

- CHT nurse created group chat with Ms V and mother to remind on fluid management
- Referred to social worker for counselling to Ms Vs mother for care giver stress
- Referred to pharmacist for smoking cessation clinic

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Ms V's Journey

- She stayed free of admission / community stay more than 6 months
- Her mother was happy and felt supported – what's app
- On the 7th month she got admitted worse than before

Community partners

Learning points:

- Understanding client's challenges
- Get family to assist with medication packing and monitoring weight & fluid intake
- Consider setting up group email thread with various community partners so that everyone is updated and on the same page
- Coordinate, collaborate and co-manage with community partners

HOME NURSING FOUNDATION
家护基金

NKF

THANK YOU

太和观 THK

TOUCH *Home Care*
A Service of TOUCH Community Services
触爱家居护理服务