Palliative Care Nursing Support in the Community

Ko Po Shan, Polly
Nurse Consultant (Palliative Care), KEC
Hong Kong Hospital Authority
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
Identification of patients with palliative care needs by parent teams
 Advance care planning
 Coordinate palliative care through shared care approach
 Care in place with support from hospital to community

Palliative care as an integral part of the care continuum to support patients and their families/carers

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)

Caritas Medical Center
Shatin Hospital
Bradbury Hospice
Tuen Mun Hospital
Our Lady of Maryknoll Hospital
Hong Kong Buddhist Hospital
Queen Mary Hospital
United Christian Hospital
Grantham Hospital
Haven of Hope Hospital
Pamela Youde Eastern Hospital
Ruttonjee Hospital
Palliative Home Care Services under HA
(No. of Home Care Nurses @ 6.2018)

Caritas Medical Center
Shatin Hospital
Bradbury Hospice
Tuen Mun Hospital
Our Lady of Maryknoll Hospital
Hong Kong Buddhist Hospital
Queen Mary Hospital
United Christian Hospital
Haven of Hope Hospital
Caritas Medical Center
United Christian Hospital
Haven of Hope Hospital
Queen Mary Hospital
Grantham Hospital
Pamela Youde Eastern Hospital
Ruttonjee Hospital

49.5
Palliative Home Care Services under HA
(Total no. of Home Visits @2017)

~35000

Caritas Medical Center
Queen Mary Hospital
Grantham Hospital
Tuen Mun Hospital
Our Lady of Maryknoll Hospital
Hong Kong Buddhist Hospital
United Christian Hospital
Haven of Hope Hospital
Shatin Hospital
Bradbury Hospice
Pamela Youde Eastern Hospital
Ruttonjee Hospital
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

Patient's Particulars (Address and Tel no. are essential)

<table>
<thead>
<tr>
<th>Name</th>
<th>ID No.</th>
<th>Tel No.</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Referral should be made by medical physician

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

Disease Trajectories of Life Threatening Diseases

Outpatient

Day Care

Home Care

Inpatient

Consultative
Psychosocial & Spiritual care

Drug supervision & Education

Advance Care Planning Discussion

Psychosocial & Spiritual care

Support patient to stay at home as much as possible

Facilitate use of community resources

Pain & Symptom Management

Hands on nursing procedure

Coping Empowerment (Patient & Carer)

Grief Support

Care Coordination by HCN
## Levels of Care

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

In-patient Service

Consultative Service

Out-patient Service

Day Care Service

PC Home Care

Case Management
Multidisciplinary PC Team & Community Collaboration

NGO: Home helper/Social worker/Volunteer/OT/PT etc.

PC Home Care

Multidisciplinary PC team: Doctor/MSW/PT/OT/Chaplain etc.

Case Management

CNS/CGAT
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

PC Non-cancer (Resp.) Clinic

In-patient Service
(Resp. & PC Team’s collaboration)

Patient with Advanced Pulmonary Disease

PC Home Care Service

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

In-patient Service
(Resp. & PC Team’s collaboration)

Patient with Advanced Pulmonary Disease

PC Home Care Service
# Impact of the Review

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **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 online 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

