Post Discharge Home Follow-up Service for High-Risk Elders

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Introduction:
Comprehensive discharge planning programs by specialist nurses have demonstrated a reduction in readmission of home dwelling elderly patients overseas. In previous year, the continued growth of community geriatric services in Hong Kong has benefited care & attention home elders rather than those living at home. A post discharge home follow up program was introduced in June 2000 to support the elderly population living at home.

Purpose of the Project:
This study examined the effectiveness of a post-discharge home follow up program implemented by the gerontological nurses in reducing unplanned re-admissions and A&E attendance of high risk elders living at home.

Material & Methods:
A randomized clinical trial approach is used for the study. Eligible subjects were recruited upon discharge in the period from 12 June 2000 to 8 December 2000. Patients in the study group received conventional care plus a comprehensive discharge planning and home follow-up protocol while those in the control group received only conventional care. Outcomes were then evaluated in the 4th week post-discharge. Interventions in the home follow-up protocol included mobile phone consultations, home visits and phone follow-up services.

Results:
A total of 209 patients (103 in the study group and 106 in the control group) were studied over a period of 12 weeks. Subjects of the two groups were similar in all demographic variables. A total of 372 phone calls and 194 home visits were made during the study period.

The total episodes of A&E attendance in the study group were 16 compared to 40 for the control group (p=0.014). Mean disease-free days before first attendance to A&E was prolonged in the study group,16.2 days vs 8.9 days in the control group (p=0.004). Fewer study group patients had multiple A&E attendance (2 study subject vs 9 control subjects).

The episodes of unplanned readmission were also reduced in the study group (10 compared with 28 in the control group, p= 0.013). Mean disease-free days of unplanned readmission was increased in the study group (17.8 days vs 11 days in the control group, p=0.026). None of the study subject was readmitted twice.

Conclusions:
In conclusion, a gerontological nurse-led discharge planning and home follow-up program for high risk elders discharged to home has achieved a significantly reduction in A&E attendance and unplanned re-admissions, and lengthened the time between discharge and readmission. By decreasing utilization of acute care services, the interventions demonstrated great potential in reducing costs and promoting positive outcomes for hospitalized elders.