Empowering client and family to take charge of their own health to reduce unplanned admission

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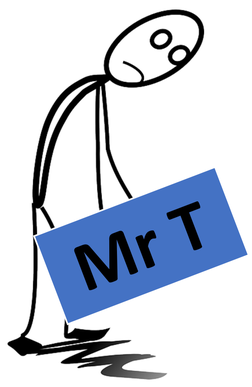
Background

Mr T is a 47 years old gentleman, married with no children. He is chair bound and requires assistance in his Activities of Daily Living (ADLs) due to a recent stroke. He has been admitted multiple times since then.



Medical History
- DM/HTN
- Nephropathy with ESRF on dialysis
- ICH with seizure
- Depression
- Retinopathy
- Gastroparesis
- Gout

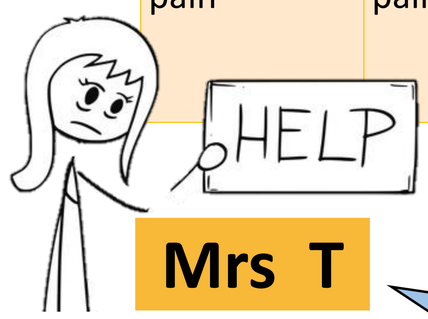
Problem

His wife verbalised feeling extremely stressed with the multiple admissions and felt extremely helpless with the situation (Table 1).

MAY 17	JUN 17	JUL 17	AUG 17
Adm 1: Seizure Abdominal pain	**Adm 2:** Hypotension Abdominal pain	**Adm 3:** Diarrhoea ? GE **Adm 4:** Hypotension	**Adm 5**: Fever, pneumonia **Adm 6:** Pneumonia

Table 1: Details of Admissions From May to Aug 2017

6
ADMISSIONS!
Out of 6 admissions, 5 of them are potentially avoidable!



"I was told by the ward to send back to hospital if he is unwell"
"I do not know what to do if he has fever"
"I am scared!"

Methodology

Mrs T was engaged through 1 to 1 interviews conducted during home visits. The nurse worked with Mrs T to identify the causes of readmissions and designed a plan to prevent avoidable admissions in partnership with Mrs T (Diagram 1).

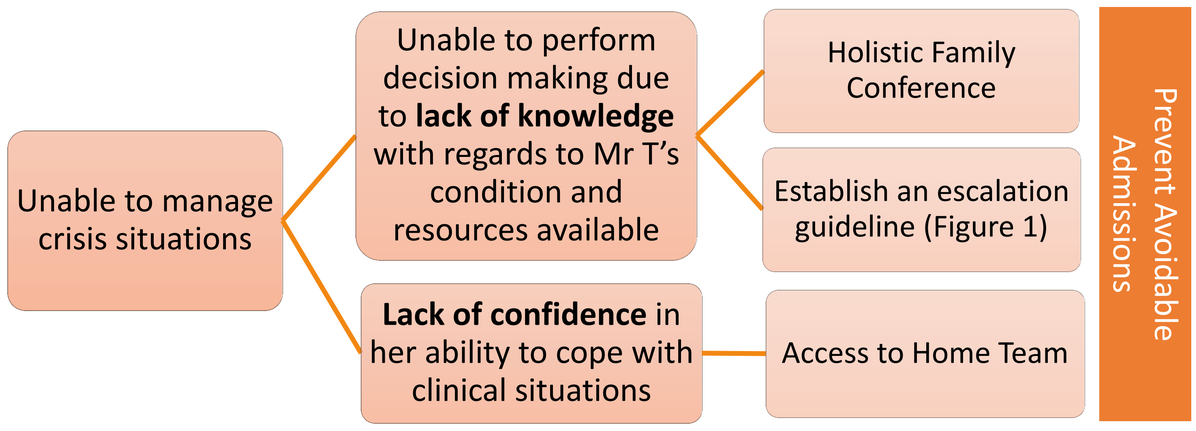


Diagram 1: Causes of Readmissions

Aim

1. To empower Mrs T in decision-making during crisis periods
2. To increase Mrs T's confidence in managing "Esther's" condition
3. To decrease unplanned visit to ED

Proposed Solution

To empower Mrs T in her decision making, the home team focuses on addressing her gaps in knowledge by conducting a family conference. In consultation with the team physician, an individualized escalation guideline was developed so that Mrs T has clear instructions to aid her decision-making (Table 2). Caregiver's training was done to ensure that she is capable of performing interventions stated in the guideline.

Acknowledging that time is needed for Mrs T to build her confidence in managing these clinical situations, the Home Team continued to support her with their clinical expertise during the care episodes.

	Regular Monitoring	Close Monitoring and Update Team	Call Team immediately (office hours)
Blood Pressure	SBP < 160mmHg	SBP < 100mmHg, client alert - Elevate both legs and recheck 30min later.	SBP < 100mmHg, client drowsy or lethargic
Bowel	Stools between type 3-5. Continue laxatives.	No bowel movement X 1 day - Insert bisocodyl suppository and monitor No bowel movement in 2 days despite biscodyl suppository Stools between type 6-7, stop laxatives.	Stools with blood
Fever	Temperature < 37.5	Temperature between 37.5 to 38 – Serve Panadol strictly	Temperature > 38 X 2 episodes, start antibiotics. Continue Panadol strictly.

Table 2: Escalation Guideline

Outcome

After intervention, Esther's wife managed to handle 3 crisis at home without any ED visit and there is NO admission from Sept 2017 to Nov 2017.

26 Sept	• Wife managed to initiate PR Bisacodyl insertion when patient BNO for 1 day
20 Oct	• Patient developed low-grade fever. Antibiotic was given for standby and advised wife to serve if temperature was more than 38 degrees Celsius.
25 Oct	• Wife initiated Augmentin when temperature spike more than 38 degrees Celsius.

Learning Point

In the community, while the competency of the home care team is important, the ability to motivate and empower Esther as well as their families to take responsibility over their health is even more essential. This can come in the form of clear instructions and support.

It is only through empowerment that Esther and their families can gain confidence and continue the care of their loved ones in the community. As such, the act of empowering the Esther and family to take charge of their health is the best strategy for long-term management of chronic conditions and decreasing unnecessary stress from avoidable admissions.