Objectives:

- Promote healthy lifestyle & provide health education to patients & families.
- Ensure safety while taking medication at home.
- Improve patient compliance to their medications.
- Check appropriateness of chronic medications

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References : Slides , doctor's notes , 432 team

[Color index : Important | Notes | Extra]

HOME CARE

❖ WHAT IS HOME CARE (HC)?

Refers to any type of care (medical or non--medical) that is provided for the client in their home (companionship/ homemaking services and personal care services) (anyone can do it).

What is the difference between home care and home health care ?

Home Health care : refers to the provision of skilled nursing care and other care such as speech, physical or respiratory therapy.

WHAT DO WE MEAN BY "HOME HEALTH CARE"

Any Therapeutic, Diagnostic or Social support service provided in at an individual's Home

❖ WHY HHC IS NEEDED?

1- Demographical Changes :

- More Elderly Population.(elderly= 65 y/o and above)
- Diseases that occur more often in elderly patients.
- Diseases increase concomitantly as the population ages.
- Growing elderly population: aged over 65 projected to increase to 12% in 2030 .

2- Epidemiological Changes:

- Less Acute/Infectious Diseases (nosocomial infections in hospitals).
- More Chronic Diseases.
- Medical advances allow better management of chronic and incurable diseases.
- 30% of Disabled Need HHC.

3- Cost Effectiveness :

- Growing Demand for Higher Quality Life. (prevent chronic diseases).
- More widespread availability of high-technology services has resulted in increased hospital cost.
- Earlier discharge of hospitalized patients, **reducing the length of hospital stays & Need to free occupied beds.**

Taken from 432 team

❖ Evidence that HHC Improve Health Care:

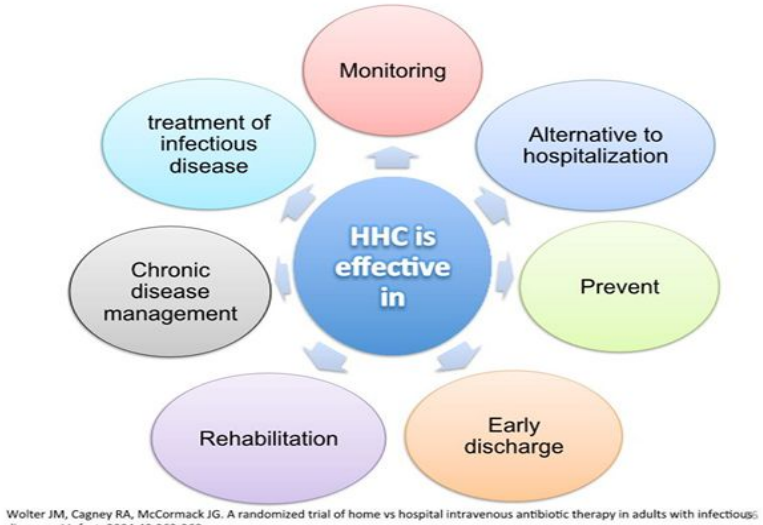
- In two domains: 1- Clinical outcome:

- Studies suggest that home visits can lead to improved medical care through the discovery of unmet health care needs.
- One study found that home assessment of elderly patients with relatively good health status and function resulted in the detection of an average of four new medical problems and up to eight new intervention recommendations per patient.
- Study showed that use of the specialist home care nurses lead to 65% reduction in hospitalization of patients .

2- cost effectiveness :

- An Economic Evaluation of Home Care Results From RCT showed that Using home care to reduce hospital stays improved the health outcomes without significantly increasing social costs.
- European study showed that HHC lead to 38% decrease in cost

- Dr. Al-Dahi study in 2007 showed 65% in secondary care & 56% in long stay rehabilitation care cost by using HHC.
- Home hospitalisation of exacerbated chronic obstructive pulmonary disease patients.



Wolter JM, Cagney RA, McCormack JG. A randomized trial of home vs hospital intravenous antibiotic therapy in adults with infectious diseases. J Infect. 2004;48:263-268.

Aeshah Alsagheir . 2016

Taken from 432 team

❖ What is HMC vision and massege ?

