TZU CHI

NURSING CARE

With the Compassion of Bodhisattvas, Where Ever Sufferings Are, We Are.


Ministry
of
Health and Welfare
Long-Term Care
Center

10-Year Long-Term Care Plan 2.0 in Tzu Chi Hospitals

The features of the Long-Term Care 2.0 by Ministry of Health and Welfare (MOHW) are the following: flexibility, expansion, innovation, integration and extension. By stretching forward to cover prevention, and extending backward to include palliative care, which ensures a seamless transition with discharge planning service, the Long-Term Care aims for everyone to live out their lives at the comfort of their home in peace.

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Mr. Tsai, almost 70 years of age, had been bedridden for years. The most frequent travel for him in the past few years was between his home and the hospital. Whether it is nasogastric tube slippage, ureteral obstruction, or asthma, he was involuntarily a regular at emergency room. The way he looks at his wife was always filled with helplessness and guilt. Although his wife, Mrs. Tsai, was committed to his daily needs, she was exhausted. Their son must work for money to lessen the family's financial burden, and rarely share the burden of care. Several times he mentioned the thought of sending Mr. Tsai to care center, but Mrs. Tsai could not bear the thought and continued to care for her husband, not wanting to think about how long she can sustain this way of life.

This story is only one of the many, and helping these families is precisely the reason why Long-Term Care 2.0 is planned and implemented.

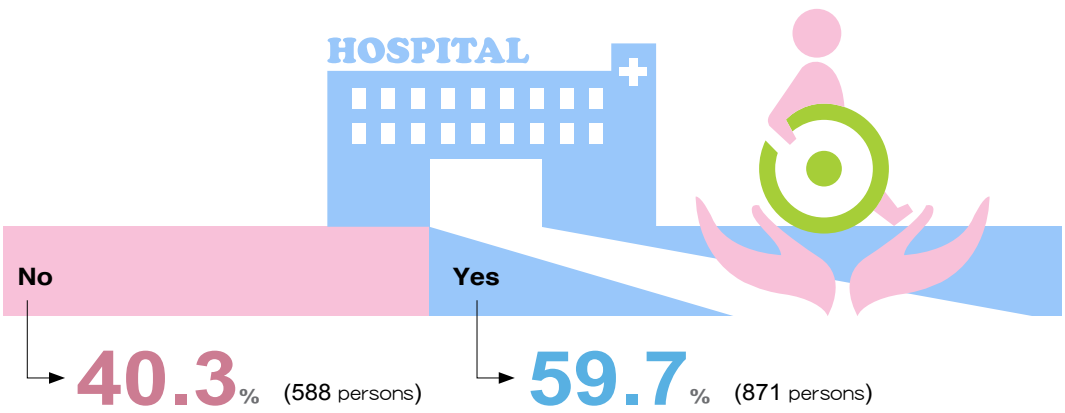
According to the census of MOHW, from 2014 to 2016 about 30% of the senior inpatients need long-term care. Within the 17 expanded services in the current Long-Term Care 2.0 is a "Connected Discharge Planning Service", yet from its implementation to this day the percentage of patients utilized this service and were connected from discharge to local health offices was a meager 2.5%; furthermore a survey of inpatients indicated a 60% for the general public did not have, or have only incomplete,

Basic Statistics

Gender	Number of People	%
Female	1,394	95.5
Male	65	4.5
Total	1,459	100.0
Age	**Number of People**	**%**
under 20	20	1.4
21~25	516	35.4
26~30	247	16.9
31~35	222	15.2
36~40	231	15.8
above 40	223	15.3
Total	1,459	100.0

Nursing Level	Number of People	%
N	471	32.3
N1	249	17.0
N2	550	37.7
N3	121	8.3
N4	68	4.7
Total	1,459	100.0
Job Title	**Number of People**	**%**
Registered nurse	1,155	79.2
Deputy head nurse	62	4.1
Head nurse	68	4.7
Supervisor	23	1.6
Functional unit/Case manager	55	3.8
Nurse practitioner/Senior RN	96	6.6
Total	1,459	100.0
Department	**Number of People**	**%**
Internal Medicine	311	21.3
Surgery	214	14.7
Pediatrics	60	4.1
Obstetrics & Gynecology	62	4.2
Intensive Care & ER	286	19.6
Functional Unit	14	1.0
Kidney Dialysis	48	3.3
Operating Room	96	6.6
Outpatient Clinic	190	13.0
Palliative Care	26	1.8
Administration	37	2.5
Others	115	7.9
Total	1,459	100.0
Hospital Working Experience	**Number of People**	**%**
Within one year	263	18.0
1~2 years	224	15.4
2~3 years	160	11.0
3~5 years	222	15.2
5 years and above	590	40.4
Total	1,459	100.0

Q1 Have you provided clinical service resources on discharge planning for patients? (N = 1,459)



information on discharge planning. If the frontline nurses can provide patients and families information on the seamless transition from acute medical care to long-term care when they are hospitalized or are about to be discharged, the window period between discharge and care should be significantly shortened, and the continuity from discharge to home care would reduce the disturbance and stress of primary caregivers (Published in: Healthcare on Apr 24, 2017).

