Journal of Health Policy and Management (2017), 2(1): 58-68
https://doi.org/10.26911/thejhpm.2017.02.01.05

Qualitative Study on the Implementation of Public Health Nursing: Objective, Resources, and Work Procedure on Home Care Patients in Surakarta

Ratih Novitasari[1)], Rita Benya Adriani[2)], Eti Poncorini Pamungkasari[3)]

[1)]Masters Program in Public Health, Universitas Sebelas Maret
[2)]Diploma Program in Health Polytechnics, Surakarta
[3)]Faculty of Medicine, Universitas Sebelas Maret

ABSTRACT

Background: Dynamic changes of disease development call for improvement in health care. In light of this context, public health nursing with home care has an increasing role in the management of diseases. Comprehensive public health nursing requires partnership between healthcare providers, patients, and their environment. In Indonesia the focus of nursing remains on hospital care, while rarely on home care that fulfils the need of the community. This study aimed to examine the implementation of public health nursing, encompassing its objective, resources, and work procedure, on home care patients.
Subjects and Method: This was a qualitative study with case study approach. This study was carried out at PKU Muhammadiyah Hospital, Surakarta, from February to March 2017. The key informants of this study included nurses, home care coordinator, doctors, dieticians, and physiotherapists. Methods of data collection included interview, observation, and archival review. Data were analyzed in stages normally employed in case study.
Results: The objectives of home care have generally been understood by most health providers. On the other hand the objectives of home care have not well-understood by the families of the patients, leading to inconsistency with the objective. There is a need to increase resources necessary for the nurses, particularly improvement in competency, as well as case selection, review, planning, coordinating, and evaluation. Likewise, collaboration between health care provider, patients, and their families, need to be improved in order to maximize home care.
Conclusion: There is a need to strenghten commitment of all parties involved in home care. The objectives of home care need to be understood by all parties. Hospitals are expected to have stronger responsibility with both work procedure in order to deliver optimal health care. By doing so, the public health nursing with home care will be able to fulfil the need of the community.

Keywords: home care, objective, resources, work procedure

Correspondence:
Ratih Novitasari, Masters Program in Public Health, Universitas Sebelas Maret. Jl. Ir. Sutami 36A, Surakarta 57126, Central Java. Email: ratih.noph@yahoo.com Mobile: +6285649524070

BACKGROUND

The development of the disease is currently a major concern of the world, infectious and non-communicable diseases continue to increase in several countries related to climate change and lifestyle. Indonesia as one of the developing countries in the world is facing triple burden diseases, namely the incidence of infectious diseases, the existence of new-emerging and re-emerging diseases, and the incidence of non-communicable diseases that continue to increase over time (Nur and Citizens, 2016).

Patients care with terminal illness or chronic disease patients will require a long time and a lot of money if only getting treatment at the hospital. The World Health Organization (WHO) has said that the care of patients at home (home care) is needed to fulfill the epidemiological transition that

is currently occurring in relation to the increase in the number of people with disease (Oliviera et al., 2012).

The Canadian Nurse Association (2013), stated that home care is comprehensive health care through a partnership approach to the family and environment of the patient. Home care can have an optimal impact on patients because nurses can increase the support of family and surrounding communities, establish the health care system needed by patients, establish mutually supportive relationships with families, and communicate more efficiently.

The implementation of home care in several countries is growing rapidly, this is due to the increasing need for care for the elderly as the life expectancy increases. Data from the Centers for Disease Control (CDC) in 2013 estimated that there were 4.9 million patients throughout the world who carried out home care and in 2014 there were 12,400 service providers.

Indonesian society in general focuses on hospital care with the existence of health insurance so that home care is used more by patients with cancer (Grehension, 2015). Criteria for patients eligible for care at home according to Harkness and DeMarco (2012), one of them is patients who have an inability to leave home or patients with disabilities.

The number of disabilities in Indonesia in 2014 was 17%. One of the provinces with the highest number of disability is Central Java, which is 10.3%. Surakarta has a population with disabilities of 2,352 people out of 563,659 total population or 0.26% (The Ministry of Communication and Information Technology, 2013).