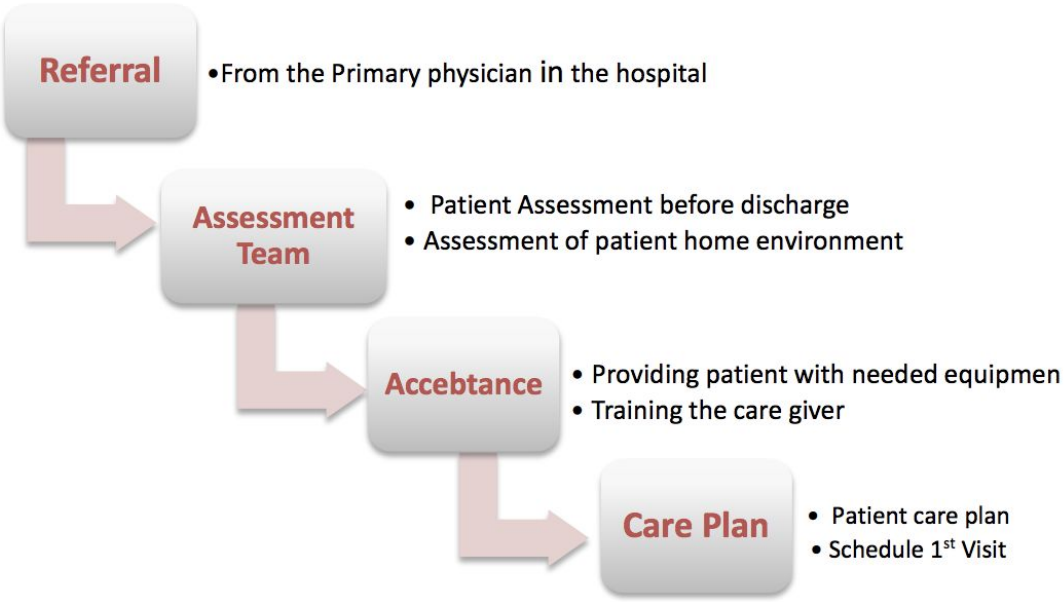
Vision : Provide HMC services for all regions & provinces in SA according to the international quality standards.

Massage : Provide the best types of constant & comprehensive health care for the patient at his home, within the framework of Islamic values & traditions of the society using the latest technologies

❖ GOALS and OBJECTIVES:

- Enhance patient's quality of life
- ↓ **the need for unnecessary & prolonged hospitalization**
- Prevent readmission to the hospital & ER visits.
- Support patient to be more independent at home.
- **Provide equipment & consumables to patient family**
- Promote healthy lifestyle & provide health education to patients & families.
- Ensure safety while taking medication at home.
- Improve patient compliance to their medications.
- Check appropriateness of chronic medications

STEPS TO HOME MEDICAL CARE



Taken from 432 team

❖ CONDITIONS WHICH BENEFITED FROM HHC:

- Bed sores.
- Immobility.
- Nasogastric tube related complications.
- Chest secretions related complications.
- Foley catheter related complications.
- Gastrostomy tube care.
- Suprapubic catheter care.

❖ HHC Unit:

- Head of the Unit/administration
- Office development/case manager
- Physicians
- Nursing staff
- Physiotherapists
- Other supporting services: SW, Dietician

Type of diseases & medical conditions benefiting from the HMC service in 4th quarter 2015	%
Aging accompanied by organic disease	74%
Chronic diseases (Hypertension & heart diseases) & its complications	19%
Diabetes and its complications	15%
Stroke and paralysis	11%
Wounds - ulcers and diabetic foot	8%
Chronic respiratory disease	7%
Muscular and Skeletal diseases	5%
Urology	3%
Psychological diseases	3%
Neurological diseases	3%
Cancer	2%
Gastroenterology	1%
Diseases of the blood and immune system	1%
Infectious diseases	0.20%
Other diseases	3%

❖ HMC in KKUH

- 3 years in the service.
- HHC Unit location – 2nd floor, OPD building.
- HHC serves all KSU staff and their dependents in Riyadh City.
- Received referrals from Inpatient, OPD and from the community.
- It's integrated with eSiHi system.

Taken from 432 team

- **HHC assessment team**

A- Physician **(Team leader)**

B- Nurse

C- Social worker

And others (Physiotherapy, Dietician, Respiratory therapist, Family caregiver)

- **Services provided by HHC:**

1- Medical: Chronic Disease Management: **DM,HTN,DLD, BPSD, Ostop.,PD, Fragility.**

2- **Wound care:** Debridement, dressing, wound treatment.

3- Polypharmacy management.

4- Pain management.

5- **Procedure**: NGT, Foley catheter, post-op care.

6- ED admission.

7- **Laboratory investigations: Sampling and transfer.**

8- Medication delivery.

9- **Equipments & Personal supply:** Chairs, beds, mattress, CPAP, O2 nebs, personal care materials.

- **How frequent should the HHC be?**

-Depends on the patient's condition.

-Routine Average of 5 patients per round .

-Urgent call visit.

- Physician phone consultations.

Taken from 432 team

❖ Eligible patients for HHC:

- Post Cerebral Vascular Accident condition care
- Chronic Neurological Disorders (Parkinson, Alzheimer, Multiple Sclerosis and Amyotrophic lateral sclerosis etc.)
- Geriatric patients -
- Chronic Wound monitoring (bed sores, leg ulcers and diabetic foot)
- Post-accident Rehabilitation
- Diabetes Mellitus care
- Enteral tube feeding
- Foley catheter insertion and removal
- Super-pubic Catheter Care and management.
- Stoma (Tracheostomy, colostomy and any stoma) care.
- Oxygen Therapy and Nebulizer.

