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JCEcc

Jockey Club End-of-Life Community Care Project

HKEC Symposium on Community Engagement XII
港島東醫院聯網醫社合作研討會 (十二)

Seminar 2: Palliative and Dementia Care in Elderly - Integration and Innovation

講座二：認知無障礙 紓緩在家中

捐助機構 Funded by:

香港賽馬會慈善信託基金
The Hong Kong Jockey Club Charities Trust
同心同步同進 RIDING HIGH TOGETHER

合作夥伴 Project Partner:

聽病人說話

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怎可以回家？

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家中沒有設備儀器

工人姐姐什麼都不懂

他可以食什麼

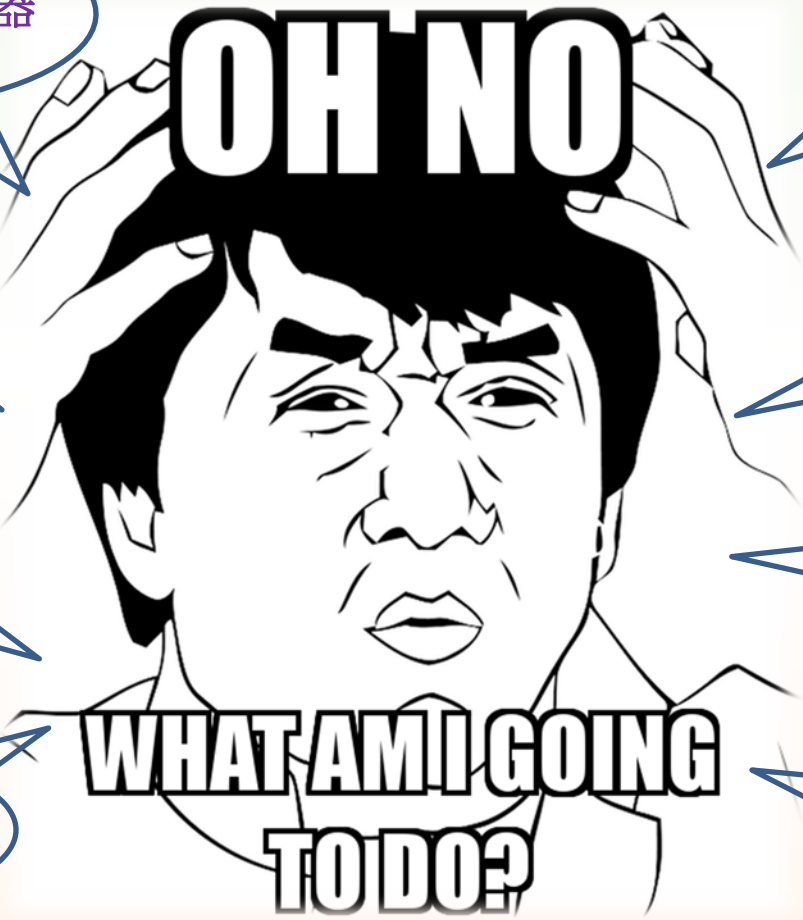
發生狀況誰可以幫忙

怎樣帶去覆診

住在醫院安全些，有事都有醫生睇住

有事情要問誰

？？？



對末期病人來說，重要的是……

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- **減少住院或院舍**：大部份病者期望可以留在熟悉的環境渡過在晚期的日子
- **居家照顧**：只要增加一點點社區照顧及護理，超過五成的病人可留在家中
- **照顧的不平等**：在醫院的晚期病者大都是較貧窮、老人、女性等
- **有計劃的照顧**：透過有計劃的資源運用、照顧者的支持、症狀控制、經驗分享

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JCECC Hospice at Home Project

安寧頌 -- 安居晚晴照顧計劃

Haven of Hope Sister Annie

Skau Holistic Care Centre

靈實司務道寧養院

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合作夥伴 **Project Partner:**

Key Components

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- **Service Model:** Using case management model to assist family in providing EOL care to patients with advanced disease in the community.
- **Key Features/Components of Services:**
  - Case management model -- Nurse as the case manager throughout the journey
  - Coordination – to facilitate to access the wide range of supports, including medical, psycho-social, rehabilitation, respite care and bereavement.

Key Components

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(continue)

- **Key Features/Components of Services:**
  - Communication -- regular reviews with family and referring partners
  - Medical back up by specialist in palliative medicine
  - All nurses and social workers are equipped with skills to discuss Advance Care Plan (ACP). Routine engagement of clients and their family for ACP depending on the readiness of clients.

