Palliative Care Nursing Support in the Community

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Strategic Service Framework
Palliative Care (2017)
(Hong Kong Hospital Authority) :

Vision

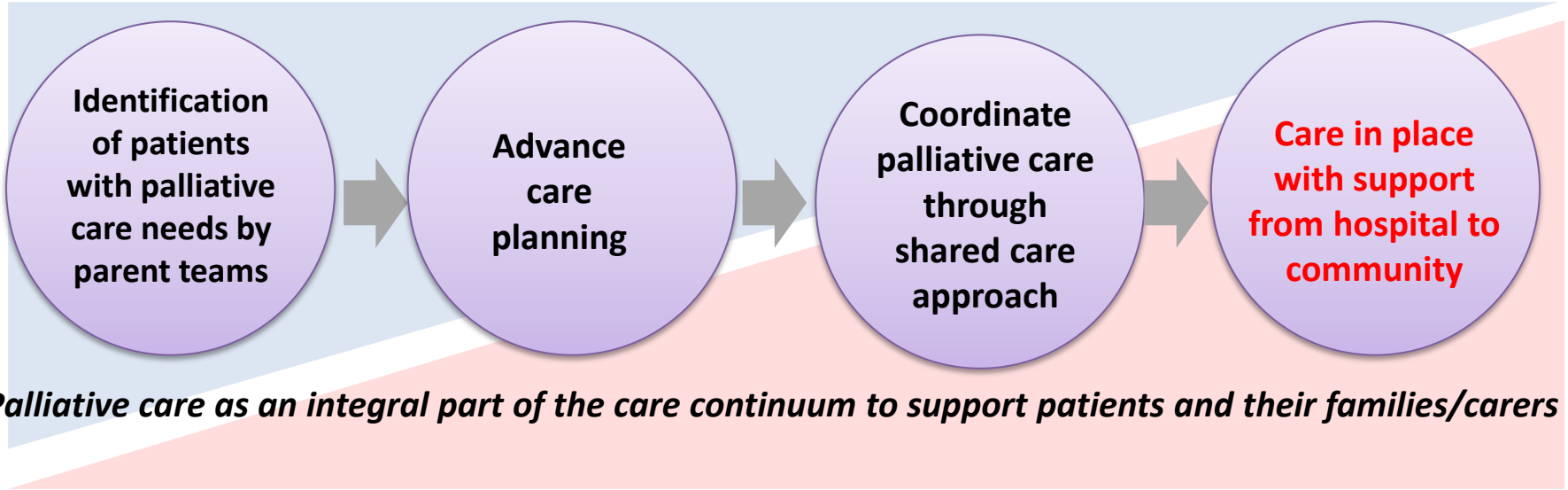
All *patients facing life-threatening and life-limiting conditions and their families/carers receive timely, coordinated and holistic palliative care to address their physical, psychosocial and spiritual needs, and are given the opportunities to participate in the planning of their care, so as to improve quality of life till the end of the patients' life journey.*

Strategic Service Framework for Adult Palliative Care 2017

Enhance governance collaboration of medical & oncology palliative care specialist	Promote care collaboration between palliative care & non palliative care specialist through shared care model	Enhance palliative care in the ambulatory and community settings to support patients	Strengthen performance monitoring for continuous quality improvement

Service Model of Adult Palliative Care in HK Hospital Authority (HA)

Cluster-based service with enhanced governance and collaboration between medical and oncology palliative care specialists



Underpinned by strengthened performance monitoring

Strategic Direction

(Care in Place)

Expand Palliative Home Care Service

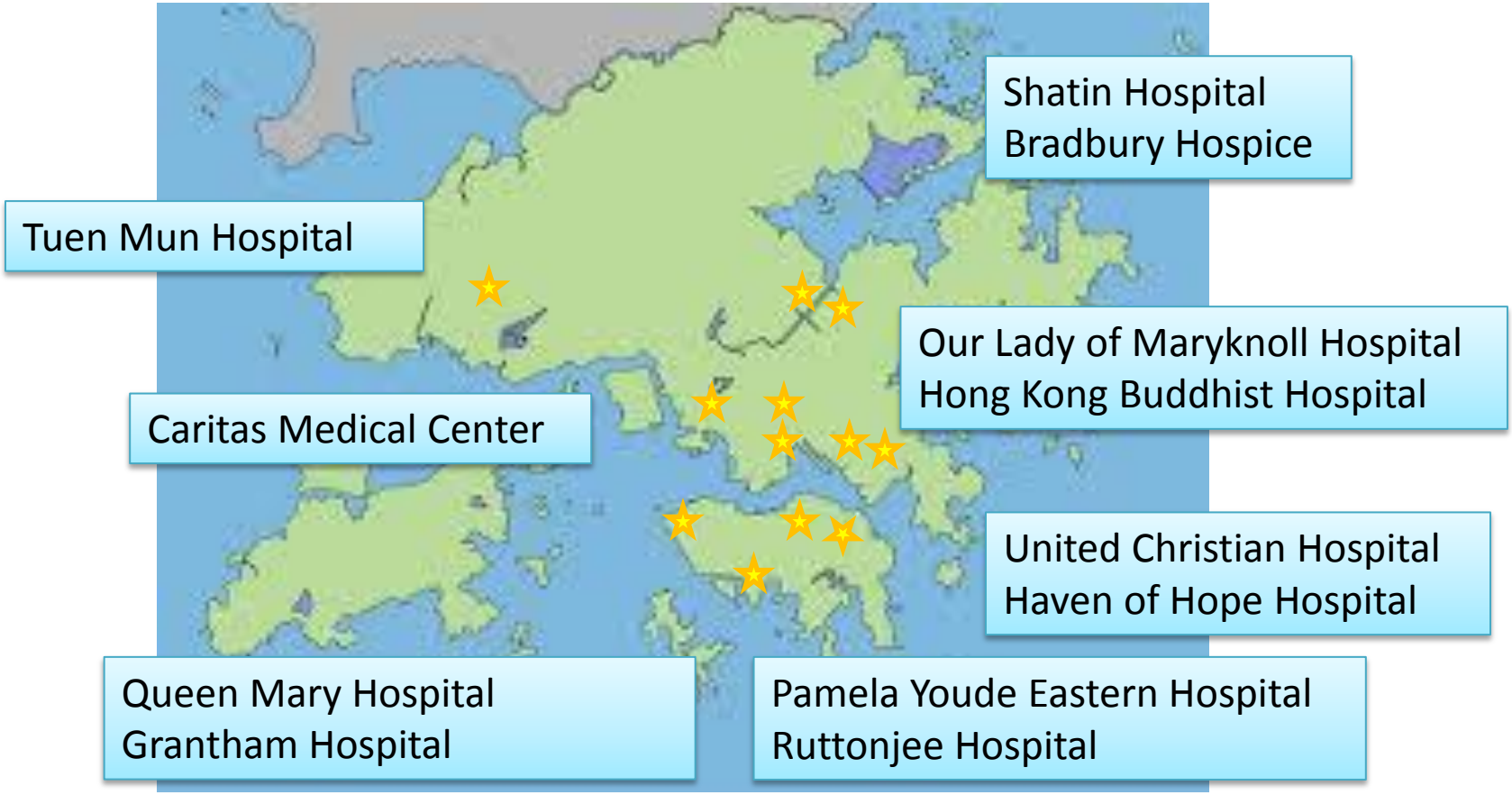
Enhance Palliative Care Support to elderly patients in residential care homes

