Home Visit Patients and Family with Cleft Lip and Palate

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Background: The operating process for cleft care, requires continuity of care involving a multidisciplinary team. When the patient goes to hospital to receive surgery, parents and family feel nervous about their children and need to know how to take care of their children afterwards. Some patients will have operations into their teenage years. The scar on their face will give them low self esteem and feelings of isolation. Patients and family need information and encouragement. Home visit should be a good process to convey information and encourage patients and family.

Objective: Of this project were to convey information and encourage patients and family and to evaluate patients/family problems and needs as well as to promote networking.

Material and Method: A team meeting took place to decide about the families to be visited. After selection the family nurse coordinator contacted them by telephone, as well as contacting the primary care unit near to the family and then travelled to visit the family. The collected data was by questionnaire, observation and in-depth interview.

Results: 2 families were visited before and after operation, 8 families were visited 2-3 days after operation. The families have better knowledge, more confidence and can take better care of their children. Unfortunately health care professionals in primary care unit were too busy to join with the team.

Conclusion: Home visit is a good process to convey information and find patients and family problems/needs because they are more relaxed than in hospital, so can better understand and talk more easily. The families are happy to see the home visit team and are more confident to take care of their children after visit.

Keywords: Home visit, Patients and family, Cleft lip and palate

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needs.
3. To promote networking.

Home visit
Home visit is a part of continuity of care and involves a interdisciplinary team and planned to maximize effectiveness and efficiency of care(7). This process can help health care professionals with home evaluation, can reduce the burden of transportation, as well as provide comprehensive assessment such as performance based functional, observation of activity during daily living, better understanding of environmental factors and promote health care professional-patient relationship(9).

Objective of home visit(8)
1. To better understand and know patients and family.
2. To promote holistic care.
4. Provide health care service to patients and family.

Home visit process(9)
Home visit has 3 steps: before visit, visiting, and after visit. In the first step the health care professional will prepare data and material. The second is the actual visiting to assess, make relationship between nurse and family, conference about health problem and problem solving. The last step is data recording and evaluating for future plan. Each step has detail thus:

Before visit
The team need to prepare:
- Objective setting, make a plan
- Learn about the patient’s community.
- Try to get more information about patients and family from medical history record
- Research any necessary background knowledge, decide and prepare any tools to carry.

Visiting
Team should be respectful of their culture and beliefs, have good observation skills, use simple language, the questions should be easy and not too long.

After visiting
This step is recording for follow-up and making a future plan.

Home visit can be provided in 4 groups(7,8).

Illness home visit
Visit patients who cannot come to the hospital or in cases where doctor order admitted at home, patient not responding to therapy, elder mistreatment and caregiver burnout. In these cases doctor or nurse will go to visit at home to assess psychosocial, provide wound care in patients with paralysis etc.

Dying patient home visit
Palliative care: sometimes patients need to spend terminal life at home. The health care professional will go to see and help prepare patient and family. The team needs to have knowledge, skill to help patients and family to reduce suffering in that difficult situation.

Assessment home visit
To assess related health status factors that can help health professionals to know and understand patients and family in other dimension.

Hospitalization follow-up home visit
In this group health care professionals will follow patients who were admitted in hospital such as after operation, accident, newborns/moms breastfeeding assessment. The aim of this visit, part of the continuing care service is to see if patients can adapt to family or family can take care of patients and if they have any problem.

The visiting nurse should have good knowledge, communication skill to make good relationship with the patients and family and use INHOMESS guide(9), as follows:

I = Immobility
Assess that care giver has the ability to take care of their children or if need some help from the others.

N = Nutrition
Assess about patients nutrition, milk feeding because it may have effect on patients readiness for operation, wound healing and growth.

H = Home environment
Home environment is the factor that affect patients and family health such as pollution and germs.

O = Other people
Relationship between family members or
relationship with neighbours. If they can help each other when have any problem.

\textbf{M = Medications} \\
Assess about health history, medication including evaluation of parents/care giver drug administration for patients and other source in community.

\textbf{E = Examination} \\
Physical examination, wound care, feeding such as how well patients sucking milk and other health problems.

\textbf{S = Safety, Spiritual Health} \\
Assess culture, health belief, attitude, values and socioeconomic factors that affect patients and family that can help the health care professional understand patients and family health behavior better.

\textbf{S = Service} \\
Assess provision of health care service and problems, patients and family feeling regarding health care service system.

\textbf{Material and Method} \\
This project is the one part of Nursing care system development for patients with cleft lip-palate and craniofacial deformity in Srinagarind Hospital. The period of the present study from October 2008-September 2009. The team visited patients and family with cleft lip and palate who were admitted in Srinagarind Hospital, Faculty of Medicine, Khon Kaen University 1 time per month, before and or after operation. Collected data was by observation and interview.

\textbf{The process of this project} \\
1. A team meeting took place to decide about the families to be visited. 
2. After selected the family nurse coordinator contacted family by telephone. 
3. Contact was made with the primary care unit near the family by telephone. 
4. Find maps and get driving directions. 
5. Prepare document and assessment forms.