Team Members

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Doctor

Nurse

Health Worker

Social Worker

Volun-teer

“Hospice at Home” in Action

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- Case Manager: Nurse
- Social Worker (SW)
- +/- Health Worker (HW)
- +/- Volunteer

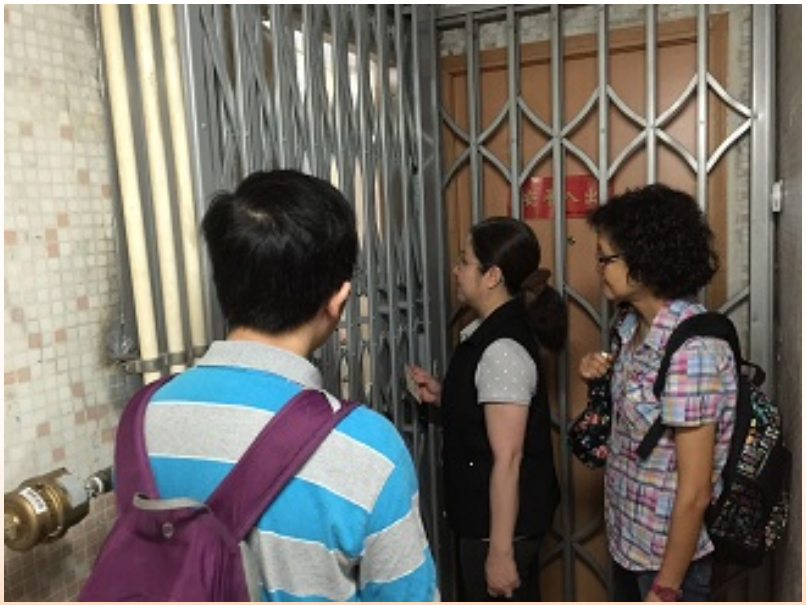
Physical

Psychological

Social

Spiritual

- Define needs of client/ family
- Coordinate services (e.g. doctor visit, personal care, rehab training, counselling, escort/transport service)
- Schedule visit frequency



Range of Supports

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Service Output

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Service Type	Output Jan 2016 to Apr 2017	
Client served (headcount)	64	
Family served (headcount)	136	
Doctor visit	163	
Nurse & Health worker visit	**1257 ***	~20 per patient
Social Worker visit	**252 ***	
Volunteer visit (started in July)	104	
Telemedicine by doctor	57	
Counseling session	**661 ***	~10 per patient/ family

Advance Care Planning

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Majority Died Naturally with DNACPR

Among 64 patients, 57 (89%) with ACP completed

DNACPR
39 (61%)
Verbal AD : 25, Written AD: 14
(29 died)

Indecisive / Active Intervention
18 (39%)
(11 died)

Died with CPR (1)

Un-known (1)

Died with DNACPR (27)

Died with DNACPR (10)

Died with CPR (1)

Overall DNACPR
37/40 (93% of death)

Period: Jan 2016 – Apr 2017

Health Care Utilization (Last 6 mths)

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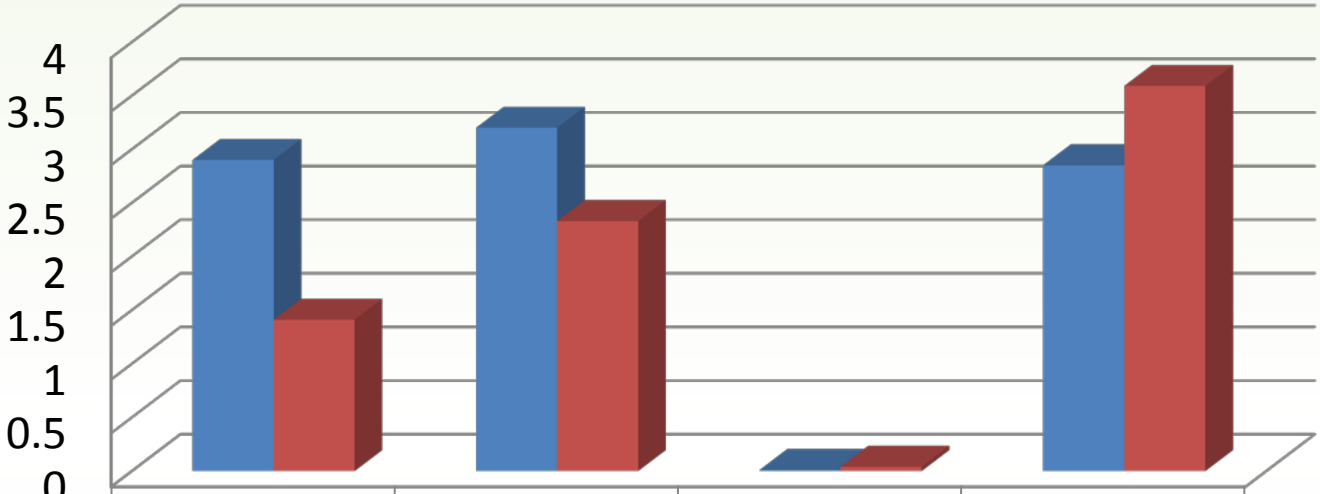

