Original Research Article
DOMICILIARY CARE SERVICE AT A TERTIARY CENTRE

ABSTRACT

BACKGROUND: The domiciliary service comprises of medical and rehabilitation services done at the home of patients to ensure uninterrupted care upon early discharge, render support to the family members in training the caregiver and to reduce readmission by providing quality care. **OBJECTIVE:** To explore the facilitators and barriers of domiciliary services at Hospital Seberang Jaya (HSJ), Penang **METHODS:** A total of 53 respondents (34 trained nurses, 8 sisters, 5 matrons, 4 occupational therapists and 2 physiotherapists) involved in domiciliary care from the medical, surgical, orthopedics and pediatrics wards were interviewed using a semi-structured questionnaire as homogenous focus groups or as individuals, audio recorded, transcribed and thematically analyzed. **RESULTS:**3 domains were identified as facilitators and barriers; Health System factors, Health professional and Patient and Caregiver factors. In facilitators, health system factors (ongoing measures in domiciliary updates, having a reference file in ward, cluster hospital concept and a dedicated person in charge). Health professional factors (teamwork, synchronized explanation and pre planned discharge), patient and caregiver factors (suitable caregiver, locale convenience of health facility) and finally the proactiveness, motivating and supportive factors that encompasses all 3. The Health System barriers were (inadequacy in; man power, public information and ineffective domiciliary team). Health Professionals Barriers were (bias selection of cases and default in responsibilities). Patient and Caregiver Barriers (unsuitable caregiver, misconception on nursing role, lacking confidence to learn and financial issues). Encompassing all were lack in continual monitoring, communication and supervision. **CONCLUSIONS:** For a successful domiciliary care, health system factor, health professional factors, patient and caregiver factors need to be addressed. Its Implementation will involve all stakeholders to work for a common goal for an effective delivery of domiciliary services at HSJ.

Keywords: Domiciliary services, Nurses, Allied health, facilitators and barriers

1. INTRODUCTION

The domiciliary service comprises of medical and rehabilitation services done at the home of patients to ensure uninterrupted care upon early discharge from hospital, render support to the family members in training the caregiver to care the patient at home and to reduce repeated admission by providing quality medical care at home and in the community. This is carried out by trained medical personnel who render medical care and guidance to the care giver to ensure that the patient care is continuous and uncompromised upon discharge. Studies have reported effectiveness of domiciliary services in improving health care cost, quality of life (QOL) of patients and recovery of patients[1,2,3,4,5]. In Malaysia, domiciliary service uses the home care concept (HCC) where a patient is discharged when the care giver is capable of continual care or after a maximum three months home visit; whichever comes first. In a study which explored on long-term cost effectiveness of home care reablement programme and concluded that it could increase the cost effectiveness and maximize their independence as they age[3]. Similarly, in another study, on effectiveness of a home care program in dementia patients reported that the program me is feasible, acceptable and leads to significant improvements in

caregiver mental health and burden of caring[4].However, there are barriers of implementing the domiciliary services as reported by another study.[3]
Although the HCC policy was approved in the year 2001 and was on trial at 5 government health clinics, lack of resources had halted the projects in year 2003.[2] No study was done to explore it. Our study, based on grounded theory, therefore, aims to delve into the perspectives of allied health care workers on the facilitation and barriers of domiciliary services at Hospital Seberang Jaya, Penang and 3 domains were identified; Health System Factors, Health Professional Factors and Patient and caregiver factors. The insights garnered will be instrumental in devising strategies for a more efficacious and streamlined service implementation across the nation.

2. OBJECTIVE

To study the factors that facilitate and barriers at Hospital Seberang Jaya in the 3 domains; Health System Factors, Health Professional factors and Patient and caregiver factors.

3. MATERIAL AND METHODS

Setting: There are only two tertiary hospitals in the state of Penang. Hospital Seberang Jaya (HSJ) where the study is conducted is in the mainland. Penang General Hospital in the island part of Penang. The mainland is referred as *Seberang Perai* and divided into northern, mid and south with additional one district hospital in each. The patient influx to HSJ were mainly from the aforementioned areas and of mixed urban and rural population. Northern is in area of 261.12km^2. Two hospitals (HSJ and Hospital Kepala Batas) are here and within 17.8 km from each other. Hospital Bukit Mertajam (HBM)is in mid Seberang Perai, in area of 237.55 km^2 which is 12.1km from HSJ. Hospital Sungai Bakap is in southern in area of 239.74 km^{2}and which is 23.2km from HBM.[6]
Duration: 3 years; August 2019 till September 2022
Study Design: This is a qualitative study, prospective study utilizing individual in-depth interview and focus groups discussion
Participant recruitment

Inclusion criteria

Allied health staffs of HSJ in the medical, orthopedics and surgical wards involved in domi (domiciliary) cases and consented to be interviewed.

