UNIT NO. 6

IMPLEMENTING HOME CARE

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OBJECTIVES

At the end of this unit, the course participants should be able to describe:

1. the need for preparing the patient and caregiver for home health care
2. the areas to consider in preparing for home healthcare
3. the formulation of a management plan
4. review and follow-up
5. patient training / caregiver training and skills evaluation
6. desired outcomes of management goals and plans.

1. INTRODUCTION

For optimal delivery of homecare, the patient and family should play an active part of the care delivery. Preparing for home care therefore starts with proper discharge planning and involves preparing the patient, preparing the caregiver/family and preparing the environment.

2. PREPARING FOR HOMECARE

- Preparing the patient

  The homecare patient should be medically stabilised and willing to receive homecare services.
- Preparing the caregiver/family

  The patient and/or the caregiver should have been trained to provide for self-care activities, and ideally know how to administer therapy e.g. ranging exercises. They may have been linked up with homecare supplies vendors e.g. for nutritional milk supplements and diapers and equipment vendors e.g. for wheelchairs and shower commodes.
- Preparing the environment

  The process of making the transition from hospital to home which is often not designed for handicap use or specialized use can be imposing.

  Nonetheless, it can be accomplished with a common-sense approach and some planning.

  The 3 major concerns in preparing the home environment are:

  i) safety
  ii) accessability
  iii) physical adaptations

Safety issues include elimination of possible hazards and barriers which may cause falls. Lightings should be adequate. Installation of grab-bars next to toilet seats and shower area can be done.

Accessibility issues relate to exterior and interior doors and steps. There must be sufficient space to allow for patient mobility or wheelchair or shower commode access. There may be a need for re-arrangement of furniture. Placement of the hospital bed if necessary should allow ease of access to bed-bound patient.

Physical adaptation of the home may include building a ramp between the living and kitchen areas to allow for wheelchair access. The occupational therapist can also advice on the variety of personal assistance devices that can adapt the bedroom, bathroom and kitchen into a safe and useful area for the patient; e.g the use of elder-friendly tap handles, night-lights, kitchen appliances and utensils.

3. FORMULATING MANAGEMENT PLAN FOR THE HOMECARE PATIENT

At the first home visit, the doctor can begin listing the problems. With subsequent visits and as he becomes more familiar with the patient, family and environment, a comprehensive problem list can be generated.

A patient-centred model places as much emphasis on traditional biomedical problem listing as to understanding the meaning the illness has for the patient and caregiver.

Broadly the problems can be categorized as:

i) Medical/nursing
ii) Functional
iii) Environmental
iv) Social/family – including caregiver issues.

Special concerns in homecare include end of life matters as well. The management of the problems of the homecare patient usually involves a multi-disciplinary team.

For the family physician working solo, he can enlist the help of relevant professionals and agencies. For the homecare physician practising in a multi-disciplinary team, he may function as a facilitator and direct members together with patient and family to collaborate and agree upon common goals.

Communication is the key in formulating common goals.There are formal case conferences within the team as well as informal exchange of information.Meeting up with patient and family/caregiver is also crucial and may involve telephone calls or meeting face-to-face in home or in a neutral environment if necessary to discuss medical and psychosocial concerns. Such meetings may involve different members of the multi-disciplinary team as appropriate.

4. REVIEWING AND FOLLOW UP OF THE HOMECARE PATIENT

While the doctor generally visits the stable homecare patient on a 2 to 3 monthly basis for review of chronic illnesses, care plan goals and management are usually reviewed at regular intervals with other members of the multi-disciplinary team e.g. at 6 monthly intervals. This is unless there has been an acute event or hospitalisation that has resulted in the change of functional status.

For example, the stroke patient who was previously able to feed orally now requiring tube feeding because of a recurrent stroke. Changes in family situations may also call for discussions at the care plan conference.

5. PATIENT TRAINING / CAREGIVER TRAINING AND SKILLS EVALUATION

All the team members of the homecare team are expected to function at a specific level of proficiency. Similarly, as caregivers and the patients themselves play an active role in care delivery and good homecare, their activities and skills should be assessed as well.