History of PC Home Care in Hong Kong

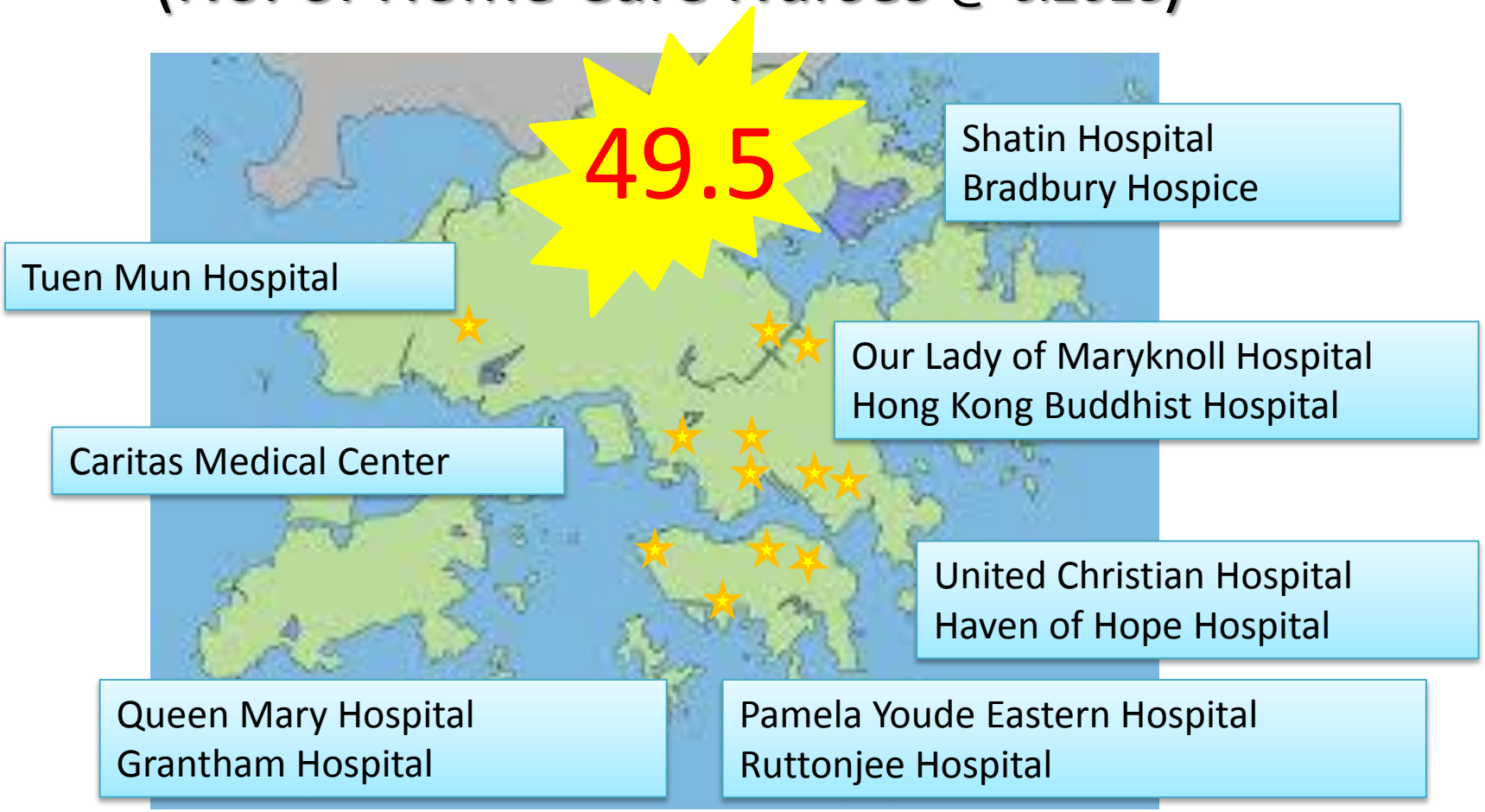
1st PC home Care Team

Hong Kong Society for the Promotion of Hospice Care (1988)

Palliative Home Care Services under HA (12 Home Care Units in 7 clusters)