- Nurses (Matrons, ward sisters, trained nurses)
- Physiotherapists
- Occupational therapists

Exclusion criteria

i) All those not involved in domiciliary care of all the aforementioned disciplines.

DATA COLLECTION:

Our team discussed on methods to conduct study and interview guide. We briefed the Head Matron of HSJ and the heads of department of medical, surgical, orthopedics pediatrics, occupational therapy and physiotherapy. We obtained a list of all nurses and staffs from the disciplines involved and shortlisted to those involved in domiciliary care. Verbal consent was obtained. A rooster was formatted according to

their preferential time as homogenous focus group or individual settings. The interview sessions were arranged during weekdays in the morning (10am till 12noon) for the trained nurses where an additional nurse for the morning shift as 'runner' to avoid disruption of ward duties and, in the evening, (2.30 pm till 4.30 pm) for the ward Sisters and Matrons. The remaining allied services were also fitted into above timings as homogenous or as individuals according to their availability. Participants were given a phone call reminder a day before and again in the morning of the interview date. A total of 53 respondents (34 trained nurses, 8 sisters, 5 matrons, 4 occupational therapists and 2 physiotherapists) involved in domiciliary care were interviewed using a semi-structured question by the principal investigator[1] and a team member[3] as note taker at the meeting room of clinical research center of HSJ. All interviews were, audio recorded, transcribed verbatim, thematically analyzed and coded by the authors [1,2,3] The respondents were explored on factors that facilitated and the barriers they faced. All transcriptions were cross checked by the principal investigator[1]. The interview was carried out only once for each assigned groups or individuals. Field notes were made during each interviews. The interview involving trained nurses reached saturation and hence was halted. As for the rest of allied health enrolled, they were interviewed till completion. The interview was recorded after the ice breaking and signing of the patient information sheet and consent from each participant. The duration of the interview alone ranged from 1 hour to 1.5 hours for the focus group discussions and between 25 minutes to 45 minutes for the individuals. NVIVO 12 software was used to organize data and a thematic approach used to analyze the data. The final themes were presented to the leads of the hospitals for comments. No further revision was required.

RESULTS

Barriers of Domiciliary care

This section synthesizes the barriers identified across three domains—health system factors, health professional factors, and patient and caregiver factors—highlighting the multifaceted challenges faced in domiciliary care.

Health System Factors

Shortage of manpower

The study identified several barriers within the health system that impact the efficacy of domiciliary care. A significant shortage of manpower in wards was noted, leading to lack of support services and a lack of timely knowledge updates for staff. This has resulted in prolonged bed occupancy rates and an ineffective domiciliary team.

Nurse 4: *We nurses take charge of as many as 12 cases at hand, if there is a domiciliary team, they could handle. Our ward sister attends meetings, hence no one else to handle domiciliary cases in ward.*

Nurse 6: I don't see any smoothness in the handling of domiciliary cases. We nurses had to coach caretakers, one by one, how to give Ryle s tube feeding, suction etc., its time consuming as we have other patients too. If I had the time, I will observe how caretaker carry out the procedures as well as give them health education.

Lack of dissemination of information and shortage of necessary equipment

The dissemination of information regarding domiciliary services to the public is insufficient, with a notable lack of informative brochures. Additionally, lacking staff orientation and training on domiciliary care practices and inadequacy of the necessary equipment.

Nurse 5: The patients and their families seem to be aware of zakat aid (aid from Muslim charity fund) only but not domiciliary services.

Nurse 3: We list the equipment or things needed and ask the social worker each time. They then give a list of dealers and we give the caretakers. They aren't any brochures or guidance in the ward.

Lack of staff orientation, understanding and knowledge on domiciliary

The inadequate knowledge on domiciliary care had also caused conflict of opinions in selection of cases and most importantly in conveyance to the patient and family. The attendance tracking in wards seem inconsistent for the various updates with missed opportunities.

