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JCEcc

Jockey Club End-of-Life Community Care Project

From Hospital to community -

Bridging the Gap to Enhance Life Rainbow for Terminal Dialysis Patients & Their Family Members

「醫社互補 – 為晚期病人帶來美麗的告別」

The Hong Kong Society for Rehabilitation

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:**

Background

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- Support by the Hong Kong Jockey Club Charities Trust Fund
- Aimed to
  - Improve the quality of end-of-life care patients and families
  - Enhance the capacity of service providers
  - Raise public awareness of this issue

Target Groups of HKSR

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- *Patients with **Late-Stage Non-Cancer Diseases**, including:*
  - *End-Stage Renal Failure*
  - *Chronic Obstructive Pulmonary Disease (COPD)*
  - *Heart Failure*
  - *Neurological Diseases (such as Parkinson's Disease, Motor Neuron Disease)*

Progress

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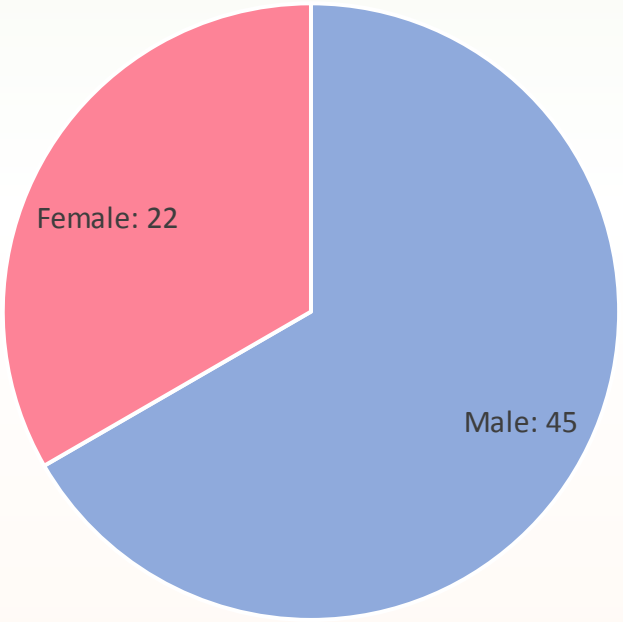
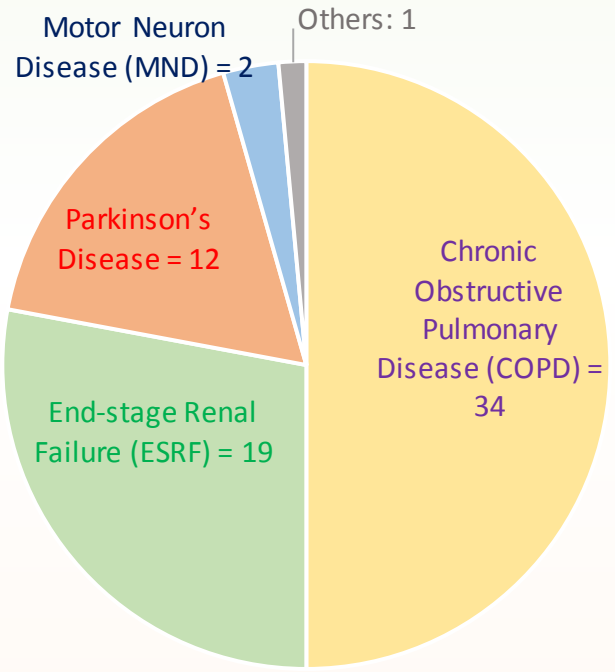
No. of beneficiaries:

No. of patients served: 67



No. of caregivers served: 99

Types of chronic diseases



Most patients were referred from PYNEH, Department of Medicine. Few were referred from other NGOs or self referral.