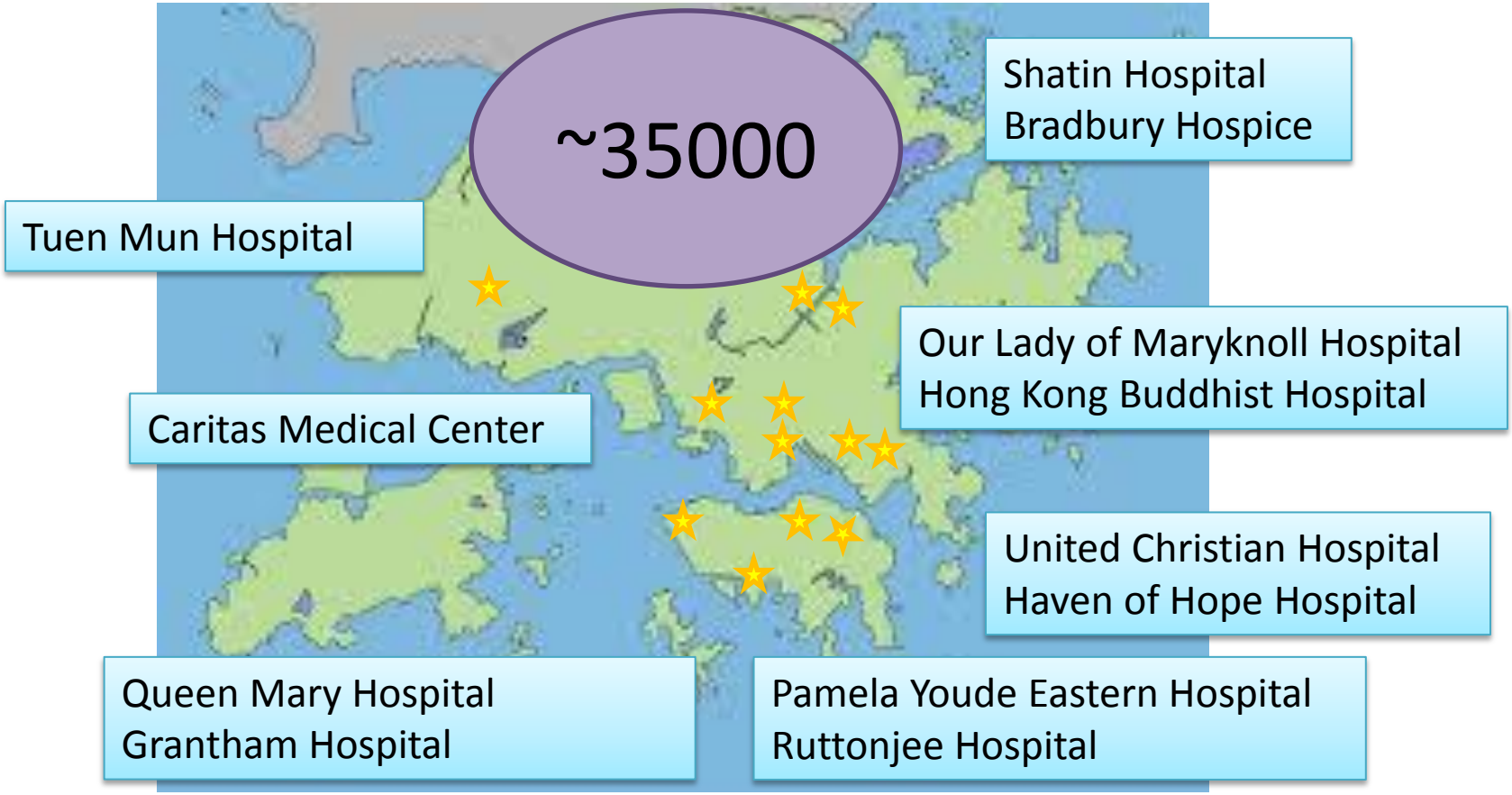


Palliative Home Care Services under HA (No. of Home Care Nurses @ 6.2018)



Palliative Home Care Services under HA

(Total no. of Home Visits @2017)



Service Target

Patients suffer from Advanced Progressive Disease:

I. Terminal Malignancy

II. Advanced Organ Failure

- End Stage Renal Failure
- Advanced Pulmonary Disease
- Advanced Heart Failure
- Others: e.g. Neurodegenerative Disease – Motor Neuron Diseases, late stage dementia etc

Hospital Authority Standard Referral Form for Palliative Care

HOSPITAL AUTHORITY
Standard Referral Form for Palliative Care
(Please read the 'points to note' overleaf before completing this form.)

To:_____Hosp/Inst

Patient's Particulars (Address and Tel no. are essential)
Name :_____
ID No. :_____
Tel No. :_____
Address :_____
_____
_____

Ple... ...l or ...

Referral should be made by medical physician

1.1 Referral for
☐Palliative In-patient Care
☐Palliative Home Care (Please specify the expected date of discharge_____)
☐Palliative Out-patient Care
☐Palliative Day Care
☐Palliative Consultative Service

1.2 Where is the patient at present?
Home_____Hospital (Please specify)_____Others (please specify)_____

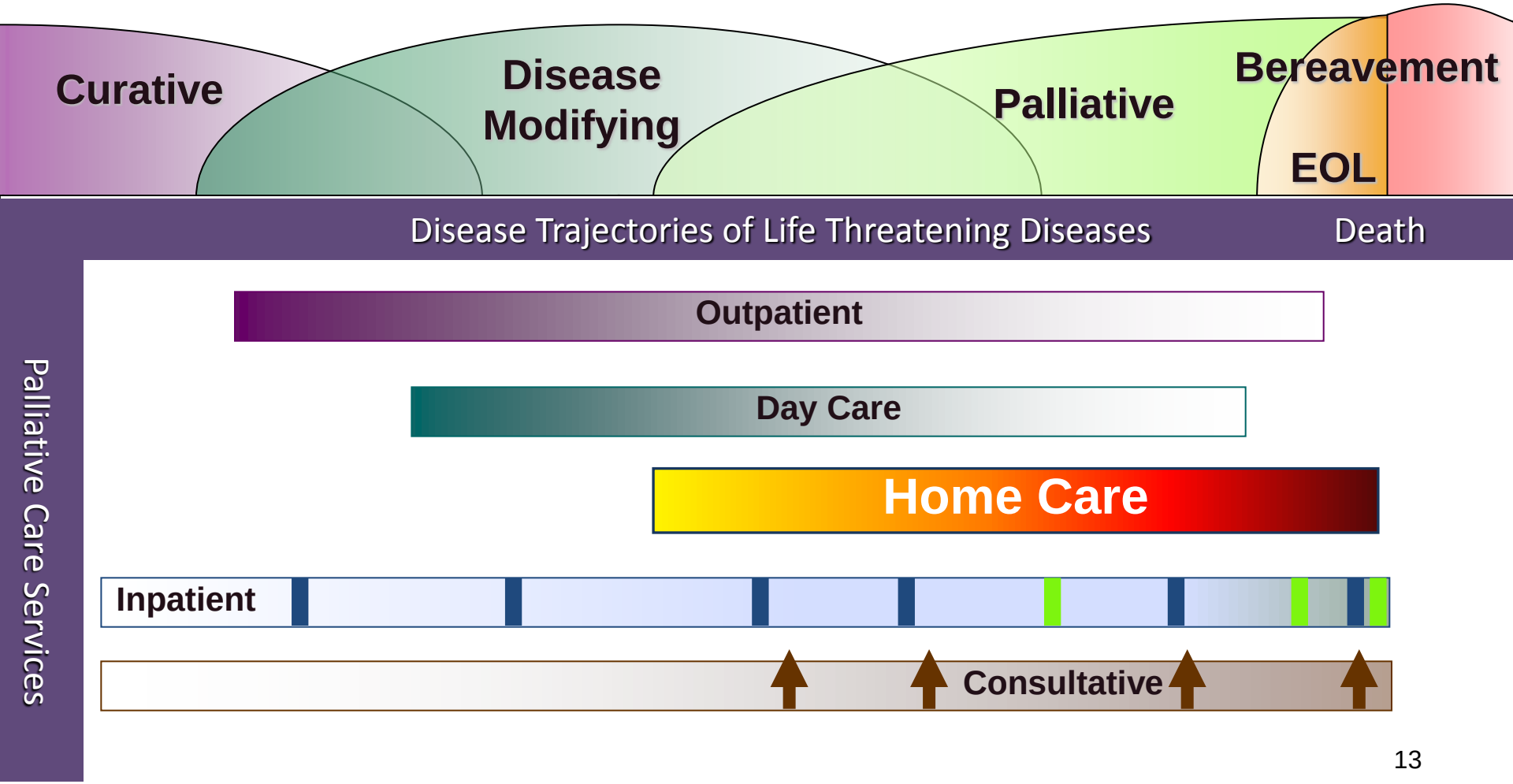
2.1 Diagnosis:
For Cancer: Primary:_____ Site of Metastasis:_____
For Non-Cancer: (Please specify)_____
Diagnosis known to patient: ☐Y ☐N Diagnosis known to family: ☐Y ☐N
Patient's consent for referral (Verbal): ☐Y ☐N