<u>Concerning nurses</u>

Nurse E: There is less exposure on domiciliary at HSJ so we have limited understanding on that subject.

Nurse L: We follow rotation to attend CNE (continuous nurses education training). In my 3 years, somehow, I did not get a chance.

Matron No 4: I had no meetings with the matron in charge domiciliary and I never had any discussion regarding domiciliary issues with her. (Matron No 5 nodded)

Nurse F- The ward sister barely knows on domiciliary as we nurses are the ones who handle domiciliary cases, coach the care taker and monitor them.

<u>Concerning doctors</u>

Subject N: In my experience, doctors do not know what domiciliary is all about just as subject M had highlighted. (Subject M smiles) Example the houseman informs patient that the nurse will go over to patients' house to continue dressing upon discharge. Doctor should know the role of nurse during home visit is to monitor and it is the caretaker who should learn dressing to be carried out at home. (Nurse O nods). We had to end up clearing the air on domiciliary to the patient and relatives.

Subject R: In my ward (name hidden), only staff nurses handle domiciliary cases as the specialist and medical officers themselves don't seem to have any knowledge. The same with our ward sisters and we had to update them instead.

From other Allied Health Team

PT (physiotherapist) B: Although orientation and CME (continuous medical education) sessions are there and attendance taken but no tracking on staffs who missed and ensuring they are enrolled in subsequent sessions.

Occupational Therapist (OT) A: So far, there aren't any guidelines on domiciliary at HSJ. I rely on the nurses totally. It's odd that I was not asked to refer to my counterpart at health clinics at discharge in my 4 months stint at HSJ. (OT D nodded)

No clear policy regarding criteria and management for domiciliary care

Indecisiveness among higher-level management regarding the inclusion criteria for domiciliary care was observed, often influenced by personal preferences rather than established guidelines.

OT B :I depended on the ward nurses, to guide me as I myself not been orientated at my department. The nurses replied that they are not sure but to just to carry out as with other patients. Hence, I used my usual Modified Bartel form as assessment of the patient. However, I am yet to be asked to refer to the health team of my assessment at discharge so I wonder how my health counterpart will know the progress upon their home visits.

Health Professional Factors

Bias selection of cases

Health professionals exhibited biasness in selection of domiciliary cases, often influenced by personal preferences to patient needs. Exerting influence, misconstrued opinions and personal preference by superiors in managing domiciliary cases can further compromise on intended domiciliary care. It also

rendered indecisiveness on the part of nursing staffs in wards and carried risk of potential domiciliary cases being missed out.

Nurse R: Many specialists (discipline hidden) give preference to own relatives or neighbors. One refers and another cancels it where race is involved. Left in quandary, whom should we follow?

Prevalent default in responsibilities

There was a prevalent default in responsibilities, characterized by incomplete tasks and a failure to pass over crucial information. Our study also found that tasks were selectively performed based on individual discretion rather than protocol. Having check lists on tasks to be completed and passed over will also curtail and alleviate communication issues and for smoother transition of work force.

Concerning doctors

Nurse T: I find there is frequent changing of house officers (HO) in my ward. I noted the doctors are calculative and blame each other for the incomplete tasks.

Nurse 7: I am actually confused, how come I had to end up literally forcing doctor to fill up the forms. It's the doctor who first saw the patient who should do the referral, instead they push the tasks amongst themselves and causes delay.

Concerning Nurses

Nurse Q: Referrals are made at discharge and we could not carry them out. Nurses too had missed passing over domi cases.

Concerning Support staffs

Nurse 2: For OT referrals, the forms needed to be sent to their department. Often the ward attendant missed out hence a delay for response from OT.

Compromise nursing tasks and feel intimidated by nursing superior

There seemed to be a methodical and concise approach in handling domiciliary cases However, nursing staff faced several challenges, including a shortage of patient beds and feeling intimidated by superiors, particularly regarding domiciliary referrals resulting in fear and reluctance among nurses to engage with the person in charge (PIC).

Nurse 4: I felt hard pressed with time as cases kept coming into ward thus compromising other nursing tasks. I also felt intimidated by the domiciliary PIC as she reprimands at any slightest mistakes in the forms.