Based on a preliminary study conducted at PKU Muhammadiyah hospital in Surakarta, a home care program that has been running since 2011 is trying to provide maximum service to patients at home. The type of demand for services provided by the majority is the care of babies and patients after treatment at the hospital. The implementation of home care programs can be seen from several aspects, namely goals, resources, and work procedures. Therefore, the title of this study is "Qualitative study on the implementation of public health nursing: Objective, resources, and work procedure on home care patients in Surakarta"

SUBJECTS AND METHOD

This study used a qualitative design with a case study approach. The case study approach was used to explore a single entity or phenomenon (case) that was bound by time and activity (a program, event, process, institution, or social group) and various data collection procedures over a fixed period of time were used to collect detailed information (Suleman, 2015)

The study was conducted in PKU Muhammadiyah Hospital at Surakarta and was held from February to March 2017. The types of data used in this study were primary data obtained from informants, namely 7 people who where implemented home care. Secondary data was obtained through hospital document studies. The sampling technique used was purposive sampling. In this study the informants were 3 nurses, program coordinators, and 3 other health teams (doctors, nutritionists and physiotherapists).

The technique of collecting data was through in-depth interviews, observation of the implementation of the treatment process and the patient's environmental conditions, and the study of documents in the form of home care guidelines and SOPs of activities and actions. The study instrument was interview guides and tape recorders. According to Yin (2003), data analysis was done through within-case analysis

study of each case to describe the themes in detail, conducting a cross-case analysis study, namely the themes of the study results per case studied cross-crossed, interpreted and integrated the meaning contained in it, and formulated then interpreted information and interpretive analysis then the researchers reported the significance that could be learned (Suleman, 2015)

RESULT

Seven informants who participated in this study were nurses, doctors, physiotherapists, and nutritionists. The home care nurse as the main informant were 3 people and they were PK 1 nurse (level 1 clinical nurse) with work experience less than 5 years, aged 23 and 24 years, and had third level of associate's degree of nursing education. The home care coordinator was in charge as the coordinator and person in charge of the program, a PK3 nurse (level 3 clinical nurse) with work experience of more than 9 years and had third level of associate's degree of nursing education. Other health teams involved were doctors, physiotherapists, and nutritionists.

1. The Purpose of Implementation

The purpose of home care delivered by all informants through interviews was a continuous care for patients with long-term care needs who experience limitations and to provide health education and increase family involvement.

"The goal is the implementation of a service that acts further, for example from a hospital, it is still ongoing in improving the health of patients and their families" (P2)

The goal also required nurses and other health teams to provide health education as an effort to achieve the implementation goals in order to make the patients become independent.

"We will teach patients so that patients can do their own activities that can be done by patients or their families" (FT)

Nurses experienced obstacles in achieving one of the goals of home care, namely in providing comfortable conditions for patients due to lack of family attention. This caused the achievement of goals was not maximal.

"Yes there were those who could and couldn't, but they must be motivated continuously because there are also families who were indifferent, there are families who did not care. There were patients who also have strokes but the condition is much different from the others because of the condition of families who do not care. They only care about changing the NGT DC but for the ADL, the patient's personal hygiene is lacking "(P1)

From the results of observations, home care activities had been optimized by the entire team to be able to provide patient care needs, but there were still patients who were in an uncomfortable environment.

2. Resources

The resources in this study were human resources and facilities. The results of interviews of all nurse informants were PK 1 nurses, the third level of associate's degree of nursing education, and had attended training from the hospital regarding the care measures to be taken in providing home care services.

*"We are all the same (*associate's degree of *nursing), besides here there are also training ... installation of NGT DC, every 3 months, the hospital has held training."*

Nurses had not received home care training or other training aside from nursing actions training from the hospital.

"Training was planned yesterday, we went to Jogja but because at the same time

there were accreditation, it had not yet been approved. Actually, the plan already exists but has not been implemented, 2 people will be sent" (KH)

Except nurses, there were several other health workers involved including doctors, nutritionists, and physiotherapists.