(as at 31/3/2017)

生活就是等？

Life Count Down

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Characteristics of Target Groups

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- *Patients referred from **Department of Medicine**, rarely receive hospital's Palliative Care Service*
- *What kind of medical & healthcare services they receive?*
  - ***Follow-up in SOPD***
  - ***Admit to A&E for emergency need***

- ***Less than 10%** are users of Enhanced Home & Community Care Services **(EHCCS)***
- ***Age: 40%** of patients are ≤69*

Features of Service Model

Four Intervention Focus

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Symptom Management Education & Optimize Health Functioning

Psychosocial Spiritual Support

Positive Death Preparation

Connecting to Community Resources

Symptom Management Education & Optimize Health Functioning

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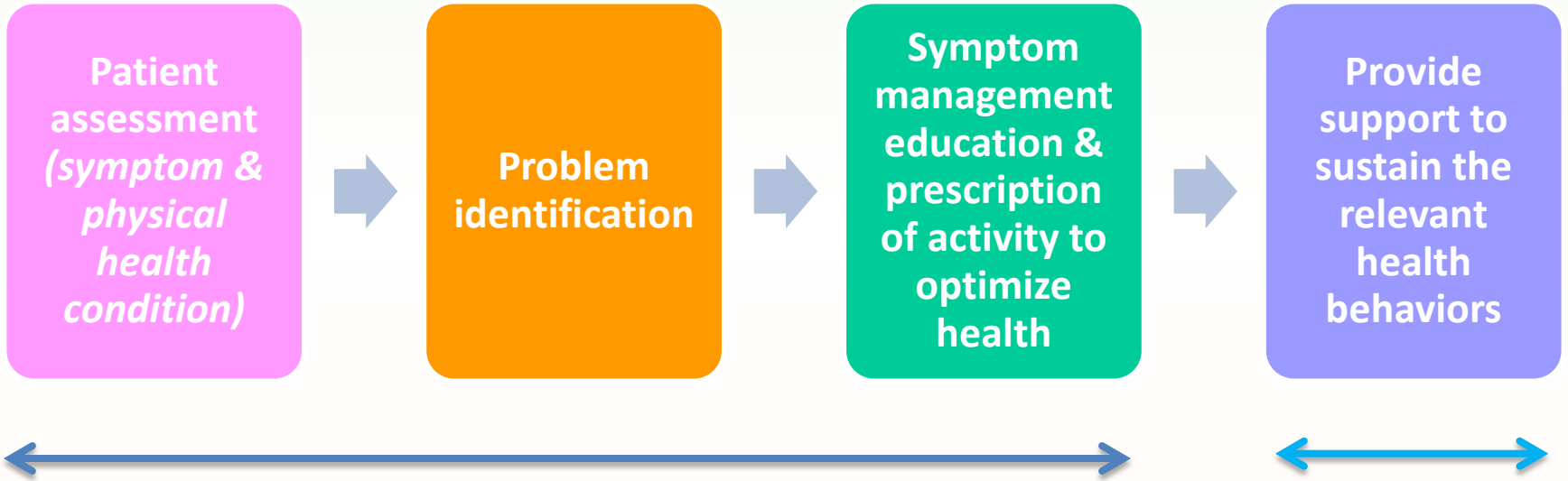
- ***Why?***

  Patients & Caregivers:
  - *Lack of relevant knowledge and skills*
  - *Lack of self-efficacy*
  - *Unexpected difficulties encountered in home environment*
  - *Related home-based support is insufficient*