Discharges on weekends and public holidays and short interval between referral and discharge

Discharges on weekends and public holidays were problematic, leaving insufficient time to train identified caregivers.

Physiotherapist B: Cases discharged at weekends and they realized they missed out referral to physiotherapist. The doctor may refer to the visiting home domiciliary physiotherapist but there will not be any initial assessment on the patient from the HSJ physiotherapist to be passed over to that team nor the patient or caretaker be given initial explanation. There are also instances I was in the midst of giving physiotherapy sessions but the patient is discharged during the weekend. So, I find the timing of weekend discharge forms a barrier.

Inadequate documentation

Meetings concerning domiciliary care were not minuted, and verbal feedback was not documented, leading to a lack of accountability and continuity.

Sister 2: Me and Sister No 1 are the only domiciliary team member along with the PIC domiciliary. We never had any meetings.

Patient and Caregiver Factors

No suitable caregivers

Some participants highlighted the issue of no suitable caregivers with regard to age and health condition. Others are working, stay far away or single status.

Sister 5: The caretaker agreeable to care but he is advanced in age to care for the wife and fear of learning and carry out procedures as Ryle's tube feeding. We call the children to come and learn as caretaker but unfortunately either they are working or stay far away. The single one has no one to be caretaker.

PT B: The choice of caretaker is a barrier. I experienced the patient is 70 years old, the caretaker too around that age with hearing problem and cannot comprehend whatever that was conveyed.

Inconsistent and poor commitment of caretakers

The participants also highlight the challenges regarding caretakers. They faced difficulty in coaching and training the caretakers who frequently change. This inconsistency requires retraining new caretakers from scratch thus hinders patient progress and continuity of care. Additionally, caretakers too did not keep the appointments, further complicating the caregiving process.

PT-A: The problem is varying caretakers, example, we ambulated one patient and coached the caretaker, but when it comes to new care taker, I had to start all over again.

Nurse 4- We pass over to the evening shift that the caregiver informed they will be coming and they don't turn up. There was also changing caretaker; one learnt dressing and the other learnt Ryle s tube feeding. The first caretaker is at home 24 hours but still asks the other to take over whereby the nurses still had to coach that second caretaker.

Unsuitable home conditions

The home conditions of patients presented significant barriers, with poverty and the state of the home environment acting as deterrents to future visits by healthcare professionals. Highrise flats posed logistical challenges for the mobilization of patients.

Nurse 2: There are ones who fulfil the domiciliary but, in the end, they rejected; reason being they felt ashamed of their home condition if visited by the health team.

Nurse J: One of the barriers I encountered is they stay in high rise apartments and there is issue of mobilization of patients whenever the need arises.

Misconception among patients and families regarding nurses' role

There was a widespread misconception among patients and their families regarding the role of nurses in domi cases. The caretakers were opinionated that they relieve nursing ward duties which demoralized the nursing team.

Nurse 1: Some caretakers in my ward just refuse to change pampers citing reason that its nurses' job, not theirs. Suck remarks demoralize us.
Nurse W: There was a 24hours caretaker who expected nurses to change pampers. Despite advice, they sarcastically remarked that caretakers alleviate nurses ward tasks.

Caregivers lacked confidence

Caregivers often lacked confidence in learning which was exacerbated by apprehension towards medical processes.

Nurse S: Caretakers exhibit apprehension on procedures such as suction, Ryle s tube feeding hence they decline domiciliary.

Financial issues

Financial issues were also a barrier, with delayed aid from the HSJ social welfare unit impacting the timely provision of care.

Nurse V: The barrier the family face financial constraints in getting the equipment ready in time hence a referral made to medical social unit of HSJ but there is a delay. If the patient is Oxygen dependent, all the more the waiting time be.

Facilitators of Domiciliary care

Facilitating factors

The perceived or suggested factors that facilitated domiciliary care at HSJ were; Health system factors, Health professional factors, Patient and caregiver factors. Encompassing all 3 were proactiveness, supportive and motivating factors

Health System Factors

Ongoing updates and monitoring

Participants agreed that regular updates on domiciliary care ensure consistency and quality. Nurses from different wards described their experiences with ongoing education such as bed side teaching. In one ward, a file related to clinical work requires reading and signing under supervision. These files serve as a reference guide for healthcare professionals, ensuring they have access to necessary information.

Nurse N: The Matron in charge and ward sister do bedside teaching. We also have CNE for nurses. In all the attendance were taken.