"We involve physiotherapists and nutritionists, for the stroke bed rest patients, physiotherapists, they still have to be mobilized, while for nutritionist, if they go home, bring the feeding hose, the family usually wants the hospital catering" (P3)

From the results of observations and document studies, there was only one nurse on duty on each shift with the obligation to carry out patient home visits, carry out prospect activities (activities to direct patients who are still being treated to approve home care after being allowed to go home), and carry out tasks in treatment room, emergency room, or poly after the visit is complete. This caused obstacles for nurses to be able to work optimally and caused complaints from patients.

"We have been complained because of the service ... every shift is one person, many people want home care, while the time is not enough ... then they were complained why we did not come" (P3)

Based on the results of document studies and observations of facilities and infrastructure, means of transportation, communication, and health education had been provided by the hospital even though the home care room was united with the supervisor nurses for a while. The equipment provided were 3 sets of nurse kits, medical sets and oxygen transport, and documentation files. Care materials were adjusted to the needs of patients and family agreements.

"There are some that are provided here, for the tool, for example, there is a medication set, but storing it is not in home care so we take it in CSSD for sterility of the device. Later, for example, if there is a medical patient, the drug is prescribed, it's from the doctor first, sometimes it's been brought home with the recipe. If the ingredients that come from the family go home, they are prescribed, gauze, the tape can be from the family, unless the necessary medicines, for example ointments or liquids that cannot be bought themselves, then have just been prescribed from here. "(P2)

3. Work Procedure

The work procedures in home care services consisted of selecting cases, reviewing patient needs, planning activities, coordinating services, monitoring, and evaluating. Based on the results of interviews, all nurse informants conveyed the selection of cases through data from hospital medical records.

"We look at the computer. The mother and child services data are seen, for example in Surakarta area, the mothers who give birth, we offer home care for the care of their babies. Before the patient returns home we offer home care and deliver the details of the rates "(P1)

From the results of the SOP document review, prospect activities were carried out by home care nurses in patients in the care ward by making prior selection through patient data from the patient's medical record. In the home care guideline and SOP documents, no selection process for patients from outside the hospital was found.

The next process was the assessment of patient needs doing by nurses by looking at medical record data and reviewing when visiting the patients on the ward to carry out prospect activities. As for patients from outside, the initial assessment could be done by telephone when the family/ patient wanted to get home care.

Besides the physical condition of the patient, the nurse also conducted an assessment of the patient's environmental conditions as long as the patient received care at home.

"We see the condition of the patient, whether the surrounding environment is clean or not ... and whether he or she is being cared for or not ... the patient is treated properly not by the family, if not they are very sorry" (P1)

The planning phase of the activity was planning visits, planning actions, and adjusting resources that were owned by family needs. The whole process was an agreement between the patient and family by prioritizing the choice of patients and families.

"Depending on the what family wants, we had scheduled to replace DC on Monday but if the family wants to do it on Tuesday the family must do it themselves, we usually educate them because we fear of infection" (P3)

All processes in work procedures took place through a process of coordination between nurses and patients and nurses with other health teams. Nurses coordinated in managing guard duties, adjusting patient needs to existing resources, and coordinating with other health teams in service optimization.

The nurse conveyed that obstacles in coordination had occurred when there was information needed for the next officer not delivered. This harmed the patient because his visit request was not fulfilled.

"After we visit, we are asked to go to the ward and we forget to pass, so it is like that which makes miscommunication because we have to do other activities immediately" (P3)

Nutritionists and physiotherapists said that coordination with nurses needs to be improved because barriers to communication regarding patient conditions and development had occurred. This was feared to cause conflicts or actions that were conflicting and detrimental to patients.

"Sometimes we take action to patients, we find something that might not be handled properly, for example, one day I found a wound in the foot area, it turns out that the wound has not been treated so sometimes we need fast communication to be handled immediately. I want to say that I don't know what a fast, telephone way is, because I and the nurse don't know who the officers were, whether it was just a nurse or several nurses. Today is nurse A, tomorrow can be nurse B, now this is what you need to think about is the media ... how when nurse who attends is nurse B, then I say there are wounds and then other nurses can evaluate it later (FT)

The home care patient team wanted their coordination become better through existing communication facilities or integrated medical records as in the implementation of patient care in the ward.