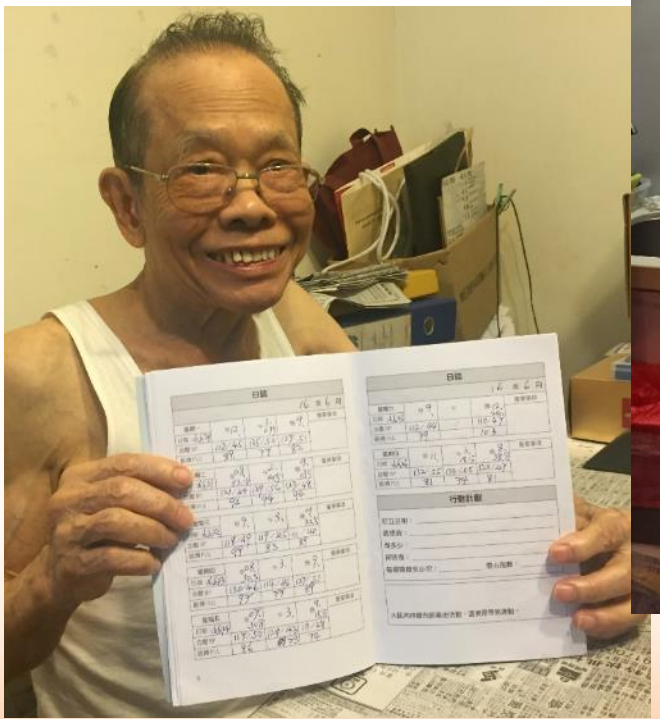
- ***How & Who will Provide?***

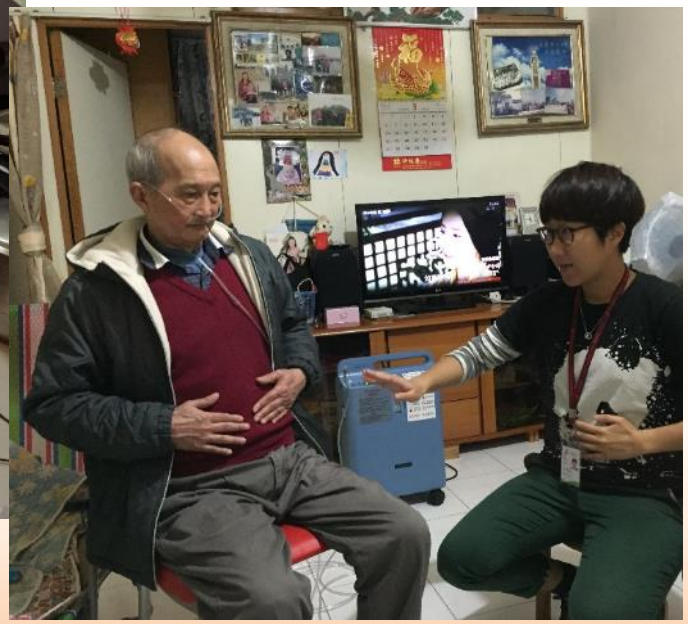


(by Project Nurse or Professional Volunteer, assisted by Project Social Worker)

(by Community Volunteer, & Project Social Worker)

Symptom Management Education & Optimize Health Functioning





Psychosocial Spiritual Support

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- Celebrate life and reconstruct meaning
- Relationship reconciliation
- Prescribe joyful activity
- Prescribe activity to optimize social participation

Psychosocial Spiritual Support

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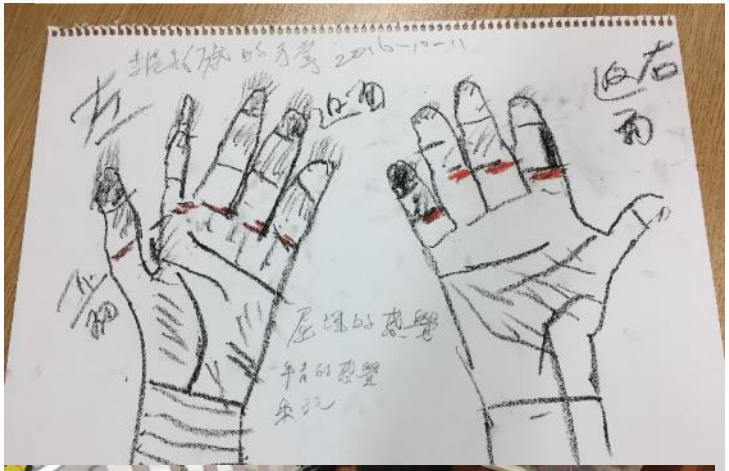

