Empowering Residential Homes for the Elderly (RCHEs) as a Key Strategy for Delivering Quality End-of-Life Care in Hong Kong

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End-of-Life Care Policy Issue Brief 2

ABSTRACT

The Issue

- High institutionalized rate of elders in Hong Kong (6.8%) compared to other Asian countries
- Residential Care Homes for the Elderly (RCHEs) that implement a holistic care model can offer a feasible option for non-hospital based, person-centred End-of-Life (EoL) care

The Concerns

- 97.4% of the participating homes indicated that routinized communal care needed to be modified to allow for flexible personalized EoL care to meet individual needs of dying elders
- Inadequate manpower was a serious concern. 58% of the participating RCHEs did not offer EoL care training for staff members while 78.4% said that they were understaffed in meeting service demands of EoL care
- Insufficient service infrastructure was reflected: 12% of the participating homes did not provide a separate room for EoL care; 56% did not have EoL care service protocol and guidelines; 66% of the homes did not implement advance care planning for residents and 97% indicated that communication and coordination between care homes and hospitals was a major challenge

The Solutions

- Set clear policy mandate and culture for compassionate personalized care for caring-in-place until death in RCHEs
- Increase the manpower ratio of health care workers, nurses and social workers to ensure adequate care-intensity that is required at the EoL stage and provide mandatory training for all staff
- Develop sector-wide benchmarking EoL care service protocols and procedures for comprehensive assessment, care planning and family engagement
- Set up a well-equipped separate room for EoL care in each RCHE
- Enhance medical support and coordination mechanisms in care interface with medical care
Introduction

Hong Kong has the highest institutional rate of the elderly (6.8%) among other Asian countries. Functional limitation and cognitive impairment are major factors predisposing to institutionalization. Whether elderly care homes have the capacity to provide adequate care for elders during the final stages of their lives has become a growing concern.

Holistic End-of-Life Care in RCHEs

Pursuing optimal human dignity is recognized as the bedrock of all human services and is the fundamental value of EoL care in both local and overseas practices. Enhancing the dying experience of the elderly can alleviate unnecessary suffering such as loneliness, lack of privacy and a dwindling sense of autonomy, which are common among physically deteriorating elders who are receiving care in institutional settings.

EoL care should go beyond symptom and pain control to include psychosocial health and existential fulfillment (see fig.1). Care practitioners have to be familiar with residents’ past history as well as their significant relationships when trying to resume residents’ social connectedness and promote their self-expression.

Promoting ‘good deaths’ in RCHEs

1. Challenges as perceived by RCHEs

In the survey study conducted by Hong Kong Council for Social Service, we have found that the challenges facing RCHEs actually reside in (a) organizational culture, (b) human resource and (c) service infrastructure.

1.1 Communal living coupled with regular care routines is the dominant organizational culture in RCHEs. Yet, 97.4% of the participating homes reveal a strong need for flexibility to carry out personalized EoL care to meet individual needs and changing physical conditions when death is imminent.

1.2 Human resource is inadequate for delivering quality EoL care. 58% of the participating RCHEs do not offer EoL care training for staff members while 78.4% indicate that they experience staff shortages at all levels in trying to meet service demands of EoL care.

1.3 Insufficient infrastructure in terms of (i) physical infrastructure: 12% of the participating homes do not provide a separate room for EoL care; (ii) service infrastructure: 56% do not have EoL care service protocol and guideline, 66% of the homes do not implement advance care planning for residents; and (iii) system interface: 97% indicate that communication and co-ordination between care homes and the hospitals is a major challenge.

2 Realizing Good Death by Adjusting Policy Mandate and Practice Culture, Resourcing the RCHEs with Manpower and Appropriate Service Infrastructure

2.1 Mandate and Culture

(i) We need an explicit policy mandate to encourage caring/dying-in-place in RCHEs and to remove legal and administrative barriers.
Incorporate the care for dying and death as a key service component in the policy directive of continuum of care for the elders in RCHEs, so to align common vision and culture for quality end-of-life care.

Related public services in support of caring and dying-in-place (including increased medical support, ambulance transfers, death reporting and certification, transportation of body and use of mortuary services) have to be aligned with defined interfacing roles and responsibilities to ensure the advanced directives and wishes of the dying are respected.

(ii) Allow for flexibility in care routines to meet individual needs of dying elders and their families. Strive to cultivate a “collective compassion” culture, which includes devotion in care, empathetic understanding of the sufferings of elders and families and compassionate actions.

2.2 Manpower

(iii) Increase staffing level, both day and night shifts, is a necessary condition to provide round-the-clock quality EoL care. Appropriate manpower ratio of personal care workers, nurses and social workers can take reference from a local study for ensuring adequate care-intensity that is required at the EoL stage.

An EoL care financial supplement be given to RCHEs to hire additional staff is proposed by the sector. The calculation of the supplement could be based on the death rate of residents in the past years and taking reference of the manpower resources utilization to care for the elders in an EoL programme or with severe frailty as previously studied.

(iv) Mandatory on-job training on the necessary skills and compassion to ensure quality of death and psychosocial well-being of the dying elders.

- Knowledge and skills: (a) palliative nursing, (b) pain/symptom management, (c) communication skills with residents and families, (d) attitudes for EoL care, (e) counselling skills and (f) skills for cross disciplinary communication are confirmed to be important for care staff in RCHEs by different local studies.

- Training is needed to deliver the spectrum of care interventions: (a) conduct life review, (b) resume social connection, (c) nurture trusted and supportive relationships, (d) family reconciliation, (e) bringing psychological comfort and (f) post-mortem financial and funeral arrangements.

2.3 Appropriate Service Infrastructure

(v) Develop sector-wide benchmarking EoL care service protocols and procedures for comprehensive assessment, care planning and family engagement.

- To include in the current upgraded InterRAI (International Resident Assessment Instrument) the chapter on palliative care for the admission assessment and calculation of resources utilization for the EoL Programme. Work with the sector to localize overseas service outcome tools and promote good practices in benchmarking service standards that can address the holistic wellbeing of the dying elders as well as their family dynamics and family care capacity.
Working with families should be counted as service deliverables:

Enhancing care capacity of family caregivers and supporting anticipatory grief and bereavement are components of good EoL care. Family conferences should be formalized as a care mechanism to ensure that both the dying residents and their families are involved as much as possible in care planning, implementation and review.

(vi) Set up a well-equipped separate room for EoL care in each RCHE by changing the Schedule of Accommodation. A well-equipped and homely palliative care (PC) room equipped with medical equipment and drugs is needed in allowing extended families to participate in the routine care. Amend Code of Practice to allow for storage of non-designated drugs for emergency symptom relief in the ever-changing dying process.

(vii) Increase Medical Support and Coordination with hospitals. Establish medical and social care integration mechanisms, e.g. CGAT, VMO/GP and integrated mobile team, by working out a set of new service protocols and service agreements with external medical service providers to increase medical care capacity and ensure continuity of care in care transitions. This will be discussed in detail in separate issue brief.

Conclusion

Empowering RCHEs for holistic EoL care is a key strategy to improve the quality of death in Hong Kong. To achieve the ultimate goal of dying well in residential care, namely, a flexible, personalized and psychosocial-oriented end-of-life care the government should assist RCHEs to develop their fit-for-context environment, provide adequate staff level and training as well as service protocols and procedures of care for the dying..

References


The average death rate of RCHEs is 16.6%, and the median of no. of residents in the surveyed RCHEs is 110, giving rise to the average no. of death in RCHEs be 18.26.