<table>
<thead>
<tr>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

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

Quality of Life of Patients

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

<table>
<thead>
<tr>
<th></th>
<th>T1</th>
<th></th>
<th></th>
<th>T2</th>
<th></th>
<th></th>
<th>T3</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>1st Physical symptom**</td>
<td>107</td>
<td>5.36</td>
<td>3.14</td>
<td>63</td>
<td>5.74</td>
<td>3.30</td>
<td>32</td>
<td>4.09</td>
<td>4.09</td>
</tr>
<tr>
<td>2nd Physical symptom</td>
<td>107</td>
<td>4.61</td>
<td>3.46</td>
<td>54</td>
<td>4.41</td>
<td>3.48</td>
<td>30</td>
<td>2.41</td>
<td>3.22</td>
</tr>
<tr>
<td>3rd Physical symptom</td>
<td>107</td>
<td>1.84</td>
<td>2.25</td>
<td>44</td>
<td>2.02</td>
<td>3.25</td>
<td>29</td>
<td>1.22</td>
<td>2.71</td>
</tr>
<tr>
<td>Physical well-being**</td>
<td>105</td>
<td>3.93</td>
<td>2.37</td>
<td>88</td>
<td>3.15</td>
<td>1.76</td>
<td>32</td>
<td>2.88</td>
<td>1.96</td>
</tr>
<tr>
<td>Depressed</td>
<td>102</td>
<td>1.89</td>
<td>2.98</td>
<td>87</td>
<td>1.54</td>
<td>1.85</td>
<td>32</td>
<td>2.28</td>
<td>3.29</td>
</tr>
<tr>
<td>Anxious</td>
<td>105</td>
<td>3.01</td>
<td>3.50</td>
<td>87</td>
<td>2.37</td>
<td>2.05</td>
<td>32</td>
<td>2.67</td>
<td>3.44</td>
</tr>
<tr>
<td>Sad</td>
<td>104</td>
<td>2.13</td>
<td>3.11</td>
<td>87</td>
<td>1.70</td>
<td>1.97</td>
<td>32</td>
<td>1.88</td>
<td>3.14</td>
</tr>
<tr>
<td>Fear of future</td>
<td>103</td>
<td>1.66</td>
<td>2.91</td>
<td>87</td>
<td>1.05</td>
<td>1.73</td>
<td>32</td>
<td>0.56</td>
<td>1.88</td>
</tr>
<tr>
<td>Personal existence</td>
<td>90</td>
<td>4.18</td>
<td>3.07</td>
<td>86</td>
<td>3.58</td>
<td>1.98</td>
<td>30</td>
<td>3.17</td>
<td>2.59</td>
</tr>
<tr>
<td>Achieving life goals*</td>
<td>89</td>
<td>3.54</td>
<td>3.15</td>
<td>84</td>
<td>2.61</td>
<td>1.91</td>
<td>31</td>
<td>2.94</td>
<td>2.59</td>
</tr>
<tr>
<td>Life... worthwhile</td>
<td>85</td>
<td>3.58</td>
<td>2.91</td>
<td>85</td>
<td>3.18</td>
<td>1.97</td>
<td>29</td>
<td>3.21</td>
<td>2.50</td>
</tr>
<tr>
<td>Feel good about myself</td>
<td>101</td>
<td>3.61</td>
<td>2.96</td>
<td>87</td>
<td>3.40</td>
<td>1.84</td>
<td>32</td>
<td>3.13</td>
<td>2.64</td>
</tr>
<tr>
<td>Closeness to people</td>
<td>105</td>
<td>1.84</td>
<td>2.25</td>
<td>86</td>
<td>1.85</td>
<td>1.55</td>
<td>32</td>
<td>2.75</td>
<td>2.86</td>
</tr>
<tr>
<td>Every day 'seems a gift'</td>
<td>99</td>
<td>3.29</td>
<td>2.83</td>
<td>86</td>
<td>2.62</td>
<td>1.73</td>
<td>31</td>
<td>2.94</td>
<td>2.45</td>
</tr>
<tr>
<td>World is caring*</td>
<td>99</td>
<td>2.61</td>
<td>2.53</td>
<td>87</td>
<td>2.63</td>
<td>1.79</td>
<td>32</td>
<td>3.31</td>
<td>2.80</td>
</tr>
<tr>
<td>Face</td>
<td>96</td>
<td>0.65</td>
<td>1.75</td>
<td>87</td>
<td>0.59</td>
<td>1.03</td>
<td>32</td>
<td>0.44</td>
<td>1.50</td>
</tr>
<tr>
<td>Eating*</td>
<td>105</td>
<td>3.33</td>
<td>3.95</td>
<td>86</td>
<td>3.45</td>
<td>2.62</td>
<td>32</td>
<td>1.38</td>
<td>2.87</td>
</tr>
<tr>
<td>My QOL has been satisfied</td>
<td>18</td>
<td>4.78</td>
<td>4.76</td>
<td>5</td>
<td>1.60</td>
<td>3.58</td>
<td>1</td>
<td>0.00</td>
<td>na</td>
</tr>
</tbody>
</table>