Nurse Q: We have a reference file in ward which contains domiciliary forms, flow of domi referral, Modified rankin scale (MRs), list of health clinics etc. When in doubt I just refer the file.

Standardized Approach

The participants shared that the uniformity of the implemented standardized approach had facilitated the delivery of domiciliary care. These involve filling out relevant forms, screening and informing caretakers, and referring to allied health professionals.

Nurse L: When a domi case is identified, the doctor studies on patients' needs and accordingly refers. We nurses fill up the relevant columns and do final check and inform the PIC who screens through before we fax to the health center.

Nurse 5: We have a standard referral to allied health at HSJ. Referral to our assigned physiotherapist in ward are written in a special book for them to check and attend accordingly. As for the OT, they come over upon receive the referral in their unit

Cluster Hospital Concept

Decanting patients to different hospitals within a network to ease congestion in wards with efficient use of resources can be a very effective measure to ensure uninterrupted domiciliary care.

Nurse 4: It takes a long process to get the welfare settled or get the equipment ready at home, hence we transfer the patient to other cluster hospitals to ease ward congestions.

Dedicated Person in Charge:

Participants agreed that the dedication of PIC at HSJ who served as a reference point ensured continuity of care.
Subject S1: In (name of the discipline hidden) ward if there are problems related to domiciliary, we will inform the PIC Matron.

Nurse 2: The PIC (name withheld) comes and explains on domiciliary to the patient and caretaker although prior explanations were given by any of the doctors or nurses.

Social welfare and non-governmental organizations (NGOs) support

The nurses' highlighted the reliance on various NGOs for patients and appreciated the support from the HSJ medical social worker.

Nurse 3: I noticed outsourcing from Zakat as one of the financial measures.
Nurse 4: We get financial support for the patients from NGO s such as Charity One Hope, Buddhist Zhi Chi and also Zakat for the Muslims whereby we ask the relatives to get the forms from the centers.
Nurse 5: We get good support from our HSJ medical social worker.

Availability of informational brochures and equipment guide in wards to assist patients and caregivers

The nurses collectively highlighted a well-organized approach to providing domiciliary care information and support within the hospital wards. Brochures and pamphlets are readily available in various locations, ensuring that patients and their families have access to essential information.

Nurse 7: The domiciliary pamphlets kept in the domi file were given to patients and visitors. The ward sister also keeps an equipment purchasing guide which are shared with the patients or medical social workers when needed.

Positive impact and feedback
The observations and feedback from the nursing staff highlight several key points that motivated them. This includes impromptu ward visits by the hospital director which significantly boost morale among staff and patients enhancing the overall hospital environment.

Subject J: One motivating factor for me and my colleagues, is the visit by the HSJ hospital director. It gives added value to especially the bedridden patients.

Reduced Readmissions in Domiciliary Cases: There is a clear trend of lower readmission rates among domiciliary patients compared to non-domiciliary ones. This is attributed to better disease understanding, effective coaching, and strong family support. The involvement of health teams in home visits also plays a crucial role in monitoring complications and ensuring proper care.

Nurse L: I had seen readmission mostly involving those not under domi as I know they are monitored during home visits too.

Encouraging Feedback*:* Positive feedback from health centers, patients' family and other sources serves as a significant motivator for the nursing staff. It reinforces the effectiveness of their care strategies and highlights the success of domiciliary care in maintaining patient health and preventing readmissions.

Nurse S: I heard from my colleague who does part time job as home visits which gave us much encouragement. In her experience, nutrition, hygiene and bed sores are compromised among those not in domiciliary services.

Health Professional Factors

Team approach and preplanned discharge

Collaboration among healthcare professionals are crucial. Joint participation and open communication ensure that all team members are on the same page, leading to better patient outcomes.

Nurse 8: Throughout my experience, (name of the discipline hidden), the factors that facilitated were teamwork . A part from that the understanding of disease as

explained by staff nurse, ward sister and doctors they understand what is expected out of them, eventually lead to success of this domiciliary services.

PT-A: In my experience, there are multiple team approach in domi cases for the best patient outcome.

Consistent and clear communication among team members, especially during shift changes, prevents confusion and ensures that patients and their families receive accurate information. This consistency helps in maintaining the quality of care.

