Welcome to
Maharat Nakhon Ratchasima Hospital
Promotion Community-Based Continuing Holistic Care Among Palliative patient

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Context analysis: started in 2001

1. Policy: did not clearly mention about caring for palliative patients.

2. Health care providers: attitude, abilities ???

3. Health care service system: separate part, lack of continuing care, IPD patients are two times of bed capacity and supporting system? (counseling and referral system, EMS, team work and networking strengthening)
ทุกข์ของใคร????

WARD1 ห้องแม่บัดดิ
WARD3 หน้าลิฟท์
Mother’s home

(CA Cervix patient)

Daughter’s home

the main caregiver
1. HA, PMQA principles; CPG&CNPG that focus on patient & family, health care service system and health care provider.

2. Chronic illness care model; factors related to health & empowering people and community ability of health care

3. Self-Care & Nursing standard

4. Community-based care; strengthen individual...

5. Dying stages (Kubler-Ross, 1975: 5)
Innovative Care for Chronic Conditions Framework

Positive Policy Environment
- Enhance and allocate human resources
- Promote regular financing

Health Care Organization
- Encourage better care through leadership, quality improvement & incentives
- Organize health care team and clarify roles
- Equip health care team with expertise and tools
- Collect and use patient data to plan care
- Support self management and prevention at every patient contact
- Monitor treatment and outcomes

Community
- Encourage better outcomes through leadership and support
- Mobilize and coordinate resources
- Raise awareness and reduce stigma
- Provide complementary services

Health Care Team
- Prepared
- Informed
- Motivated

Patients & Families

 Better Outcomes for Chronic Condition
Integrated Health Service System

To meet people expectation

1. Quality

2. Not overlapping
   - Referral system
   - Support

3. Networking & Information system

1° Care
   (General Practice)

2° Specialists
   (Specialists)

3°

To meet people expectation

Coverage
Comprehensive continuity
Integrated involvement

Chronic diseases

- Early dx & simple treatment & refer

COV CON COMP I CI
Referral Service and Continuing Health Care Promotion Center (R&C Center)

In Nursing department of MNRH
Objectives

1. Palliative patient meet effective standard of care.

2. Implementation of discharge plan and community-based care for palliative patient.
Goals

1. To provide holistic continuous care for palliative patient who participate in this study.
2. Initiate and established effective referral network, Supporting & communication system among stakeholders to improve quality of care.
3. Enhancing abilities of health care providers on palliative care
Continuing care

Admit

Dr./ Treatment

RN Ward; Care, D/C plan

RN – R&C Center; self-care of patient and caregivers

Informed patient data to Hospital/PCU /

Hosp/PCU

Evaluation; HHC/Tel/ FU

Acute phase

Transitional phase

Continuing phase

Feedback
Dying concept

Definition

Dying is a part of life cycle but human fear of it. (Kubblerr - Ross, 1975 : 5)
5 Stages

- Denial
- Anger
- Bargaining
- Depress
- Accept
1. Joint hands with patient and their family

2. Emphasize on patient’s needs

3. Implement with Assess, Advise, Agree, Assist, Arrange

   such as arrange supporting system for continuing care,
   active care at patient’ home, use peer group

   coordinate to mobilize resources etc.
Standard of caring for palliative patient

1) Appropriated treatment

2) Supportive care

3) Decrease stress and suffering

4) Provide appropriate care by significant person

6) Patient’s family participate in decision making

7) Concerning patient and family need; believe, culture, hope, value and expectation
8) Provide an effective system for continuous counseling.

9) Caring for the patient and their family.

10) Patient & Family as center of care.

11) Seeking for the main caregiver.

12) Providing continuously care for the patient’s family in 24 hours and after the death of the patient.
Referral system
Line of coordination

PHM

MRNH

Social medicine; PCU/

PH/CH

Regional committee
for improving quality of health care service

Nursing department : OPD, IPD, PCU & HHC co.
Health team

Dr./Dent. Pham /RN

Social Worker

Palliative patient&Family

NGOs&Local

Psychiatrist

PT

PT& Others

HE/Nutritionist
Process

Ward/hospital/Department/
sending palliative patient data

PCU.&HHCco.

Assess pt S-C

Conclude pt data & Caring need

Sending to Hosp./CMU/PCU.

