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POSTER ABSTRACT

Wit-Gele Kruis good practices in outpatient home care

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Wit-Gele Kruis is an outpatient home care organization, spread across five Flemish provinces in Belgium. Each has an autonomous organizational structure, but for large-scaled projects forces are joined under an umbrella headquarters, in Brussels.

Person-centered care, emancipatory methods and interdisciplinary teamwork are among our core methods. Since integrated care is part of our DNA, we present some of our good practices.

Limburg & West-Flanders

In these two provinces, a handful of nurses go onto the streets to try and provide care for homeless persons. Their scope of work ranges from motivating them to go to a shelter for a shower, to wound care treatment, oral hygiene and getting the necessary vaccinations.

“Wit-Gele Kruis aims to provide warm quality outpatient home care, but what if there’s no roof over one’s head? Then we still make sure those too receive warm care.”

In Limburg the initiating partner is a city, whereas in West-Flanders organizations specialized in mental health are taking the lead. Other partners include hospitals, police, welfare and well-being city services and an outpatient shelter for drug users.

Mostly (young) male adults are reached. But in Ostend sex workers also reach out, seeking advice.

“Street nursing is on the city council’s agenda to ensure that even the most marginalized groups have (health) care access.”

East-Flanders

One of our dementia care experts participates in the care network around a chronically ill patient, to guide and refer them and their informal caregivers to the proper channels.

This care network consists of home care nurses, general practitioners, pharmacists, cities, hospitals, mental health/ welfare themed organizations, patient care organizations. They focus on the patient’s resilience, autonomy and participation in their own healthcare process.

“I consider this to be an extremely useful and valuable project that enables people diagnosed with dementia e.g., to remain safe in their own home environment as long as possible.”

Antwerp

In 2021 51% of our palliative care patients received end-of life care by a team consisting of our nursing team, the general practitioner and an external palliative care equip. Given the channel

trough which patients in care are reported, the hospital social worker may also be added to that care team.

Usually when the need for voluntary services arises, and the advanced care planning conversations are on the table or when the informal caregiver obstructs the care setting, nurses can suggest to the general practitioner to have the equip involved.

“There’s is nothing earth-shattering that we are doing here, but it does provide a quality service to everyone involved in the dying process.”

Flemisch Brabant

There is a transitional limited stay arrangement for elderly people above 60 years, whose home situation is no longer suitable and where there is no medical reason for hospitalization. This project is a collaboration between general practitioners, health insurance funds, city care & welfare services, home care organizations and hospitals.

“This project aims to support elderly people to live safely at home for longer and avoid (re)admission to the hospital.”