	AED attendance	Hospital admission	ICU admission	LOS (days)
2010*	2.9	3.2	0.01	28.5
JCECC (overall)	1.41	2.33	0.04	35.9

- The statistics from HKU showed that patients under JCECC program had less AED attendances and hospital admissions c.f. local data in 2010.

* Lau KS, Tse DMW, Chen WT. JPSM 2010;40(5):704-714

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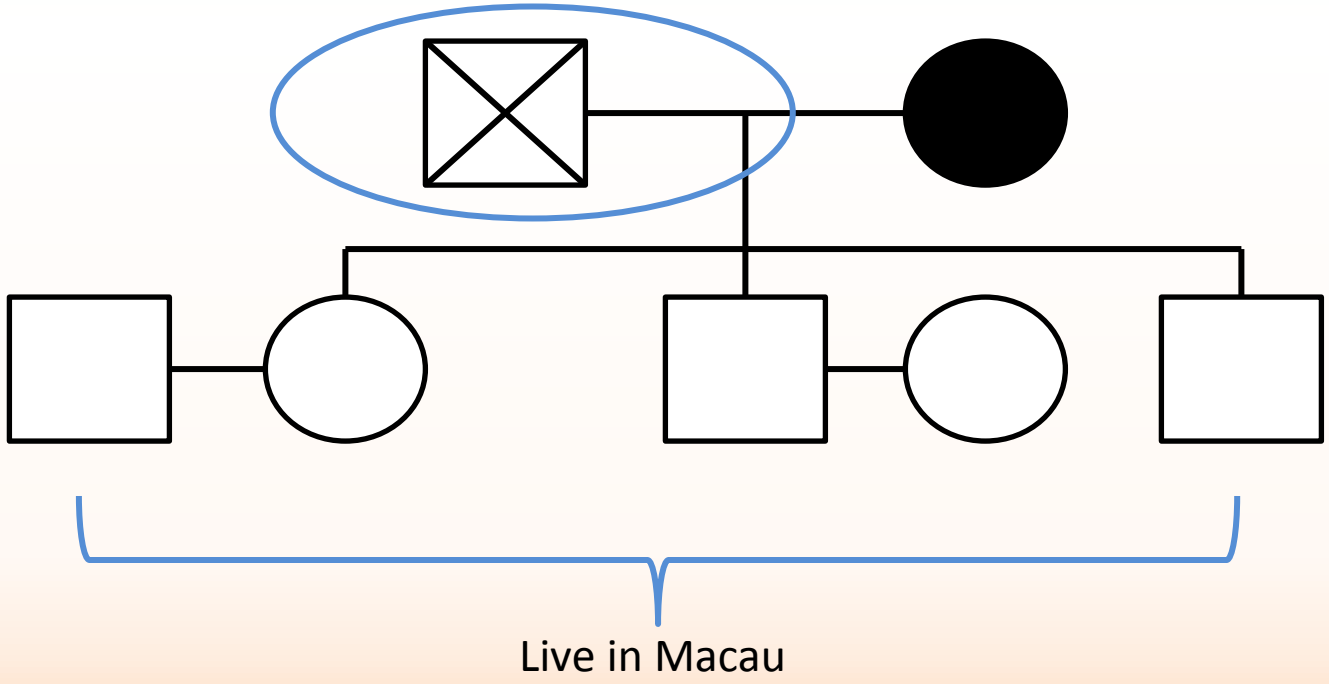
Case Sharing

Mr. Wong

- 81 years old. Referred from PYNEH Onc.
- Live alone since his wife moved to OAH 3 years ago. 3 children lives in Macau with poor relationship.