\textbf{Results} \\
The team visited 2 families before operation, 8 families after operation, 7 cases of cleft lip and 3 cases of cleft palate. In 2 cases parents could not dress their childrens wound and nurse demonstrated it again. In one case parents had some mental problem and their relative can take care of patients. 4 families had neighbours with them on the visit day. All of these families are farmers. The families felt satisfied with the team and felt more confident. The families have more knowledge and the home visit help them take better care of their children. Health care professional in primary care unit had no time to join with team. From indepth interview we quote some comments as follows:

\textbf{Pre operative care} \\
“Nurse told me be careful if baby get cold, if the baby have fever then can not operation”. 
“I am not sure now if when the baby can get operation, because just breastfeeding probably last week and weight gain very slow”. 
“My child cannot take milk as good as other children”.

\textbf{Post operative care} \\
“It is very long time for breast feeding sometime about 1 hour, but nurse said breast feeding is good for baby so have to be patient”. 
“The wound not quite clean, but I am not sure about dressing, so wait for his mother to comeback from work”. 
“I would like to get more operation on nose, it is not balanced now”. 
“After meal sometime he did not take water, because he did not want to do”. 
“The wound still wet, is it a problem?” “what can I do with that”.

\textbf{Opinion about team visitor} \\
“very glad to see all of you” 
“Would like team come to visit again, feel more confident” 
“I felt a little bit worried to take care of my child, but when see all of you I feel better” 
“When your team visit we have more knowledge and can help us take better care of my child”. 
“In hospital everybody seem very busy, have no time to talk, but at home we have more time to talk, and ask each other”. 
“local nurse sometime they are busy and cannot come to visit us”.

\textbf{Discussion and Conclusion} \\
Home visit is a good process to convey information and find patients and family problems/
needs because they are more relaxed than in hospital, so can better understand and talk more easily. The family are happy to see home visit team and more confident to take care of their children after visit. Some family have neighbours with them on the visit day because they like to share about health care with team. Team visitor understands more about patients and family life style, so can adapt the process to their life style and have some feedback from family to improve the process in future.

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**References**

การติดตามเยี่ยมบ้านผู้ป่วยปากแหว่งพื้นที่และครอบครัว

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ภูมิหลัง: กระบวนการในการดูแลผู้ป่วยปากแหว่งพื้นที่ เป็นกระบวนการรักษาที่ต่อเนื่อง และเกี่ยวข้องกับสาขาวิชาชีพ รวมถึงผู้ป่วยในกลุ่มคนด้วย ผู้ป่วยจะต้องได้รับการดูแลอย่างต่อเนื่อง ผู้ป่วยจะต้องอยู่ในสถานีอนามัยที่ใกล้บ้านที่จะได้รับการดูแลอย่างต่อเนื่อง การติดตามเยี่ยมบ้านเป็นช่องทางหนึ่งที่สามารถช่วยเหลือผู้ป่วยในสถานีอนามัยได้

วัตถุประสงค์: เพื่อให้ข้อมูลและให้กำลังใจครอบครัวของผู้ป่วยปากแหว่งพื้นที่ เนื่องจากการอยู่ในสถานีอนามัย จะต้องมีการประเมินปัญหาการดูแลผู้ป่วยและครอบครัว รวมทั้งการสร้างเครือข่ายในการดูแลผู้ป่วยกับหน่วยงานในพื้นที่

วัสดุและวิธีการ: ทีมเยี่ยมบ้านมีการประชุมและตัดสินใจในการเลือกบ้านที่จะเยี่ยม หลังจากนั้น พยาบาลประสานงานติดต่อครอบครัวและสถานีอนามัยใกล้บ้านที่จะเยี่ยม เก็บข้อมูลโดยการใช้การสังเกต และการสอบถาม

ผลการศึกษา: มีการเยี่ยมผู้ป่วยก่อนการผ่าตัด 2 ราย เยี่ยมผู้ป่วยหลังการผ่าตัด 2-3 วันจำนวน 8 ราย พบว่าผู้ป่วยมีความรู้ ความมั่นใจในการดูแลผู้ป่วยมากขึ้น และมีความมั่นใจในการดูแลผู้ป่วยที่อยู่ในสถานีอนามัย

สรุป: การติดตามเยี่ยมบ้านเป็นแนวทางที่ดีในการให้ข้อมูลและข้อมูล ความต้องการของผู้ป่วยและครอบครัว เมื่อผู้ป่วยยังอยู่ในสถานีอนามัย สามารถใช้การติดตามเยี่ยมบ้านเพื่อให้คำแนะนำ ความเสี่ยงในการดูแลผู้ป่วย ในการอยู่ในสถานีอนามัย ด้วยการให้ข้อมูลและข้อมูลที่จำเป็นต่อการติดตามเยี่ยมบ้านเพื่อให้ผู้ป่วยมีความมั่นใจในการอยู่ในสถานีอนามัย และมีการติดตามพื้นที่เพื่อให้ผู้ป่วยมีความมั่นใจในการอยู่ในสถานีอนามัย