Increase S-C

Continuing care
Support/Evaluation;
HHC/Tel./FU

No

Yes
Assess S-C & Asset

Offer things for good dead
Training caregiver for caring the pt. at home

Promote spiritual of pt. family
Lung cancer patient

Brain cancer

Leukemia child

Pray for her husband

11/09/2007
Palliative pt. at temple

Coordinating with health care providers at Hosp/ PCU before HHC
รายงานรายรับ

ชื่อผู้จัดจำหน่าย

จำนวนเงิน

รายละเอียด

ลงชื่อ

ลงชื่อ

ประกาศ
บ้านที่ออกจาก PCU หนงสาร้วย
ปากช่อง ช่วยให้เข้าใจผู้ป่วยและ
ญาติ จัดการดูแลให้อย่างเหมาะสม

เพื่อครอบครัวที่ PCU ขนาด

รู้ว่าผู้ป่วยได้ดูแลตนเองได้
โดยเจ้าหน้าที่ไปเยี่ยมบ้าน
Team HHC

Go to pt. home

Team at pt. home
Case Conference
Neighbor giving food while pt.'s daughter go to work

Pt. & her lover son at home
Neighbor come to visit
The pt. every day
หัวหน้า PCU ศรีษะตะลึงไปเชิญบ้าน
พร้อมกับรวบรวมเกิดแจ้งปัญหาให้ทราบด้วย

ฐานผู้ป่วยมะเร็งเจาะอาการผู้ป่วย
หลังกลับไปอยู่บ้าน
Local gov/VHV collect pt. from hosp. to his home

Tank you very much I will not come Again.
Can you help your Grandmother?

Yes, I can hold her hand

R&C Center  Maharat Nakhon Ratchasima Hospital
Activities

- Initiate CPG of PLC and evaluation.
- Teaching - Training S-C
- Refer
- Provide teaching media, resources for S-C at home
- Evaluation; D-METHOD (Disease, Drug, Env Econ, treatment, Health-Resources, FU, Observe EMS & Diet.
- Continuing care, Counseling,
- Networking enhancement abilities on PLC
- Coordination to support holistic continuing care
Stakeholders work together to develop Continuing care system

Supporting system
- resources
- Training /conference/
- visiting
- continuously quality improving

Network
- motivation
 & Empowerment
- communication
- Helping to solve problems
Demonstration
caring to health staff

Teach at
pt. home
Teach caregiver at home

Herbs for relief pain
Expert lecture

Development of network

Panel discussion
Group meeting with HIV network 1/2 mo.

Secondary school visit HIV pt. care at a temple

HIV patient’s bone at a temple

Health Promotion among sub-group who risk to HIV & palliative
Single parent care of Leukemia child

Community leader provide transportation

At home

After pt. death
supportive money from NGOs

HHC team
The most common problems

- Nutrition
- Pain
- Restless, depress
- Digestion
- Constipation,
- Respiratory system
- weakness
1. Stakeholders participation as partnership.
2. Health care providers have regular KM & Empowerment
3. Thai culture live together as relative
4. Gov policy on HCS Quality Improvement
5. Local adm. Intent to help the people
6. NGOs supporting HCS

R&C Center  Maharat Nakhon Ratchasima Hospital
1. There were 30 palliative patients participation in this study, all of them dead peacefully.

2. Caregivers were very satisfactory with continuous care that provided by nurse in HHC & HC network.

3. More than 80% of them death at home without suffering or severe pain but QOL (WHO-BRI EF) was fair.
Outcome and Measurement:

1. Pain (cancer patient) 6.66% had medium pain 1-2 days in the last week (need adjusted analgesic to control it).
2. Satisfaction with quality of care of patient and caregivers were good to very good 100%.
3. QOL of patient, caregivers were fair.
4. Health personnel abilities on palliative care were increased.
5. It has continuing care for palliative patient and network was established.
Nurse’ roles on discharge plan

1. Assessment caring need after discharge and asset.

2. Initiating care plan by cooperate with stakeholders.

3. Coordinator among multidisciplinary team.

4. Training caregiver for caring the patient.

5. Providing supporting system for continuous self-care.

Lowenstein & Hoff 1994:45

R&C Center  Maharat Nakhon Ratchasima Hospital
PCU&HHCco. activities

- CPGs
- Counseling
- Helping for problem solving
- Referral system
- HHC
- Promotion of networking
- Teaching/Training
- Assessment Promotion Pt. S-C
- Coordination/Communication
- Enhance Health team abilities

Developed CB holistic continuing care after D/C
Lessons Learned and Future Plan:

1. Administrator supportive is very important; structure
2. Health personnel have to be well prepared for palliative care.
3. Strengthening network of care (health & Volunteer) and caregivers increase quality of care and sustainable of palliative care
4. CPGs should initiate by multi-disciplinary & clients
Future Plan

1. Research on results of specific intervention among palliative patient.

2. Development a model of effective care for palliative patient in different situation; people, VHV, teacher, community leader etc.

3. Connect with other who interested in same area.
Discharge plan is a bridge to success continuing care & peacefully dead.