Coverage period: Until patient death and offer bereavement service to family

Purposes for Palliative Home Care

- To help patients stay at home as much as possible
- To enhance patients' autonomy and privacy
- To maximize the time the patient spend with their family
- To care for the patient and their family as a unit
- To respect patient's preference for place of care and place of death

Patient Journey



Care Coordination by HCN

Pain & Symptom Management

Psychosocial & Spiritual care

Drug supervision & Education

Hands on nursing procedure

Coping Empowerment (Patient & Carer)

Advance Care Planning Discussion

Support patient to stay at home as much as possible

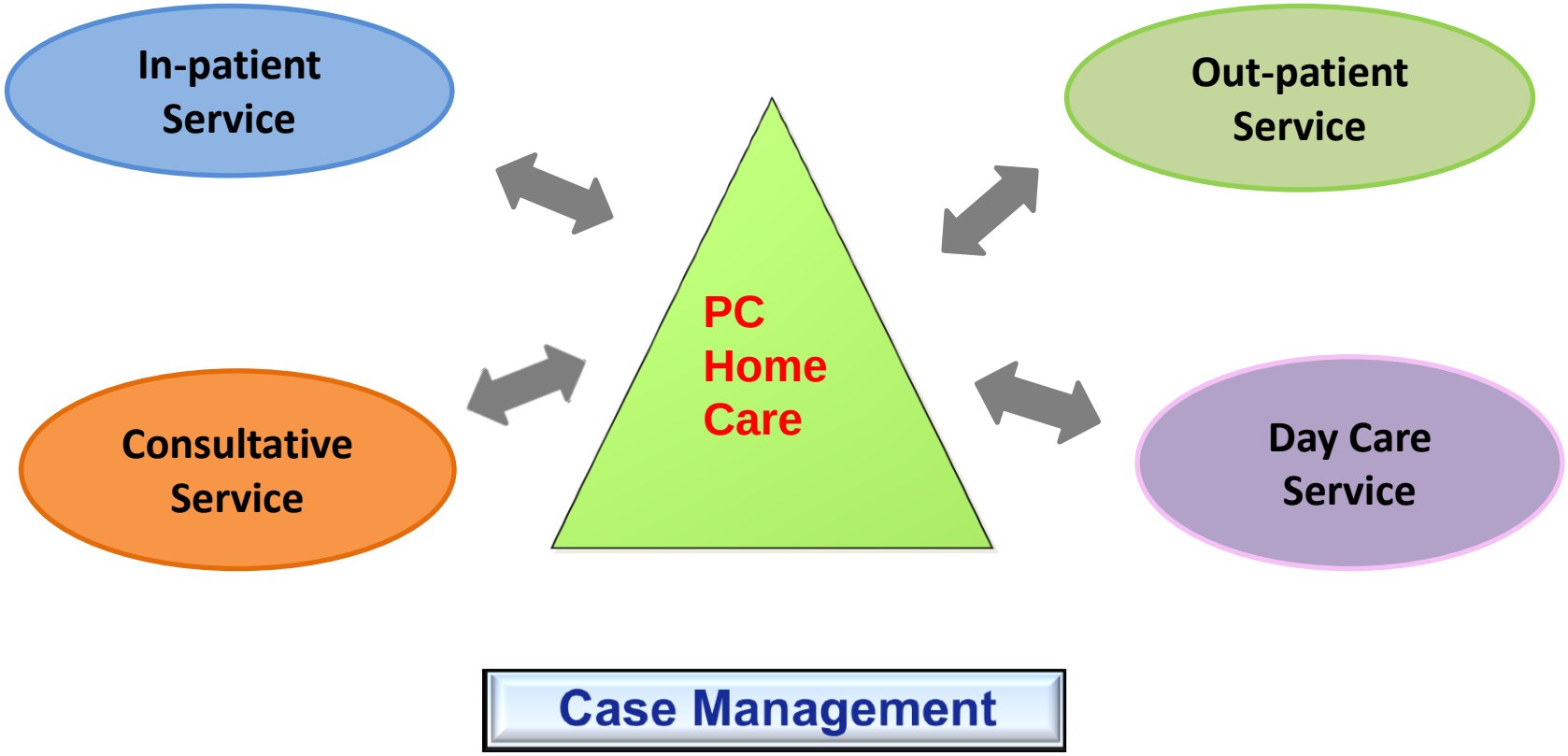
Facilitate use of community resources

Grief Support

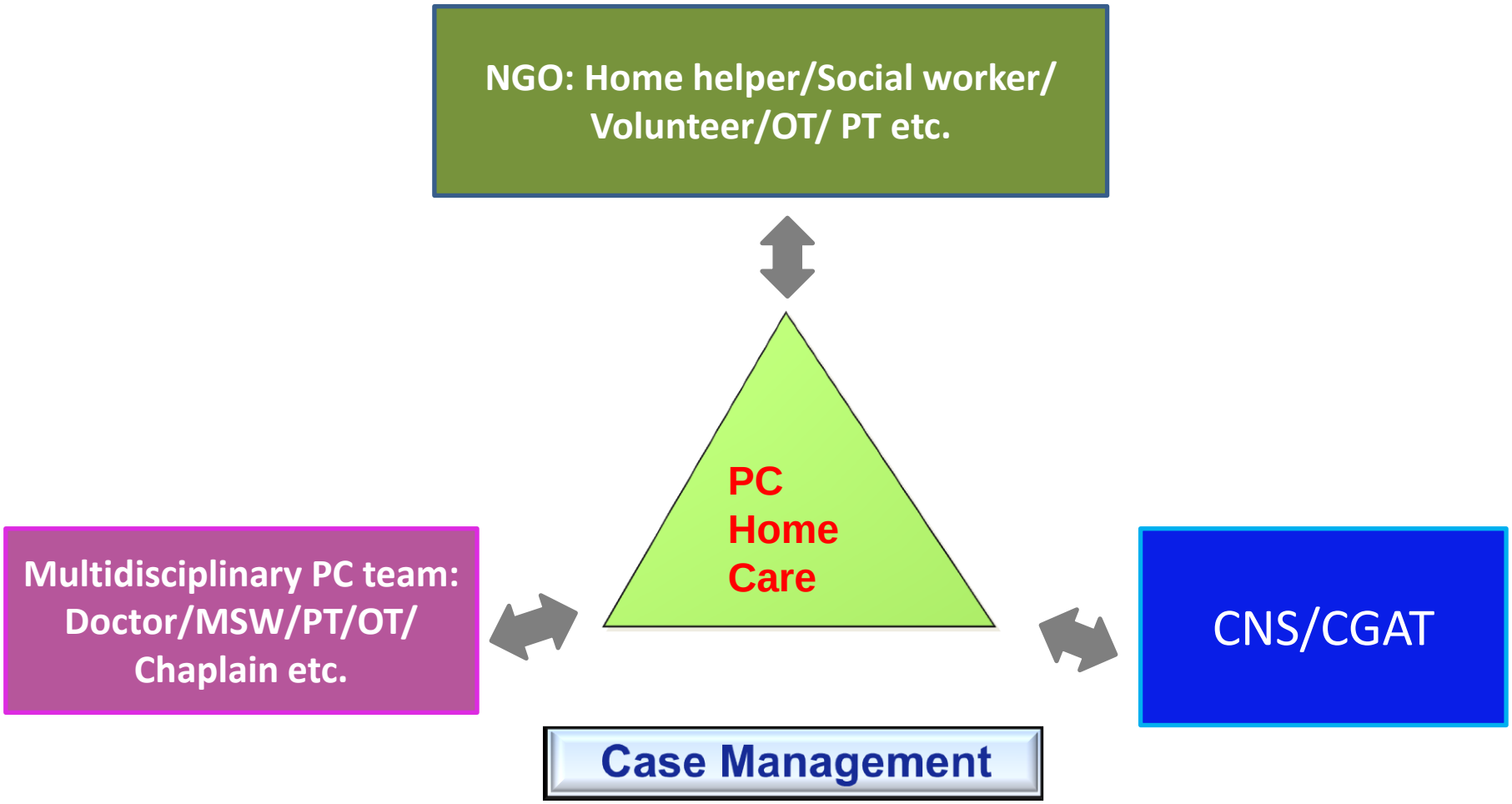
Levels of Care

Level of care	Palliative Performance Scale (PPS)	Physical-psycho-social-spiritual distress
0	90-100	Occasional mild distress – normal functioning
1	70-80	Continue mild distress – not bothering
2	50-60	Moderate distress – limit some activities