Discharge Planning, Placement, and Resource Referral

The editorial team designed a questionnaire to understand the experience of nursing staff on discharge planning and their expectation for Long-Term Care 2.0, in preparation of an aging-society. The electronic questionnaire was sent to nurses in all 6 Tzu Chi hospitals and a total of 1,459 were collected.

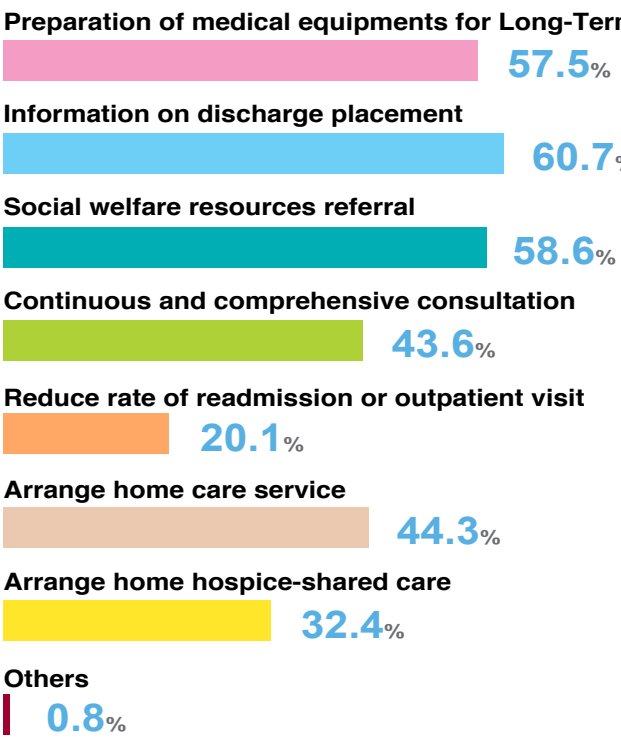
The first question tries to understand the ratio of nurses who had provided patients with relevant resources on discharge planning, which the result indicated a whopping 59.7%; on the other hand, about 40% of the nurses claimed that the responsibility of discharge planning fall on acute care nurses, not them.

Why according to the census of MOHW majority of the inpatients did not have information on discharge planning? After face-to-face interviews with several inpatients and their families, it became apparent that they did receive health education from nutritionists, social workers, or pharmacists, but had no idea that they were part of the discharge planning team.

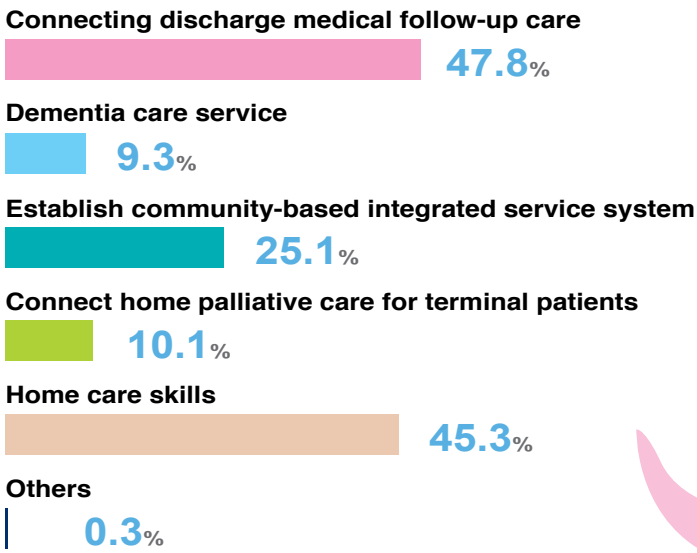
Nurses with discharge planning experience were asked what they have referred. The top three answers were discharge placement (60.7%), social welfare resources (58.6%), long-term care and other medical equipments (57.5%), arrange home care service (44.3%), and continuous and comprehensive consultation (43.6%). The content of the referrals was focused primarily on long-term care rather than short-term.