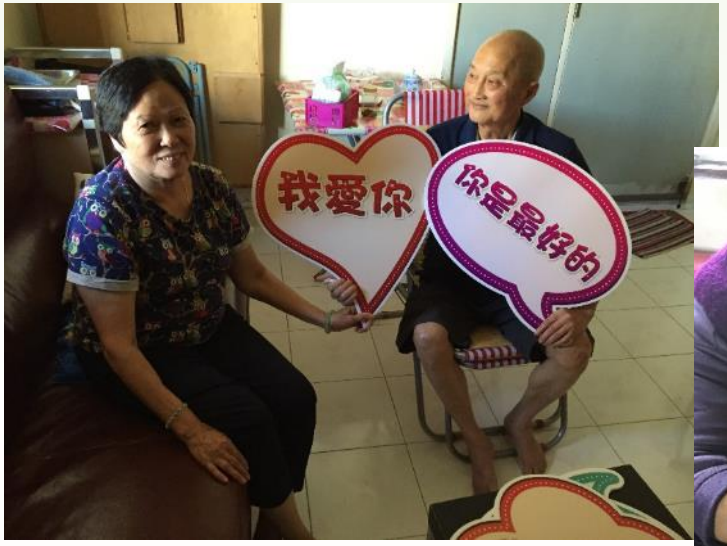

Positive Death Preparation

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- Provide anticipatory guidance in coping with patient's progressive deterioration
- Communicate on care preference & wish
- Address unfinished business
- Leave a legacy

Positive Death Preparation

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Connecting to Community Resources

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Service Pathway

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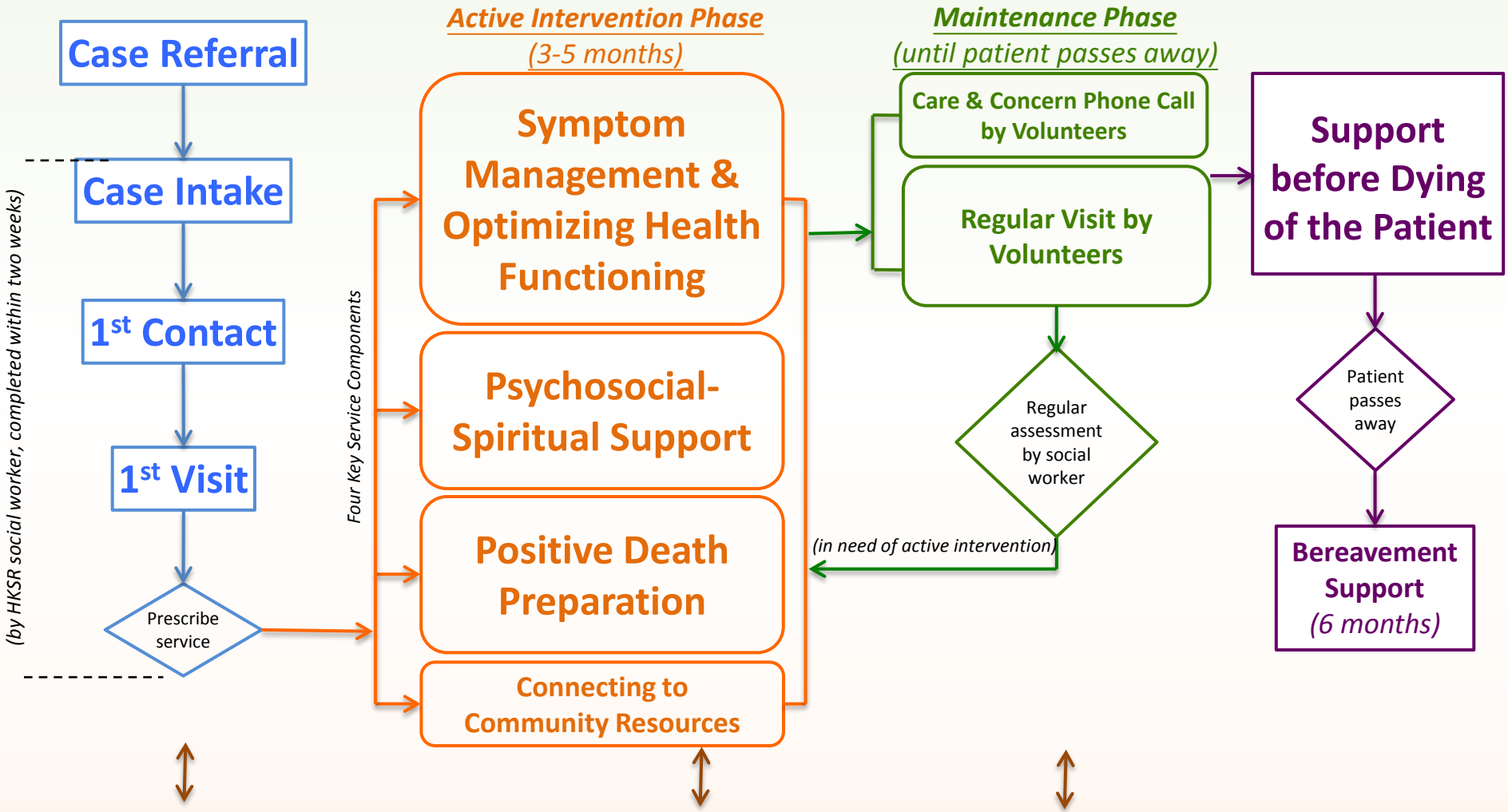