Nurse 5: One of the reasons that facilitated domi was that we nurses are consistent in our explanations and we pass over to next shift, hence no confusion ever occurred.

Preparing for patient discharge in advance and avoiding discharges on weekends helps streamline the transition from hospital to home care. This careful planning ensures that patients receive the necessary support and resources for a smooth recovery at home.

Nurse 3: We ensure we prepare everything once the doctor plans discharge and we avoid discharges at weekend.

Proactive roles of nurses

The participants emphasized the proactive roles of nurses in guiding doctors, coaching caretakers, and ensuring proper discharge procedures. In addition, they also play an important proactive role in screening domiciliary cases, providing feedback, following through referrals and updates in their nursing chat groups.

Nurse R: In my ward, I noted doctors have inadequate knowledge on domiciliary and they can accept suggestions and opinions from nurses although at times I noted they counter check with the PIC.

Nurse L: Before a domi patient gets discharged, I ensure the caretaker is competent. We update information in nursing chat group.

3. Patient and Caregiver Factors

Dedicated Caregivers

The participants emphasize the importance of having a single, dedicated, well-trained caregiver with strong family support. Caregivers' proactive measures such as learning necessary skills and preparing essentials at home and understanding of patient's needs significantly improve the patient's QOL. It facilitated a smoother transition from hospital to home.

Nurse U: The active participation of the identified caretaker in learning and willingness to be there at appointed times, facilitated the domi.

Nurse 7: Family cooperation was significant and contributed to care continuity at home.

Importance of support from family and healthcare staffs

The nurses emphasize the significant crucial role of family in learning care practices and providing emotional support. They also highlight their own role in offering emotional support to both patients and their families, which, along with family empathy, facilitates the overall care process.

Nurse 8: From my experience, the family involvement and emotional support is fundamental. empathy from us; doctors, nurses and caregivers has facilitated the whole process.

Close proximity of Health Facility

Participants emphasize the importance of considering the feasibility of the health facility's location to ensure it is accessible and convenient for patients and caregivers.

Nurse 1: The Domi health facility being close and accessible to the family is an added benefit for them.

DISCUSSION

This study has identified several critical issues and facilitators in the delivery of domiciliary care across three distinct domains: Health System Factors, Health Professional Factors, and Patient and Caregiver Factors.

Health System Factors: The challenges within the health system include manpower shortages, ineffective domiciliary teams, lack of information dissemination, and unclear policies. These issues lead to resource inefficiency, which hampers the quality of healthcare delivery. However, facilitators such as ongoing updates and monitoring, a standardized approach, and the Cluster Hospital concept may show positive impacts. Although there seemed to be a methodical and concise approach in handling domiciliary cases, the sole handling of domiciliary referrals from wards and proactiveness were hampered by the non-availability of PIC 24/7, disparity and a lack of seemingly lesser team efforts. The referral to the allied health services seems to have some inconsistency across the wards. To avoid missed or delay need to ensure core steps remain consistent. Financial constraints, delayed aid from the welfare had resulted in prolong hospital stay. In a study [1], financial constraints were one of the perceived barriers and linked to the system disparities. A reformed domiciliary team with active involvement of the middle managers in respective wards; in supervision and monitoring is essential. They need to play a pivotal role in issues faced, address ad hoc, summarize categorically and escalate at appropriate discussion platforms. Pre-planned discharges and cluster hospital concept of HSJ in decant should be optimized to overcome overcrowding in wards.

Health Professional Factors: Health professionals face biases in case selection, intimidation by superiors, incomplete tasks, and poor documentation practices, all of which negatively impact care continuity. Exerting influence, misconstrued opinions and personal preference by superiors in managing domiciliary cases can further compromise on the care of domiciliary patients. It also rendered indecisiveness on the part of nursing staffs in wards and carried risk of potential domiciliary cases being missed out. The governing superior need to be reminded to be tactful in reprimand the subordinates. On the positive side, a team approach with synchronized explanations, preplanned discharge processes, along with proactive roles of nurses in guiding doctors and coaching caretakers are crucial towards seamless care. The inadequate knowledge on domiciliary care had also caused conflict of opinions in selection of cases and most importantly in conveyance to the patient and family. All categories of health care workers need regular documented revisions to curtail this. Having check lists on tasks to be completed and passed over will ensure smoother transition of work force. Additionally, the nurses emphasized the importance of preparing patients and their families for discharge by guiding them on the purchase or rental of necessary equipment as well as training on using medical devices. This comprehensive approach ensures patients receive the necessary support and resources for a smooth transition to home care.