The innovative model of connecting discharge planning and long-term care of Dalin Tzu Chi Hospital aspire to complete the following: a complete assessment should be done 3 days before discharge, receive service within 1 week after; the content of service include home service, home care, home rehabilitation, caregiver respite, and simple living aids, in which 3 of the services must be provided. It is apparent that this innovative model is meeting the needs of the current situation.

Q2 What services have you referred for patients during discharge planning? (Multiple choices, N = 871)



Q3 When reviewing your discharge planning services, what are the priorities of the patients and families you encountered? (Multiple choices, N = 871)



Enhance Discharge referral to Care Service Center

The census of MOHW showed that counties with the highest percentage of aged population in Taiwan are Chiayi (17.28%) and Yunlin (16.47%). Out of all the patients visiting Dalin Tzu Chi Hospital, which is located in Chiayi County, 72% are from Chiayi and Yunlin. To take care of the local seniors, Dalin Tzu Chi Hospital actively strived to become an A-level community-based integrated service center, where members of the medical teams would proactively investigate patients' needs for long-term care as soon as they are hospitalized, and refer them to the corresponding long-term care management centers of local health offices, supporting patients and their families with backups of long-term care in a timely manner.

When reviewing their discharge planning services, the nurses identified the priorities of the patients and families they have handled in the past to be connecting medical follow-up care after discharge (47.8%), home care skills (45.3%), establishing

community-based integrated service system (25.1%), connecting home palliative care for terminal patients (10.1%), and dementia care service (9.3%). In the open suggestions there were mentions of information of living aids, caregiver support groups, respites, and economic supports.

With the long-term care management center of Chiayi County Health Office as an example, the center provides services like care service, elderly nutrition, home care, home rehabilitation, respite service, transportation, aid purchase and rental, home accessibility improvement services, and long-term institutional services, which are consistent with the experience of the nurses in Tzu Chi hospitals. If inpatients can be referred to the long-term care management centers of corresponding local health offices, almost all of their families' worries can be resolved.

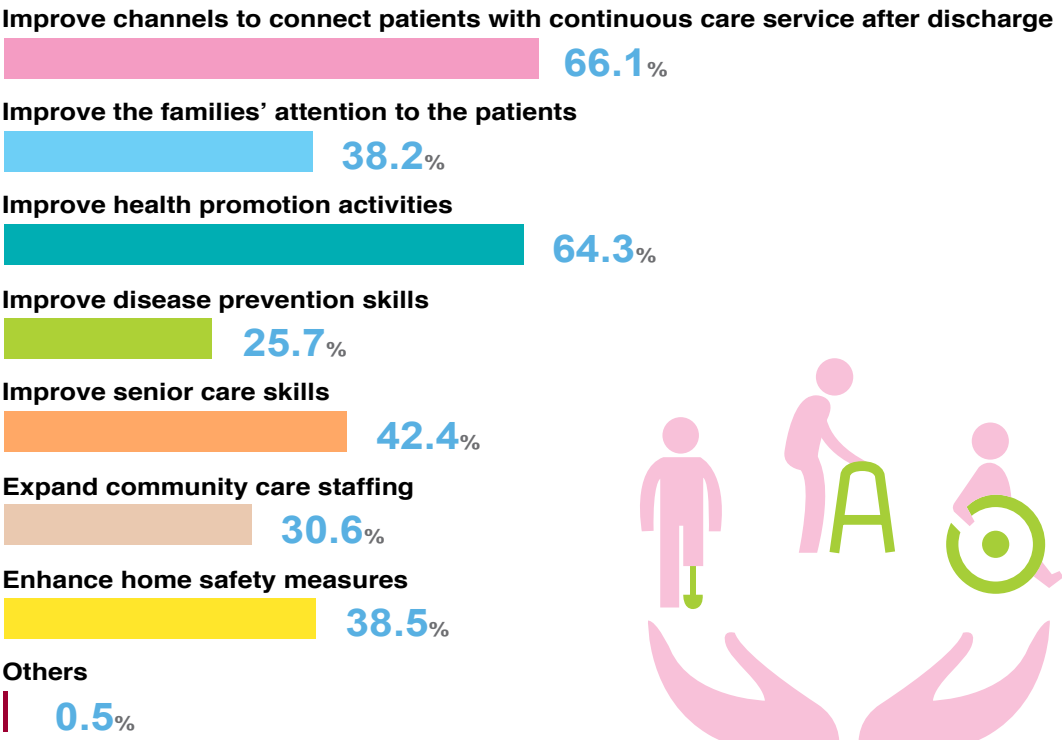
What closely links with the health office long-term care management centers are the long-term care service units, responsible for contents relating to long-term care, set up in each hospital. Take Dalin Tzu Chi Hospital for example. The long-term care management center of Dalin Tzu Chi Hospital (hereinafter referred to as the Care Center) was established in the hospital in 2016. The total number of inpatients receiving discharge planning that year was 1,316, while the number of inpatients referred to the long-term care management center of Chiayi County Health Office, and handed them over to the Care Center for follow-up service after discharge was 8. The referral rate was a stunning 0.6%, much lower than the MOHW average 2.5%. The reasons are presumed to be the lack of promotion of the referral by medical staff across all levels, coupled with the poor understanding of Long-Term Care 2.0 by patients, families, and nurses, resulting in the low rate of referral immediately after discharge.

