การดูแลผู้ป่วยสูงอายุที่จับไวรัสHAVในโรงพยาบาลอย่างครอบคลุมและต่อเนื่อง: การดูแลระยะยาวเสียชีวิตผ่านจากโรงพยาบาลสู่บ้าน

ประมวลผล**

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การวางแผนการดูแลผู้ป่วยสูงอายุที่จับไวรัสHAVใน

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การวางแผนการดูแลผู้ป่วยสูงอายุที่จับไวรัสHAVใน
Comprehensive Care of Hospitalized older Adults: Transitional Care from Hospital to Home

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Abstract: Systematic hospital discharge planning is a key issue in transitional care for hospitalized older adults to ensure safety during the transition. The purpose of this study was to develop a program of comprehensive care of hospitalized older adults during transition from hospital to home. The study was divided into two phases. Phase I: situational analysis regarding continuing care of older adults from hospital to home was conducted. Data were collected from a sample of 100 hospital health records of older adults who were discharged home and two focus groups were conducted: a) 7 family caregivers and b) 10 professional nurses. Demographic data questionnaire and home care discharge summary were used to collect data.

A structured interview guide was used for two focus groups. Data were analyzed using descriptive statistics and content analysis, respectively. Results showed that the majority (89%) of older adults' medical conditions had been classified as long term mild to extreme disabilities. All of them needed continuing care from hospital to home. The transitional period from hospital to home was the critical point for family caregivers to learn how to take care of their older adults at home safely. Nurses also needed the establishment of standard of transitional care for effective communication. Phase II: development of transitional care program, the program was developed using data synthesized in Phase I as well as literature reviewed.

The developed program was validated by 10 hospital executives and 50 nurses. The program was adjusted according to their comments and suggestions. Finally, the transitional care program comprised of identifying older patients at risk for rehospitalization, standard discharge planning, having nurse as a coordinator for discharge planning, and having personal health book as communication tool for effective continuing care.

However, the process of program testing in the clinical settings is needed for the feasibility and usefulness.

Keywords: Comprehensive care, Discharge planning, Hospital to home, Hospitalized older adults, Transitional care

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