- **How to assess a patient ?**
  1. In the hospital upon referral Patient is done
     - Patient Assessment
     - Patient evaluation in the hospital prior to discharge to ascertain that HHC can offer the services & medical equipment needed by the patient in the home situation.
     - Have a patient management plan in place, ensuring continuation of medical services.
  2. Medical assessment .
  3. Socio-economic assessment .
  4. Caregiver assessment .
  5. Environmental assessment.

- **Criteria for acceptance:**

1. Referral from the physician in the hospital .
2. Coverage area.
3. Stable medical condition.
4. Approval of home owner.
5. Appropriate home environment.
6. Capable caregiver.

Taken from 432 team

HOME HEALTH CARE ASSESSMENT

- Assessment is done to know what does the patient need from HHC and how much care does he need and to provide a good care.

1- Patient assessment

- a comprehensive process which is an integral part of managing patient care
- An ongoing process and is vital to monitor progress in the various aspects of patient care
- What do we need ?
    - current health condition and patient medical history
    - Determine if the medical equipment available will be adequate for the safe and effectiveness or not
    - For an optimal outcomes for the care in a home environment professional services is needed

2-Hospital assessment for (we evaluate the patient before starting the HHC)

- State of consciousness
- Medication in use
- diet/feeding requirement
- Ulcers surgical incisions
- Skin status

After we physically evaluate the patient we can decide if the patient need extra care plan such as (physiotherapy- respiratory therapy-dietician).
Then determine the:

- discharge date .
- scheduled specialty clinic appointment .
- discuss procedures to follow upon discharge of patient until first home visit .

3- activities of daily living

Assessment tools used to determine patient ability to perform activities of daily living

1- **Self care**:

- Personal hygiene .
- Dressing and undressing.
- Eating.
- Transferring from bed to chair.

Taken from 432 team

2-**Instrument:**

Not necessary for fundamental functioning. It allows the individuals to live independently in a community .

- Doing light housework
- Preparing meals
- Taking medication
- Shopping
- Use of telephone
- Management of money

3-**Socio-Economic**

- Number of family member sharing the home.
- Total rooms in the home.
- Equipment available to ensure good patient care .
- Financial status .

4-**Care giver**

- Educational status
- The relationship between the patient &caregiver - relative or contract worker-
- Time available for patient care
- Previous experience in patient care

Assessment of care giver needs for education

Home assessment

- **We assess the home for:**
  - The area of patient room
  - Is the patient room shared
  - Type of care given
  - Safe storage of medication
- **Then the physical environment must be evaluated for safety and suitability** :
  - Free of fire
  - Health and safety of hazards
  - Adequate heating cooling ventilation
  - Adequate electrical service
  - Provide patient access and mobility & storage facilities

Taken from 432 team

- **Then assess for infection control**:
  - General hygiene
  - Correct disposal of sharps
  - Correct handling of supplement for feeding regime
  - Correct disposal of disposable supplies
  - Correct handling of catheter/ ngt/peg tube
  - Correct of suction apparatus
  - Use of suction catheters

- **After evaluation we construct a care plan:**

  Constructing care plan by:

  ➔ Providing a written means of planning patient care based upon diagnosis of the patient
  ➔ Enables provision of holistic approach
  ➔ It serves as a mean to document change of the patient condition

- **Services provided by HHC:**
  - Wound Care and Dressing
  - Nursing CARE
  - Chest Physiotherapy
  - Medication management
  - Indwelling urinary catheter insertion & care
  - Ostomy And Ileostomy care
  - Insertion of nasogastric tube , care and feeding
  - PEG care, feeding

- **HHC outcomes:**

4 major outcomes measurement in which HHC agencies must demonstrate ability to document success:

☻ Cost
☻ Clinical
☻ Functional status
☻ Patient satisfaction

Taken from 432 team

☺ Study shows that the client reported high level of satisfaction for the element of:

- Respect
- Attention to concerns
- Consistency
- Helpfulness
- Dependability of staff
- Feeling safe
- Staff knowledge of health problem

Summary

- **WHY HHC IS NEEDED?**
  - ❖ More Elderly Population
  - ❖ More Chronic Diseases.

- **HOME HEALTH CARE:**

  Component of a continuum comprehensive health care whereby health services are provided to individuals & families in their places of residence for the purpose of promoting, maintaining or restoring health, or maximizing the level of independence, while minimizing the effects of disability and illness.

- It is reduce hospital stays improved the health outcomes without significantly increasing social costs.

- Provide the best types of constant & comprehensive health care for the patient at his home, within the framework of Islamic values & traditions of the society using the latest technologies

- **Goals of HHC:** Enhance patient's quality of life.

- **Steps to home medical care:** Referral, Assessment team, Acceptance and Care plan.

Taken from 432 team