Mr. Wong

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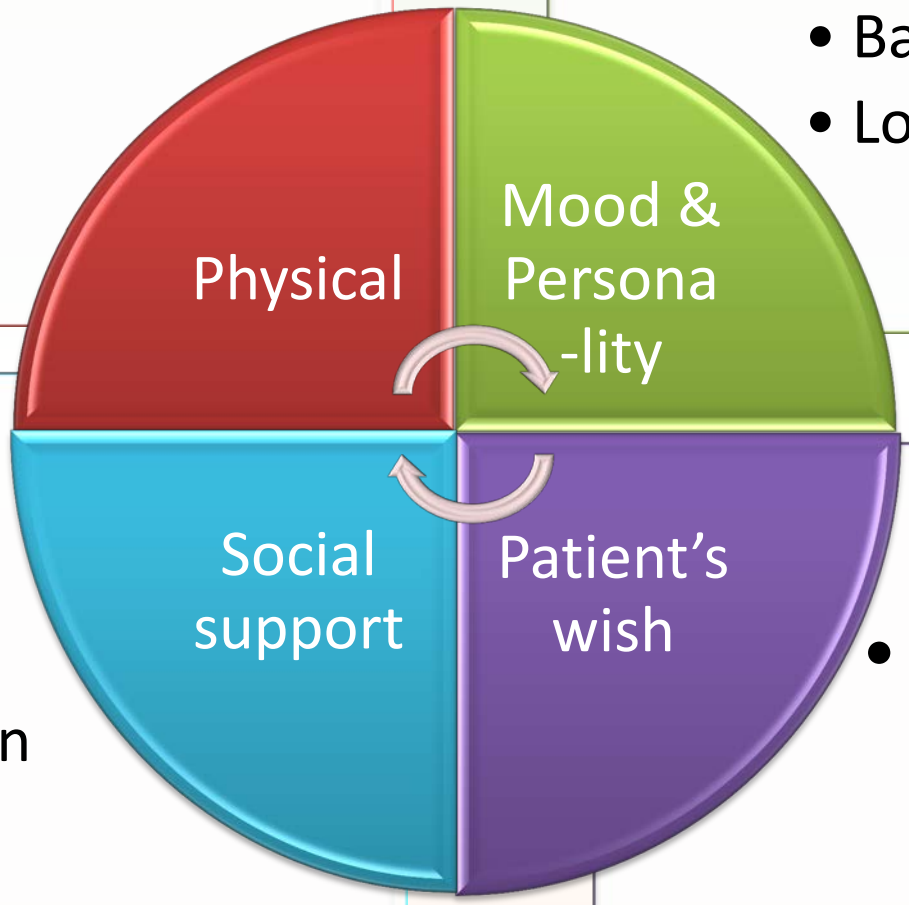
- Double primary: Ca bladder and CA prostate (2014)
- Bone metastases to pelvis (1/2016)
- Wife died of pneumonia (3/2016)
- Refer JCECC Hospice at Home Program (4/2016)

Mr. Wong

- Hip pain affecting mobility
- Walk with frame

- Introverted
- Bad temper
- Low mood



- Poor relationship with children
- Supportive neighbour

- Want to stay at home for as long as possible

Fall at Home

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- Resulting in fractured hip
- Refused moving to OAH

Case Manager / Health Worker

1. Identify needs of client & caregiver
2. Advice on e.g. medication use, fall prevention
3. Support caregiver (his neighbour)
4. Advance Care Planning: disease understanding, goal of care.