3	30-40	Severe distress – activities & concentration markedly affected
4	10-20 / dying	Overwhelming–unable to think of other matters

Continuity of Care



Multidisciplinary PC Team & Community Collaboration



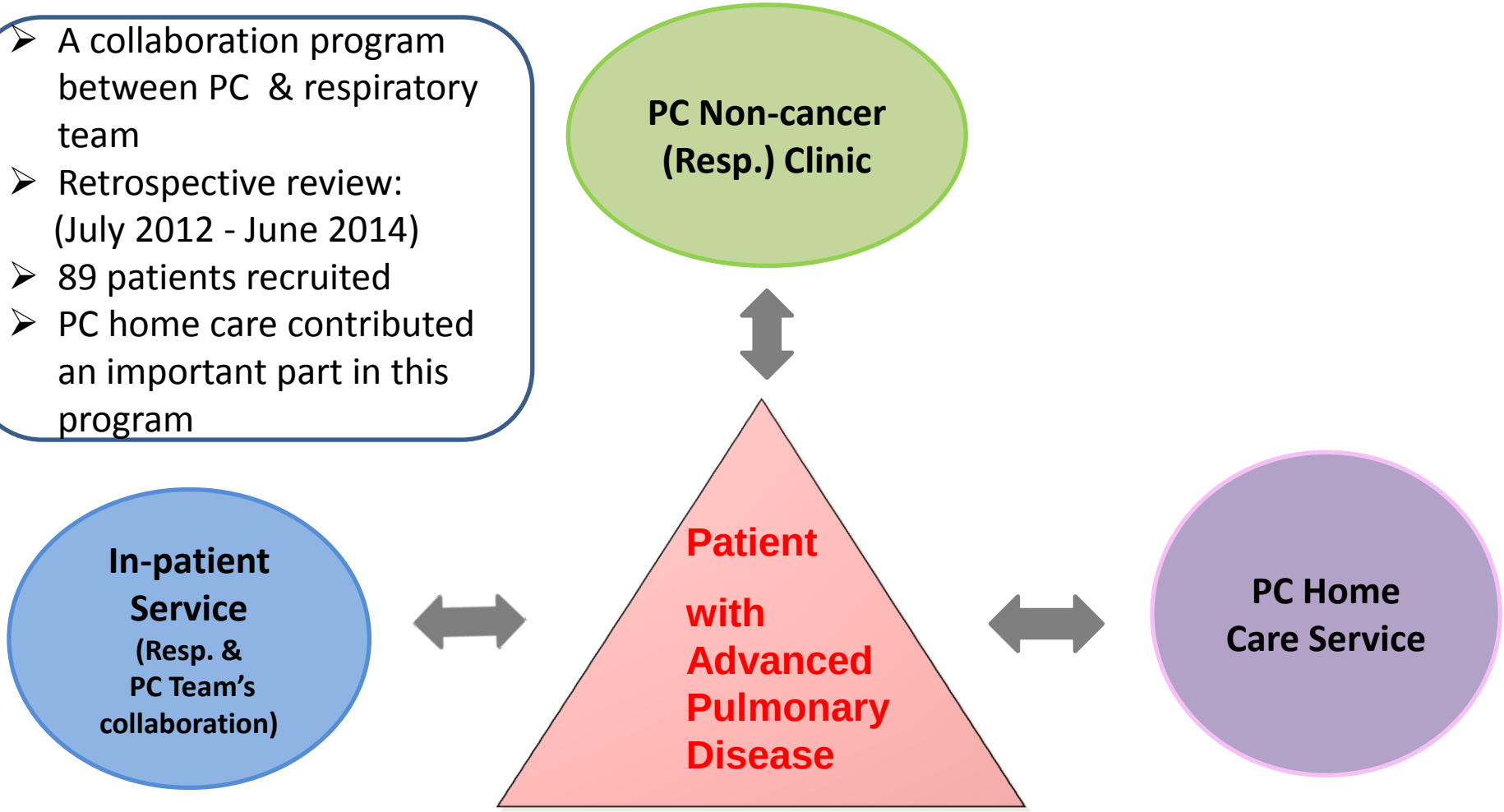
A Cohort Study

(Haven of Hope Hospital)

Palliative Care for Non-cancer Program

to provide holistic care for patients with advanced pulmonary disease

- A collaboration program between PC & respiratory team
- Retrospective review: (July 2012 - June 2014)
- 89 patients recruited
- PC home care contributed an important part in this program



Impact of the Review

1	**Symptom Control**	•Overall symptom was achieved (75.6%) •Dyspnoea can be under controlled (73.0%)
2	**Anxiety level**	•Reduced 50% (between the 1st and 2nd assessment)
3	**ACP discussion**	•98.9% documented in ACP discussion
4	**Reduction in AED Attendance and Acute Admission**	•AED attendance reduced 45.8% •Emergency admission reduced 51.7%
5	**Reduction in length of stay (LOS)**	•LOS in acute hospitals reduced 67.9% •LOS in acute plus extended care hospitals reduced 28.0%