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

Journal of Clinical Nursing, 23, 113 - 123
## Participation in ACP Discussion

<table>
<thead>
<tr>
<th></th>
<th>T1 (n = 108)</th>
<th></th>
<th>T2 (n = 87)</th>
<th></th>
<th>T3 (n = 32)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td><strong>Considered ACP</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>30</td>
<td>27.8</td>
<td>48</td>
<td>55.2</td>
<td>11</td>
<td>34.4</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>27.8</td>
<td>10</td>
<td>11.5</td>
<td>7</td>
<td>21.9</td>
</tr>
<tr>
<td>Undecided/uncertain</td>
<td>48</td>
<td>44.5</td>
<td>29</td>
<td>33.3</td>
<td>14</td>
<td>43.8</td>
</tr>
<tr>
<td><strong>Understood their treatment plan and goals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely understand</td>
<td>33</td>
<td>30.6</td>
<td>41</td>
<td>47.1</td>
<td>10</td>
<td>31.3</td>
</tr>
<tr>
<td>Mostly understand</td>
<td>22</td>
<td>20.4</td>
<td>21</td>
<td>24.1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Somewhat understand</td>
<td>18</td>
<td>16.7</td>
<td>10</td>
<td>11.5</td>
<td>5</td>
<td>15.6</td>
</tr>
<tr>
<td>Do not understand very well</td>
<td>8</td>
<td>7.4</td>
<td>1</td>
<td>1.1</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>Do not understand at all</td>
<td>10</td>
<td>9.3</td>
<td>3</td>
<td>3.4</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>Uncertain</td>
<td>17</td>
<td>15.7</td>
<td>11</td>
<td>12.6</td>
<td>14</td>
<td>43.8</td>
</tr>
<tr>
<td><strong>Considered not to receive invasive therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>31</td>
<td>28.7</td>
<td>24</td>
<td>27.6</td>
<td>3</td>
<td>9.4</td>
</tr>
<tr>
<td>No</td>
<td>41</td>
<td>38.0</td>
<td>50</td>
<td>57.5</td>
<td>18</td>
<td>56.3</td>
</tr>
<tr>
<td>Undecided/uncertain</td>
<td>36</td>
<td>33.3</td>
<td>13</td>
<td>14.9</td>
<td>11</td>
<td>34.4</td>
</tr>
<tr>
<td><strong>Signed do-not-resuscitate document</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7</td>
<td>6.5</td>
<td>46</td>
<td>52.9</td>
<td>9</td>
<td>28.1</td>
</tr>
<tr>
<td>No</td>
<td>63</td>
<td>58.3</td>
<td>19</td>
<td>21.8</td>
<td>2</td>
<td>6.3</td>
</tr>
<tr>
<td>Undecided</td>
<td>38</td>
<td>35.2</td>
<td>22</td>
<td>25.3</td>
<td>21</td>
<td>65.6</td>
</tr>
<tr>
<td><strong>Completed living will</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>14.8</td>
<td>42</td>
<td>48.3</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>No</td>
<td>56</td>
<td>51.9</td>
<td>45</td>
<td>51.7</td>
<td>28</td>
<td>87.5</td>
</tr>
<tr>
<td>Undecided</td>
<td>36</td>
<td>33.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Completed advance directive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5</td>
<td>4.6</td>
<td>37</td>
<td>42.5</td>
<td>11</td>
<td>34.4</td>
</tr>
<tr>
<td>No</td>
<td>76</td>
<td>70.4</td>
<td>46</td>
<td>52.9</td>
<td>20</td>
<td>62.5</td>
</tr>
<tr>
<td>Undecided</td>
<td>27</td>
<td>25.0</td>
<td>4</td>
<td>4.6</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td><strong>Decided the place of death</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>36</td>
<td>33.3</td>
<td>46</td>
<td>52.9</td>
<td>28</td>
<td>87.5</td>
</tr>
<tr>
<td>No</td>
<td>38</td>
<td>35.2</td>
<td>28</td>
<td>32.2</td>
<td>4</td>
<td>12.5</td>
</tr>
<tr>
<td>Undecided</td>
<td>34</td>
<td>31.5</td>
<td>13</td>
<td>14.9</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Chi-square test:  
*p < 0.001.
Hospital Readmission

Table 5 Hospital readmission

<table>
<thead>
<tr>
<th></th>
<th>T1 (n = 108)</th>
<th>T2 (n = 87)</th>
<th>T3 (n = 32)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Admission to the hospital last month***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>57</td>
<td>52.8</td>
<td>20</td>
</tr>
<tr>
<td>No</td>
<td>49</td>
<td>45.4</td>
<td>67</td>
</tr>
<tr>
<td>Uncertain</td>
<td>2</td>
<td>1.9</td>
<td>0</td>
</tr>
<tr>
<td>Times of admitting to the hospital last month***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>27</td>
<td>25.0</td>
<td>67</td>
</tr>
<tr>
<td>1</td>
<td>53</td>
<td>49.1</td>
<td>10</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>2.8</td>
<td>10</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>0.9</td>
<td>0</td>
</tr>
<tr>
<td>Uncertain</td>
<td>24</td>
<td>22.2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days of admitted to the hospital last month*</td>
<td>8.45</td>
<td>12.01</td>
<td>1.41</td>
<td>3.48</td>
<td>4.48</td>
<td>7.80</td>
</tr>
</tbody>
</table>

Chi-square test: *p < 0.05; ***p < 0.01.
Wilcoxon matched paired tests: *p < 0.05.
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

<table>
<thead>
<tr>
<th>Result</th>
<th><strong>P value</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Lower readmission rate at 12 weeks</td>
<td>Intervention 33.6% vs Control 61.0%</td>
</tr>
</tbody>
</table>
| **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 et al., (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% agree to have advanced directives
- 88% to have palliative treatment
- One third of elders accept dying in old age homes

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

RCHE participation
• Empower RCHEs staff on EOL care

“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

CGAT + PC Team
Training & Mutual Learning between PC & CGAT Nurses

<table>
<thead>
<tr>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>2</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>3</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>4</strong></td>
</tr>
<tr>
<td><strong>5</strong></td>
</tr>
</tbody>
</table>
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:**

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

- Independent decision making
- Collaboration with other
- Lone working safety/Remote area
- Weather conditions
- Self awareness/Reflection
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