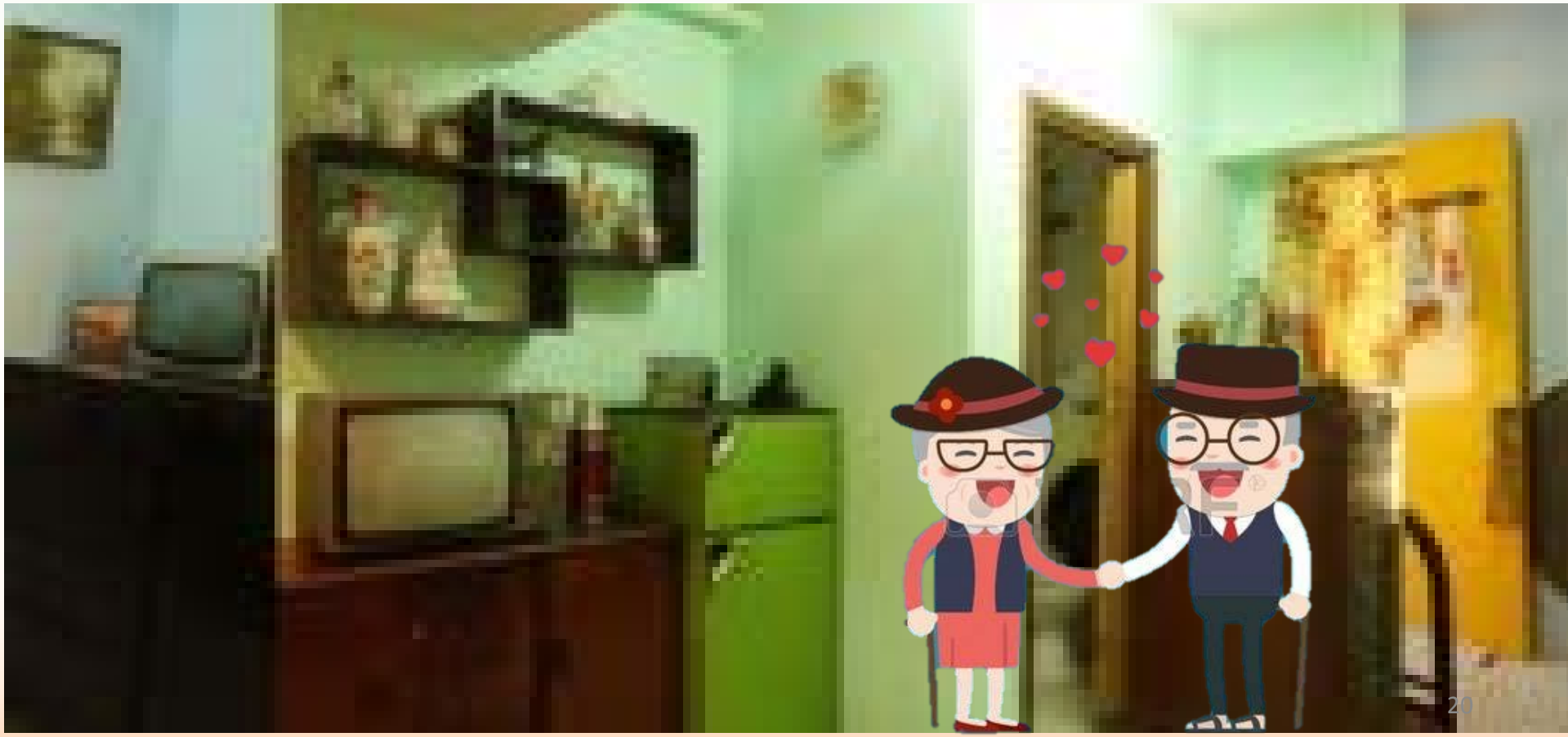
Social Worker

1. Explore community resources to support patient (e.g. volunteer to support patient going to bank and shopping)
2. Explore patient's values & preferences
3. Emotional support to patient and caregiver.
4. Link up with patient's family

Case Conference

1. Multidisciplinary team approach (Doctor, social worker, chaplain)
2. Revise care plan and service as client's condition deteriorates.

“呢一度係我同太太最多回憶的地方，所以唔捨得間屋!”



“民以食為天” -- 新鮮蒸魚

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Respect Mr. Wong's Autonomy

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- Our team and his neighbour worked together to support him to stay at home.
- Reconnected with patient's children to discuss patient's condition and funeral arrangement. He wanted to bring his ashes to Mainland China.
- Our goal is to fulfill Mr. Wong's wish to stay at home until the very last moment.

Respecting His Wish

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- 講真, 我覺得**伯伯嘅尊嚴真係好好囉**，點解咁講，因為我哋從來，我又好啦，寧養姑娘嗰邊好啦，都係**跟隨住伯伯嘅意願嘅**，一路到佢好後期都好啦，佢堅持到最後嗰一刻留係屋企到最後我哋都係夾定嘅。嗰邊幫佢夾定。其實佢已經係好有尊嚴地走！
- **始終佢都係將要離開嘅人，所以我哋都好尊重佢**。

Dignified Death

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- Mr. Wong agreed hospital admission for pneumonia.
- He passed away 2 weeks after admission.


THANK
YOU