Discharge from hospital and back to home ASAP

Tommy

Days at Home (90 days)

☑Pain control satisfactory
☑Enjoyed home environment
☑Enjoyed on line games
☑Enjoyed the care & love from family members
☑⬆Mobilization
(Visited by PT)

Family empowerment
☑ Handling of NG Tube Feeding
(soup & juicy by mother)
☑ Drug supervision
☑ Emotional support

☑ **Grief work for 2nd sister and mother**

The Evaluation of a Palliative Care Program for People Suffering from Life-limiting Diseases

Objective: To report on the effectiveness of an eight- week home care palliative care program in HK

Design: A pretest post-test design and semi- structured interviews

Sample size: 108

	Interventions
1	Symptom management
2	Intensive communication on ACP
3	Psychosocial intervention

Chan CWH etal., (2012) The evaluation of a palliative care programme for people suffering from life-limiting disease. *Journal of Clinical Nursing*, 23,113 - 123

The Evaluation of a Palliative Care Program for People Suffering from Life-limiting Diseases

Result

- ↑ Patient QOL
- ↑ Participation in ACP discussion
- ↓ Readmission to hospital
- ↓ Days of hospital stay

Qualitative interview:

- ↑ Communication of treatment plan & after-death arrangement
- ↑ Symptom management
- ↑ Emotional support

Chan CWH etal., (2012) The evaluation of a palliative care programme for people suffering from life-limiting disease. *Journal of Clinical Nursing*, 23,113 - 123

Quality of Life of Patients

Table 2 Quality of life (QOL) of patients across T1, T2 and T3

	T1			T2			T3		
	n	*M*	SD	*n*	*M*	SD	*n*	*M*	SD
1st Physical symptom**	107	5·36	3·14	63	5·74	3·30	32	4·09	4·09
2nd Physical symptom	107	4·61	3·46	54	3·41	3·48	30	2·41	3·22
3rd Physical symptom	107	1·84	3·25	44	2·02	3·25	29	1·22	2·71
Physical well-being**	105	3·93	2·37	88	3·15	1·76	32	2·88	1·96
Depressed	102	1·89	2·98	87	1·54	1·85	32	2·28	3·29
Anxious	105	3·01	3·50	87	2·37	2·05	32	2·47	3·44
Sad	104	2·13	3·11	87	1·70	1·97	32	1·88	3·14
Fear of future	103	1·66	2·91	87	1·05	1·73	32	0·56	1·88
Personal existence	90	4·18	3·07	86	3·58	1·98	30	3·17	2·59
Achieving life goals*	89	3·54	3·15	84	2·61	1·91	31	2·94	2·59
Life… worthwhile	85	3·58	2·91	85	3·18	1·97	29	3·21	2·50
Feel good about myself	101	3·61	2·96	87	3·40	1·84	32	3·13	2·64
Closeness to people	105	1·84	2·25	86	1·85	1·55	32	2·75	2·86
Every day 'seems a gift'	99	3·29	2·83	86	2·62	1·73	31	2·94	2·45
World is caring*	99	2·61	2·53	87	2·63	1·79	32	3·31	2·80
Face	96	0·65	1·75	87	0·59	1·03	32	0·44	1·50
Eating*	105	4·33	3·95	86	3·45	2·62	32	1·38	2·87
Sex	18	4·78	4·76	5	1·60	3·58	1	0·00	na
My QOL has been satisfied	101	3·76	2·68	85	3·21	1·53	31	2·84	2·00
Five components of McGill Quality of Life Questionnaire									
Physical*	103	4·04	2·53	41	3·71	2·44	30	2·39	2·40
Psychological	86	1·99	2·13	85	1·64	1·13	31	1·66	2·16
Existential well-being	81	3·65	2·68	84	3·14	1·67	28	3·17	2·38
Support**	99	2·16	2·16	86	2·24	1·58	32	3·03	2·58
Sex	18	4·78	4·76	5	1·60	3·58	1	0	na

Score range = 0–10; for the five components, 0 = better, 10 = worse; Wilcoxon matched pairs test.
*$p < 0.05$; **$p < 0.01$.

Chan CWH etal., (2012) The evaluation of a palliative care programme for people suffering from life-limiting disease. *Journal of Clinical Nursing*, 23,113 - 123

Participation in ACP Discussion

Table 4 Results of intensive communication on advance care planning (ACP)

	T1 (n = 108)		T2 (n = 87)		T3 (n = 32)	
	n	%	n	%	n	%
Considered ACP*						
Yes	30	27·8	48	55·2	11	34·4
No	30	27·8	10	11·5	7	21·9
Undecided/uncertain	48	44·5	29	33·3	14	43·8
Understood their treatment plan and goals*						
Completely understand	33	30·6	41	47·1	10	31·3
Mostly understand	22	20·4	21	24·1	0	0
Somewhat understand	18	16·7	10	11·5	5	15·6
Do not understand very well	8	7·4	1	1·1	2	6·3
Do not understand at all	10	9·3	3	3·4	1	3·1
Uncertain	17	15·7	11	12·6	14	43·8
Considered not to receive invasive therapy)*						
Yes	31	28·7	24	27·6	3	9·4
No	41	38·0	50	57·5	18	56·3
Undecided/uncertain	36	33·3	13	14·9	11	34·4
Signed do-not-resuscitate document*						
Yes	7	6·5	46	52·9	9	28·1
No	63	58·3	19	21·8	2	6·3
Undecided	38	35·2	22	25·3	21	65·6
Completed living will*						
Yes	16	14·8	42	48·3	4	12·5
No	56	51·9	45	51·7	28	87·5
Undecided	36	33·3	0	0	0	0
Completed advance directive*						
Yes	5	4·6	37	42·5	11	34·4
No	76	70·4	46	52·9	20	62·5
Undecided	27	25·0	4	4·6	1	3·1
Decided the place of death*						
Yes	36	33·3	46	52·9	28	87·5
No	38	35·2	28	32·2	4	12·5
Undecided	34	31·5	13	14·9	0	0

Chi-square test:
*$p < 0.001$.