"So that the therapy is integrated from all fields ... right if hospitalized after accreditation starts, it is integrated between nurses, nutrition, doctors, and in the care sheet it is integrated. What does the doctor give, what nutrition workers provide, so the care sheet is already visible, what is given by physiotherapy ... so there is no need to ask because it is already known what is given ... "(GZ)

Service monitoring and evaluation consisted of monitoring or evaluating the patient's condition and evaluating the overall home care service. Patients' condition was contained in the patient's medical record written after the patient had received treatment.

"For example, wounds are carried out every day of treatment, the criteria for wounds are different, each visit cleanses

later every day as well as evaluations, so every visit can be used to make the next planing while looking at the patient's condition" (P2)

Service evaluation was contained in the form of reports every month that were approved by the program coordinator and submitted to the nursing manager.

"Yes, there are reports, every month ... I received it first ... every month we have to monitor, how many times is the visit, for how many home visits, home for medication, there is a report on DC or NGT," (KH)

From the results of the document review, it was found that there were reports of home care activities in which there were a number of patients, the number of visits and the types of actions taken, as well as the condition of patients after receiving treatment.

DISCUSSION

1. Purpose of Implementation

The purpose of implementing home care based on the results of the study is to provide continuous care to patients with long-term care needs who experience limitations. This is in accordance with the objectives found in the study of Goodman et al., (2016), which stated that home care activities are carried out to meet the needs of the community for health care in the form of 24-hour care needs or occasional needs for physical limitations that cause dependency patient. The inability can be in the form of high dependence due to cognitive limitations, disability, weakness, the need for drugs or behavioral problems.

The home care implementation as conveyed by the informant also has another purpose, namely to provide health education and increase family involvement. This is in accordance with the objectives of public health nursing activities written in the Minister of Health Decree No. 279 / MENKES / SK / IV / 2006 that the focus of home care activities as part of public health nursing is to increase knowledge and skills, educate individuals and families or community groups to instill understanding and encourage healthy behavioral habits so that they are able to maintain and improve their health status.

This goal requires commitment and must be understood by anyone involved including patients and families so that these goals can be achieved. Obstacles in achieving goals can occur when the goal is not clearly known by the family so that things can happen that are contrary to the recovery of the patient.

The goals that are understood together will make everything done by each person involved continue to work for the same end result and avoid the inappropriate conditions and conflict (Farran, 2012). Objectives should be able to form a commitment in implementing a program so that it can meet the community's needs for services and the achievement of people who have a healthy lifestyle (Wijanarko et al., 2014).

2. Resources

The results of the study indicated that there were limited resources, especially in implementing resources, namely related to increasing competency and availability of program implementing resources. The provision of home care activities requires nurses to have competencies that are able to facilitate all problems that may be encountered in a patient's home. Nurses must have skills in carrying out actions, communicate well, provide information that is informative, have attention and understand patients, and be able to provide motivation.

Health care requires an increase in education and training because of the

demands of population development, technology, and treatment. Home care implementation requires nurses who are not only equipped with skills, but also master the disease pathophysiology, advanced technology, medical techniques, psychology and communication, pain management, and the ability to work in teams (Ohlen, 2015). The World Health Organization (WHO) said that one of the efforts to improve the health system is through the development of human resources, where nurses and health teams are involved in home care. Without education and training, the process of caring for patients can encounter problems or things that can endanger patients (Viola et al., 2013)

This study shows that the number of nurses is still not sufficient for all service activities so that the service process cannot run optimally. The obligation of nurses who not only carry out service duties in home care but also are obliged to carry out prospecting activities and carry out treatment in the ward causes nurses to not be able to spend much time with patients and families to establish relationships of closeness and trust. In providing optimal service, the number of resources that are needed and the task description is clear for each team member.