Patient and Caregiver Factors: Patients and caregivers encounter obstacles such as unsuitable caregivers due to age or health conditions, inconsistent caregiver commitment, unsuitable home conditions, misconceptions about nursing roles, and financial delays. These challenges hinder effective domiciliary care. Having services delivered in the homes had also reduced the burden of the caregiver as well as shown significant change in their mental well-being too [4]. Facilitators in this domain include having single, dedicated caregivers, strong family support, and logistic accessibility. As for the demoralizing remarks from caretakers that nurses' task is lessened, nurses must instead use their clinical skills to identify the shortcomings and burdens in the caretakers and guide them in coping strategies. In a study [9] where the relationship on caregiver burden and perceived health were studied, it was inversely proportional; higher burden, lesser perceived health. Abaasa et all [10] in his study had explored the psychosocial importance of the caregiver and the support they received in comparison with those who didn't. Thus, it draws the importance of the support. It became a daunting task for nurses and allied heath staffs in training and supervision of caregivers often with changing caregivers and failure to upkeep the appointed time. R. Turner Goins et all in his paper on Perceived Barriers to Health Care Access Among Rural elderly[1] had also exemplify how qualitative research in its exploratory nature can improvise the health delivery system in essence. Locale convenience was one of the factors that facilitated domiciliary care at HSJ but this same author highlighted locale inconvenience as one of the 5 barriers faced. Schoenberg NE et all [7] had highlighted the rigidness of the regime faced as among the barriers in a community-based services. Our study did not include the direct opinion of the caretakers but the interviewees had expressed how the patients who are single and working potential caretakers were opinionated that domiciliary services do not conform to their lifestyle thus embody how rigid the system was.

The motivating factors shared by the interviewees also indicated that domiciliary care at home contributed to better outcome of patients just as in other studies.[4,8] The health status of the caregiver was among the concerns. The author [9] had delineated the association of caregiver perceived health and how the nursing team are able to identify and allay their concerns. Addressing both the challenges and facilitators is crucial in enhancing domiciliary services. By focusing on these key factors, healthcare systems can provide more supportive and comprehensive care for patients in home settings. The findings suggest that a multifaceted approach, involving continuous updates, standardized procedures, and strong support systems, is essential for improving domiciliary delivery.

STRENGHS

Cluster hospital concept enabled a patient to be decant to any other 3 district hospitals to curtail bed occupancy. The general positive perception of healthcare workers towards domiciliary care, bearing the existing proactive, motivating and supportive factors helped helm domiciliary care in continuum at HSJ. During the study period we were aware of the changes for the betterment of domiciliary that were adopted in the wards based on the serial interviews.

LIMITATIONS

The interview prepared the subsequent nursing group with a standardized befitting answers by their superior. The interviewees had also expounded on their lamentations off records thus there is a need to address their concerns. Our study explored only the perception of allied health workers at HSJ. For an overall perspective, it be ideal to explore the views of patient and caregivers at their home setting and views of all categories of doctors too.

1. **CONCLUSION**

   For a successful domiciliary care, the 3 domains; health system factor, health professional factors, patient and caregiver factors need to be addressed. Its implementation will involve all healthcare workers to work for a common goal for an optimal, more feasible, conceivable and effective delivery of domiciliary services at HSJ. This will certainly soar and catapult towards an excellent domiciliary service

CONSENT (WHERE EVER APPLICABLE)

During screening of participants verbal consent was obtained. At the time of interview, participants signed the participant information sheet which included consent of participation in the research.

ETHICAL APPROVAL (WHERE EVER APPLICABLE)

The ethical approval for this study was obtained from the Medical Research Ethics Committee (MREC), registered with the National Medical Research Register (NMRR :15-983-26380).

Disclaimer (Artificial intelligence)

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.) and text-to-image generators have been used during the writing or editing of this manuscript.

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DEFINITIONS, ACRONYMS, ABBREVIATIONS

CNE- Continuous training education for nurses
CME- Continuous training education
PIC-Person in charge
Domi -Domiciliary services
HSJ-Hospital Seberang Jaya
HBM-Hospital Bukit Mertajam