This evaluation can be done at each care plan review. For the patient, his function is usually assessed via ADL and IADL assessment[1]. Common indexes used for ADL activites include the Barthel and Katz index.

Caregiver assessment is fledgling locally and increasing emphases should be given to empowering and training the caregiver.

Assessment of the caregiver can be in two areas:

i) his caregiving skills
ii) caregiver burden.

Most of ADL and IADL tools were designed with patient in mind but with some modification, can be modified to assess the caregiver's skills as well. For example, the caregiver can be evaluated on his ability to manage transfer and toiletting for the patient.

In the assessment of the burden of caregiving, an assessment proposed by the Department of Geriatric Health of the American Medical Association includes:

i) number of hours of caregiving work per day
ii) the nature of task to be completed
iii) the psychological stress related to the nature of illness and necessary care e.g. dementia patients with behavioural problems.

Other areas of assessment include:

i) attitude towards the responsibility
ii) emotional competence and stability
iii) physical capacity
iv) having other responsibilities
v) willingness to learn and work with homecare team.

There are no locally validated scales but the relative stress scale, an instrument used for caregivers of dementia patients may be helpful to detect or compare level of caregiver stress (Table 1). Other instruments commonly mentioned include the Burden Interview (Zarit).

Table 1: Relative Stress Scale

Personal Distress Items

1. Do you ever feel you can no longer cope with the situation?
2. Do you ever feel that you need a break?
3. Do you ever get depressed by the situation?
4. Has your own health suffered at all?
5. Do you worry about accidents happening to _____?
6. Do you ever feel that there will be no end to the problem?

Life Upset Items

1. Do you find it difficult to get away on holiday?
2. How much has your social life been affected?
3. How much has the household routine been affected?
4. Is your sleep interrupted by _____?
5. Has your standard of living been reduced?

Negative Feelings Items

1. Do you ever feel embarrassed by _____?
2. Are you at all prevented from having visitors?
3. Do you ever get cross and angry with _____?
4. Do you ever feel frustrated at times with _____?

Items are scored on a 0-4 scale:

not at all	0
a little	1
moderately	2
quite a lot	3
considerably	4

Note: For behavioural disturbances in demented patients, only the 6 personal distress items and the 4 negative feelings items correlated significantly.

5. DESIRED OUTCOMES OF MANAGEMENT GOALS AND PLANS

Finally, the desired outcomes of management plans in home care will include:

i) Reduced unplanned admissions to the hospitals
ii) Maintenance of functional independence
iii) Prevention of falls
iv) Compliance to medications
v) Prevention of complications such as pressure sores and contractures
vi) Promote bowel and bladder continence
vii) Optimization of environment, equipment and aids
viii) Caregivers reporting better quality of life.

Learning Points:

1. Implementing homecare starts with good discharge planning
2. Preparing for homecare involves preparing the patient, the family and the environment
3. The patient and the caregiver have an active role to play in homecare and should be involved in formulating management goals and plans.

REFERENCES AND RECOMMENDED READINGS

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2. Lim, Sahadevan et al. Burden of Caregiving in Mild to Moderate Dementia: An Asian Experience. *International Psychogeriatrics*, Vol. 11, No.4, 1999, pp 411-20.
3. Pang WS. Caring for the Elderly: A Guide for Family Physicians. Family and Caregivers.3:3.1-3.5.
4. Rothkopf. Standards and Practice of Homecare Therapeutics. 2nd ed.Williams & Wilkins,1997 Patient Selection and Preparation for Homecare.3:25-33.
5. Greene JG, Smith R, Gardiner M, Timbury GC. Measuring behavioural disturbance of elderly demented patients in the community and its effects on relatives: a factor analytic study. Age & Ageing 1982; 11:121-6.

Useful Website for caregivers locally:

http://www.caregivers.org.sg/uat/main.htm

– has useful information on community resources according to location, home modifications tips and general information for the caregiver.