Chan CWH etal., (2012) The evaluation of a palliative care programme for people suffering from life-limiting disease. *Journal of Clinical Nursing*, 23,113 - 123

Hospital Readmission

Table 5 Hospital readmission

	T1 (n = 108)		T2 (n = 87)		T3 (n = 32)	
	n	%	n	%	n	%
Admission to the hospital last month**						
Yes	57	52·8	20	23·0	20	62·5
No	49	45·4	67	77·0	12	37·5
Uncertain	2	1·9	0	0	0	0
Times of admitting to the hospital last month**						
0	27	25·0	67	77·0	12	37·5
1	53	49·1	10	11·5	12	37·5
2	3	2·8	10	11·5	7	21·9
3	1	0·9	0	0	1	3·1
Uncertain	24	22·2	0	0	0	0
	M	SD	M	SD	M	SD
Days of admitted to the hospital last month*	8·45	12·01	1·41	3·48	4·48	7·80

Chi-square test: $*p < 0{\cdot}05$; $**p < 0{\cdot}01$.
Wilcoxon matched paired tests: $*p < 0{\cdot}05$.

Chan CWH etal., (2012) The evaluation of a palliative care programme for people suffering from life-limiting disease. *Journal of Clinical Nursing*, 23,113 - 123

Effects of a Transitional Palliative Care Model on Patients with End-stage Heart Failure

Objective: To examine the effects of home-based transitional palliative care for patients with end-stage heart failure after hospital discharge

Design: RCT

Sample size: 43 (Intervention group) 41 (Control group)

	Program design (Heart Failure guidelines for PC)
1	Case management with periodic review (home visit + telephone calls)
2	Discussion of EOL issues & treatment preferences
3	Multidisciplinary approach

4C features of transitional care model

- **Comprehensives**
- **Continuity**
- **Coordinating**
- **Collaboration**

Wong, FKY etal., (2016) Effects of a transitional palliative care model on patients with end-stage heart failure: a randomized controlled trial. *Heart* , 102:1100-1108

Effects of a Transitional Palliative Care Model on Patients with End-stage Heart Failure

	Result		P value
1	**Lower readmission rate at 12 weeks**	Intervention 33.6% vs Control 61.0%	0.001
2	**Significant clinical improvement in Depression & Dyspnea @ 4 weeks**	➢ Depression→ 45.9% vs 16.1% ➢ Dyspnoea → 62.2% vs 29.0%	< 0.05 < 0.05
3	**↑Quality of life**	➢ There were significant differences between groups in changes over time in QOL measured by McGill QOL and ➢ Chronic heart failure questionnaires	< 0.05 < 0.01

Wong, FKY etal., (2016) Effects of a transitional palliative care model on patients with end-stage heart failure: a randomized controlled trial. *Heart* , 102:1100-1108

1600 Cognitively Normal Elderly Persons from 140 Old Age Homes in Hong Kong

94% inform of diagnosis of advanced illness

88% to have palliative treatment

88% agree to have advanced directives

One third of elders accept dying in old age homes

Chu LW etal., 2011, Advance directive and preference of old age home residents for community model of end-of-life care in Hong Kong. *Hong Kong Med Journal.* 17 (Suppl 3):S13-15

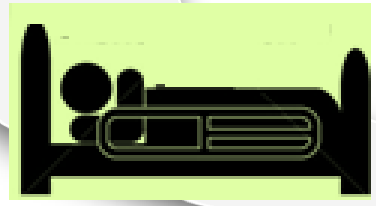
End of Life care in Residential Care Home for Elderly (RCHE)Program

RCHE participation

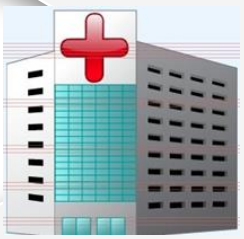
- **Empower RCHEs staff on EOL care**

CGAT + PC Team

“ Good Death ”



- **Advance Care Planning**
- **On site nursing and medical support**
- **Direct admission**



To provide more coordinated and appropriate care

To reduce unnecessary hospital admission and aggressive treatment

Training & Mutual Learning between PC & CGAT Nurses

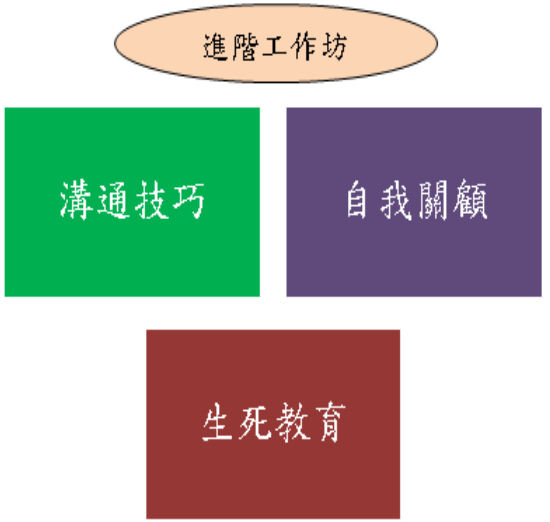
	Content
1	**HA eLearning Program on Hospice Palliative Nursing Care (12 modules)**
2	**Four sessions of EOL care lectures (8 hours)** • Palliative care concepts & service model • Pain and common symptom management • Psycho-social-spiritual care • Discussion in advance care planning • Ethical considerations • Care for the impending death • Managing family emotions and grief support • Staff stress and staff support
3	**Two communication skills drilling workshops** • Practical tips on communication with patients & families at the end-of-life • Advance Care Planning
4	**Two days Clinical attachment to Palliative Care Unit, UCH**
5	**On site coaching and clinical skill supervision**