The Soesanto et al. (2015) study stated that the implementation of patient care at home has been effectively carried out by involving 2 general practitioners, 1 nutritionist, 5 implementing nurses, 1 doctor as a case manager, 2 executive managers, 1 person administrative staff, and 1 person in the finance department. The implementing nurse only carries out maintenance activities while the executive manager who evaluates the care measures given. Implementing managers are decisive in providing nursing care by first conducting a comprehensive assessment of patient needs and providing education and guidance to the family on patient care.

Facilities and infrastructure are needed to support the patient's nursing process at home. This study shows that these facilities still need improvement to be able to maximize the services provided because they do not fully have their own rooms. This is in accordance with the needs of home care facilities delivered by the Ministry of Social Affairs of the Republic of Indonesia in Home Care Guidance and Care namely the presence of home care offices / care units, operational vehicles, file storage cabinets, cameras and communication tools (Ministry of Social Affairs, 2014).

3. Work Procedure

The implementation of home care through the process of selecting cases, reviewing patient needs, planning activities, coordination and monitoring and evaluation is a form of patient management based on case management that is important in the patient's development goals and family independence. According to study conducted by Van der plas et al., (2012), the implementation of case management is important in providing information and support and identifying patient needs properly.

The work procedure in implementing home care is carried out in accordance with the nursing process which consists of assessment, formulation of diagnosis, planning, implementation and evaluation. In providing nursing care, nurses use the nursing process approach to solve problems systematically.

The nursing process that is carried out must be open and flexible, carried out through an individual approach, handling planned problems, having direction and purpose, having a related cycle, data validation, and proof of problems and emphasizing the occurrence of comprehensive

feedback and reviews (Budiono and Pertami, 2015).

The assessment process as the first step in nursing action is the basis for determining nursing actions to be carried out so that they must be carried out specifically and continuously. This is in accordance with the study of Batbaatar el at., (2017), which stated that the implementation of correct physical assessment is one of the main keys to obtaining the satisfaction of chronic disease patients who are the largest part of patients receiving home care care. Important health status assessments are carried out by looking at various aspects, especially for those who have limitations due to their illness which not only includes physical conditions, but also mental health conditions or anxiety, stress, and depression.

This study shows that planning activities include planning nursing actions and schedule of visits, where this still requires other aspects in planning activities, namely planning related to the agreement of the final results to be achieved and self care needed by the patient.

This is in accordance with a study by Newbould et al. (2012), which stated that in planning home care activities, a joint discussion between patients and nurses is needed. Because planning activities are not only related to action plans and planning schedules but an agreement is needed regarding the output of desired activities, readiness of family and patients in self-care and self-management planning for patient emotional support.

Coordination within the team will be mostly carried out in this planning activity, where there is a need for integrated recording or documentation as well as structured communication on all the components involved so as not to interfere with patient care activities (Newbould et al., 2012).

This study shows that there is coordination that has not been effective in the home care team so that it has caused the patient's needs to not be handled quickly. This is because there is no clear coordination path within the team and the implementation of patient care is still fragmented.

A study from Philis and Gallo (2014) stated that the implementation of community-based health programs that treat chronic disease patients requires reports, laboratory results, and other data that can be accessed by the health team involved in patient care. A good and integrated coordination system in health services can be done through electronic media or other media that can facilitate implementation for each team member.

Team members also need meetings or discussions regarding the patient's cases and conditions on a regular basis to solve various problems, cases of illness, plan the expected results and to ensure that each member can coordinate well. The meeting of team members aims to get recommendations or input from other team members in efforts to improve service.

The last stage in the work procedure is an evaluation which in the study is an evaluation of the patient's condition and an evaluation of all home care activities carried out. Evaluation of the patient's condition is carried out at the end of the nursing action and documented in the evaluation sheet on the home care card.

The process is in accordance with the action of nursing evaluation which is an assessment of changes in the state of the patient after receiving nursing actions by adjusting the goals and criteria for results to be achieved at the planning stage (Budiono and Pertami, 2015)..

The form of activity evaluation in the form of preparing a home care activity

report in this study has not been able to reflect the results of the planned goals and the progress of service progress. According to Moule et al., (2016), the evaluation process in the implementation of service actions must include how the achievement of the activity and whether the activity is in accordance with the objectives of the implementation.