Collaboration between HKSR & Hospital (Pamela Youde Nethersole Eastern Hospital, PYNEH)
Case discussion, Seek advice, Refer back to better utilize existing service provided by hospital

Close Collaboration with Partners

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Medical & Healthcare Sector:

- Pamela Youde Nethersole Eastern Hospital (HA-HKEC)
- Formation of Clinical Advisory Team:
  - *"Early" identification of related patients*
  - *Case discussion & giving advice on intervention*
  - *Better utilize existing hospital services*
  - *Developing Hospital-Community "Complementary Model"*

誰適合被轉介？

Referral Criteria

- Late / End stage of disease
  - late stage COPD with long term-home O2 therapy
  - ESRF on dialysis with poor prognosis
- Presents of complications/ comorbid diseases
- Affected quality of life
- Advance dementia

致　：香港復康會「安晴・生命彩虹」社區安寧照顧計劃　　主辦機構：　　策略伙伴：
傳真: 2549 5727　　電話：2549 7744



「安晴・生命彩虹」社區安寧照顧計劃

東區尤德夫人那打素醫院　醫護人員轉介表

請於適當方格內加上✓號

由：☐呼吸科　☐腎科　☐腦科　☐物理治療部　☐職業治療部
☐社康護理部　☐醫務社會服務部　☐病人資源中心　☐其他：_____

患者資料	姓名：_____　性別：☐男 ☐女　年齡：_____ 聯絡電話：(手提) _____　(住宅) _____ • 患者轉介時必須為在家居住（居於安老院舍者不符合） • 患者居住地點必須為港島東聯網（包括灣仔區及東區） 診　斷：☐ 慢性阻塞性肺病（正使用家用氧氣機） ☐ 末期腎衰竭　（☐腹膜透析 ☐血液透析） ☐ 柏金遜症　（中後期） ☐ 運動神經元病　（中後期） ☐ 其他 (請註明)：_____ ☐ 已轉介其他服務跟進情況 (請註明)：_____
照顧者資料	姓名：_____　性別：☐男 ☐女　與患者關係：_____ 年齡：_____聯絡電話：(手提) _____　(住宅) _____

補充資料：_____

_____

建議提供之服務：

☐情緒輔導　☐照顧壓力處理　☐身體症狀舒緩　☐照顧技巧訓練　☐家庭溝通改善
☐義工關懷　☐社區資源轉介　☐心願實現行動　☐其他（請註明：_____）

轉介者資料：

Case sharing

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- Mr. Lam, M/72
- PMH:
  - Type II DM, AF, severe OSA, ESRD on dialysis for > 10 yrs. (CAPD for 7 yrs. but complicated with PD peritonitis, changed to hemodialysis since 2014
- Social background: divorced, lives with daughter & domestic helper
- Admission in July 2016 for management of fluid overload due to poor diet compliance
  - Developed chest infection, type II respiratory failure requiring BIPAP, fast AF, line sepsis, AVF thrombosis, Ryle's tube feeding

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- Poor prognosis with meeting the referral criteria:
  - Question 'Would I be surprised if this patient died in the next year? Answer → No
  - Functional impairment: Karnofsky Performance Status score < 40
- Prepared patient and daughter for end of life care
- Relieving daughter's anxiety for taking patient care

Benefit to clinical team

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- Established rapport between patient's daughter & medical team → more understanding in patient care management
  → less complaints to hospital staff
- Showed appreciation to ward staff
- Nice ward atmosphere in patient care → enhance patient quality of care

Benefit to patient & family

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Strengthen communication with daughter

More control of life

Optimize social connection

Enjoy life

假如去到疾病「晚期」你的選擇是：

1.避免痛苦？

2.「盡量救」？