Training for RCHE Staff

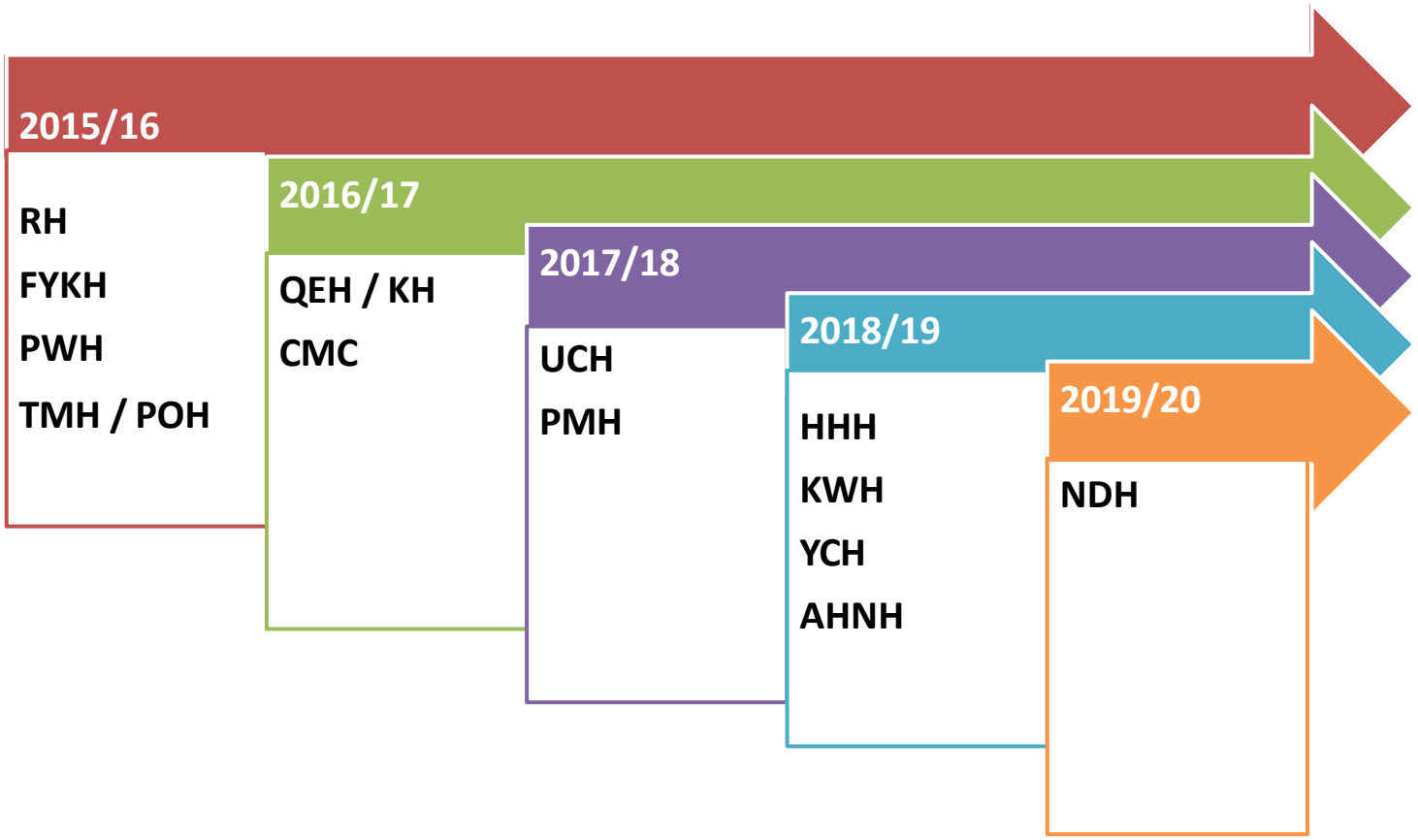
- **Aims:**
  - To understand the needs of terminally ill patients and their families
  - To enhance end of life care standard in residential care homes
  - To equip with practical skills
- **Topics:**

基楚課堂

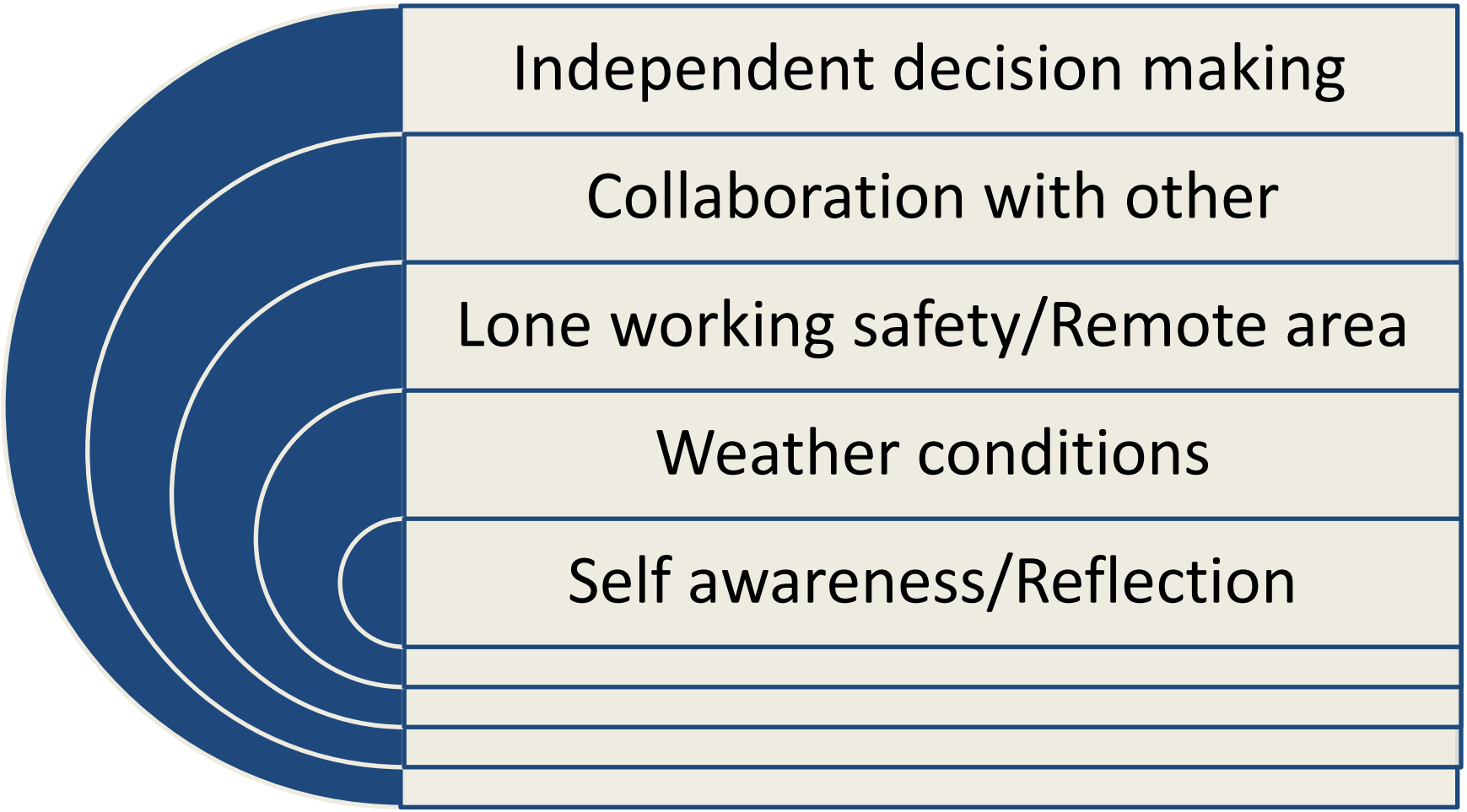
1. 安老院舍晚期醫護計劃簡介
2. 紓緩治療及臨終照顧之理念及重點
3. 晚期病患者身、心、社、靈的需要
4. 晚期徵狀及照顧方法
5. 建立有效的溝通
6. 自我關顧
7. 預設照顧計劃
8. 身後事之準備及安排
9. 哀傷的關懷及照顧
10. 關顧者之角色及基本照顧技巧



EOL care in RCHEs Program to Roll Out by Phases in 15 Hospitals in Hong Kong Hospital Authority



Challenges Face by Home Care Nurses



The Way Forward…

- To better manage growing service demand
- To strengthen community-based model of service
- To improve clinical practice to ensure service quality

Thank You