The implementation of home care as part of public health nursing requires commitment from all parties, such as service providers, health teams, and patients and families. The purpose of home care that is understood by all components, hospital responsibility in providing optimal services, and the implementation of good work procedures will be able to produce health services that are able to facilitate the needs of the community.

REFERENCE

Batbaatar E, Dorjdagva J, Luvsannyam A, Savino MM, Amenta P (2017). Determinants of patient satisfaction: A systematic review. Perspectives in Public Health. 132 (7): 89-101.

Budiono, Pertami SB (2016). Konsep Dasar Keperawatan. Jakarta: Bumi Medika.

Canadian Nurses Assosiation (2013). Optimizing The Role of Nursing In Home Health. Otawa: CNA.

Centers for Disease Control and Prevention (CDC) (2016). Home Health Care. [online] available at: http://www.-cdc.gov/nchs/fastats/home-health-care.htm Retrieved October 14, 2016.

Farran H (2012). Practice with purpose. Guident: 56-57.

Goodman et al. (2016). Effective health care for older people living and dying in care homes: a realist review. BMC Health Service Reseach. 16 (269) 1-14.

Grehension G (2015). Trend Home Care di Indonesia. [online] available at http:-//holistikhomecare.com/trends-home-care-di-indonesia/ Retrieved December 20, 2016

Harkness GA and DeMarco R. 2012. Community and Public Health Nursing: Evidance for Practice. Philadelphia: Lippincott Williams & Wilkins.

Kementerian Sosial Republik Indonesia (2014). Pedoman pendampingan dan perawatan sosial lanjut usia dirumah (home care). Jakarta: Direktorat Jenderal Rehabilitasi Sosial.

Keputusan Menteri Kesehatan RI Nomor 279/MENKES/SK/IV/2006 Pedoman Penyelenggaraan Upaya Keperawatan Kesehatan Masyarakat di Puskesmas. 21 April 2006. Dinas Pelayanan Keperawatan. Jakarta.

Moule P, Armoogum J, Dood E, Donskoy A, Douglass E, Taylor J, Turton P (2016). Practical guidance on undertaking a service evaluation. Nursing Standard. 30(45): 46-51

Newbould (2012). Experiences of care planning in England:interviews with patients with long term condition. BMC Family Practice 13 (71): 1-9.

Nur NN, Warganegara E (2016). Faktor risiko perilaku penyakit tidak menular. Majority. 5 (2): 88-94.

Ohlen A (2015). Advanced home care nurses's everyday practice. Stockholm: Karolinska Institute

Oliveria SG, Quintana AM, Budo LD, Kruse MH, Beuter M (2012). Home care and hospital assistence: similiarities and differences from the perspective of the family caregiver. Text Context Nursing Florianopolis. 21 (3): 591-599.

Philis-Tsimikas A, Gallo LC (2014). Implementing community-based diabetes programs: the scripps whittier diabetes institute experience. Curr Diab Rep: 461-471.

Soesanto E, Chanif, Supradono B (2015). Peningkatan kualitas kesehatan masyarakat melalui jasa layanan kesehatan holistik on delivery fakultas ilmu keperawatan dan kesehatan Universitas Muhammadiyah Semarang. Jurnal Keperawatan Kesehatan Masyarakat. 1(4): 53-61.

Sulaeman E (2015). Metode Penelitian Kualitatif dan Campuran dalam Kesehatan Masyarakat. Surakarta: UNS PRESS.

Tyer-Viola LA, Timmreck E, Bhavani G (2013). Implementation of continuing education model for nurses in Bangladesh. The Journal of Continuing Education in Nursing. 44 (10): 470-476.

Van der Plas AGM, Onwuteaka-Philipsen BD, van de Watering M, Jansen WJJ, Vissers KC, Deliens L (2012). What is case management in palliative care? An expert panel study. BMC Health Services Research. 12 (163): 1-8.

Wijanarko VW, Sjamsuddin S, Hermawan (2014). Pelaksanaan Program Gerakan Tuntas Gizi Buruk (Restu Ibu) di Kabupaten Ngawi. Jurnal Administrasi Publik (JAP). 2 (3): 546-549.