Expand Long-Term Care Coverage to Ease Family Burden

The features of the Long-Term Care 2.0 by Ministry of Health and Welfare (MOHW) are the following: flexibility, expansion, innovation, integration and extension; the 8 new major categories "flexibility and expansion"; promote and implement trial plans: provide dementia care service, aboriginal community-based integrated services and small-scale and multifunctional service; innovative service: set up community-based integrated service centers, combined service centers, and long-term care station in alleys and lanes; stretching the coverage of service forward and backward to include the prevention and delay of disability, and the discharge planning service and in-home medical care.

Head Nurse Liu Ying-Mei, the adjunct supervisor of the Care Center Home Service of Dalin Tzu Chi Hospital, said that the number of patients referred to the Care Center

Q4 I believe that in today's aging society the current Long-Term Care 2.0 proposed by MOHW should in terms of clinical nursing emphasize on? (Multiple choices, N = 1,459)



are few, mostly referred from nearby health offices. The farthest patient lives in Budai Township along the coast. The care recipients of the Care Center are mostly patients 65 years of age and above, with disabilities, who require home care and senior nutritional food service.

Head Nurse Liu said that, when interacting with the Care Center patients and their families, she can't help but to feel that "we came too late! They need a lot more help! How can we reduce their burden?"

Clinical nurses, when attending to their patients in the wards, handle mostly acute care, and when patients are discharged, their job becomes general health education. In comparison, the home care under the Long-Term Care allocate more time to a single

patient, which makes individualized care possible. The home care includes visitation 5 times a week, including meal delivery, bathing, rehabilitation, and other services to cope with the patients' individual needs. When providing care on daily basis, after a while it becomes more like friends or family, Head Nurse Liu said. She mentioned a message that was delivered to one of the staff at the Care Center, "my father passed away peacefully this morning. I would like to thank Tzu Chi for your company. It was because of you he was able to leave so peacefully. Thank you." The message is filled with trust from the family that inspire us in the Care Center to continue our mission, to think and do more for even more patients.

Connecting Long-Term Care of Government and Civil Sector

As to what nurses believe that the current Long-Term Care 2.0 proposed by MOHW should emphasize on more in terms of clinical nursing, the choices were increasing the channels to which can connect with continuous care after discharge (66.1%), increase health promotion activities (64.3%), and improve senior care skills (42.4%). In open suggestions, there were mentions of requests for more available channels to assist the general public to know, to understand, and to use Long-Term Care 2.0, and for better communication to allow seniors to return to their communities while having quality self-care.

It is apparent the need of clinical nurses on clinical services under the Long-Term Care 2.0 is to hope for a better and effective channel to connect patients with continuous care service after discharge. It echoed with the fact that the nurses did not know how to connect with the care management service centers of the health offices. The survey's response also recommended that long-term care should focus on preventive health care, which echoed with the integration and extension of the Long-Term Care 2.0, providing activities and events on health promotion.

In the case of Dalin Tzu Chi Hospital, in outpatient clinics or in general wards, there are many senior patients with several chronic diseases. Even for nurses who handle acute illnesses on daily basis can perceive the increasing demands of the entire society for long-term care. It is hoped that the promotion of the Long-Term Care 2.0 can grant more seniors with disabilities the opportunity to age gracefully at home, with the assistance and care from professional caregivers that would put their families at ease; and that the Long-Term Care 2.0 can be fully implemented in the future, so that when we are old, we can rely on professionals for health management, and age happily and gracefully in our own homes, without becoming someone else's burden.