賽馬會安寧頌

Jockey Club End-of-Life Community Care Project

"Life Rainbow" End-of-life Care Services

Medical Social Collaboration Approach in End-of-Life Care: Experience from a Multidisciplinary Program

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ADEC certified Thanatologist

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

主辦機構 Organized by:
香港復康會
The Hong Kong Society for Rehabilitation

策略伙伴 Strategic Partners:
HONG KONG EAST CLUSTER
港島東醫院聯網

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抱負 Vision

我們致力成為一所具效能、影響力以及關懷的全人照顧及復康機構。

We aspire to be an effective, impactful and caring organisation in holistic care and rehabilitation.

使命 Mission

透過創新復康服務及賦權殘疾或面對健康挑戰的人士，倡議全人健康、社會參與以及共融有利的環境。

Through innovation in rehabilitation and empowering persons with disabilities or health conditions, we advocate holistic well-being, social participation, and an inclusive and enabling environment.

價值觀 Values

我們信守

We strive to uphold the following values in every one of our actions and interactions:

尊重人 Value People	信任、尊嚴、尊重、平等參與及溝通 trust, dignity, respect, equal participation and communication
專業精神 Professionalism	同理心、優質服務、持續發展、勇於承擔及力臻至善 empathy, quality service, continuous development, commitment and in search of excellence
誠信 Integrity	忠誠、信實及問責 honesty, truthfulness and accountability
充能 Empowerment	自主、自強及參與公共政策 having control, self-management and participation in public policy
共融 Inclusiveness	尊重多元化、以權責為本 respect diversity and right-based approach

香港復康會
The Hong Kong Society for Rehabilitation

JCECC “Life Rainbow”
End-of-Life Care (EoL) Services

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- An **Integrated Community End-of-life Care Support Team** since 2016
- Funded by **The Hong Kong Jockey Club Charities Trust**
- Research support by **The University of Hong Kong (HKU)**
- Strategic partnership with **The Hong Kong East Cluster of the Hospital Authority**
- Provided community base EoL service to more than 505 end-stage patients and 1037 caregivers
- Service Targets are main patients with late-stage non-cancer disease, including chronic obstructive pulmonary disease (COPD), end-stage renal failure (ESRF), heart failure and neurological disease (e.g. Parkinson disease, stroke, dementia and motor neuron disease)


Medical
Social

Fragmented EoL Care Service from Hospital and Community

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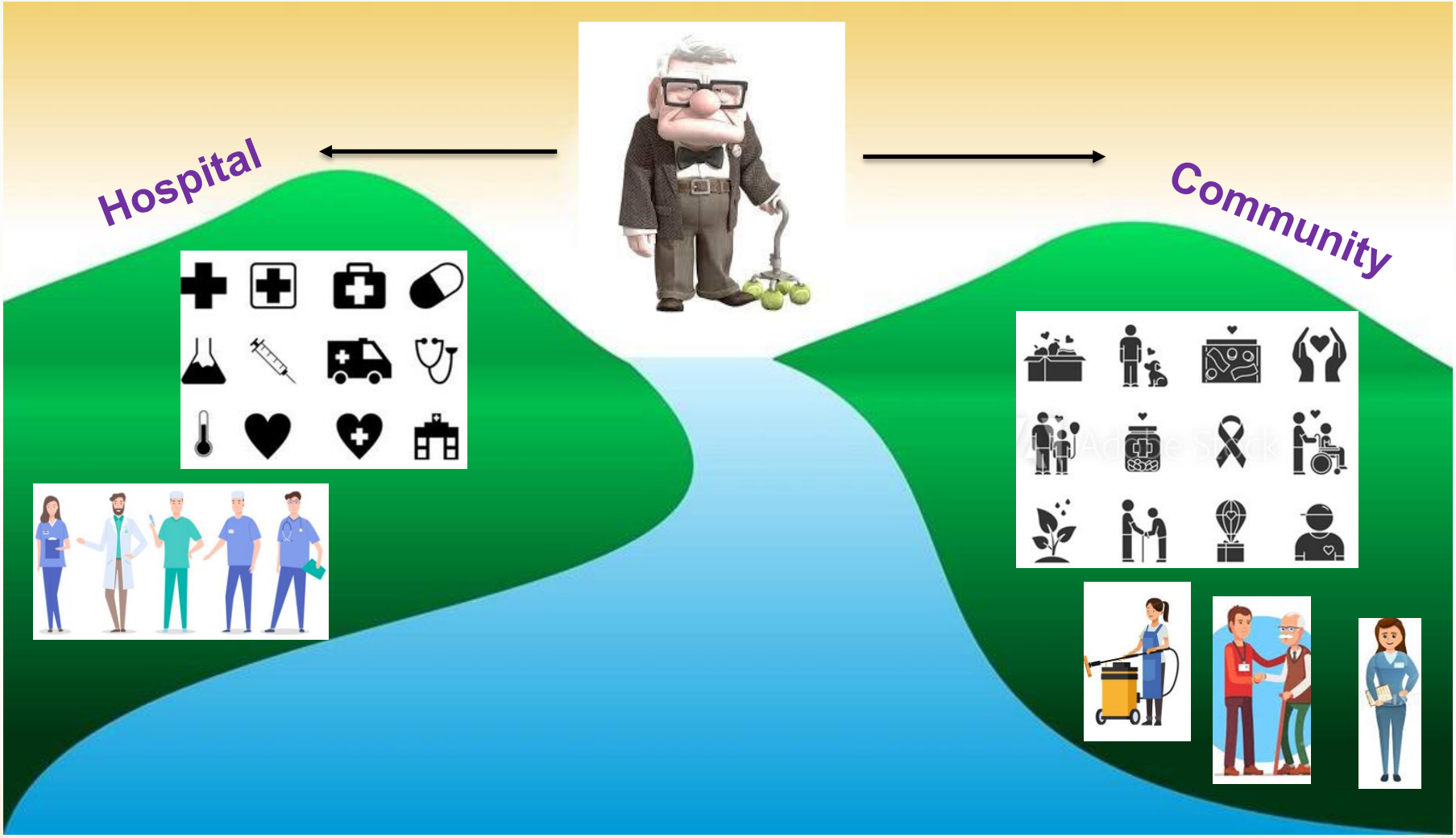

3 “S” Model in Medical Social Collaboration

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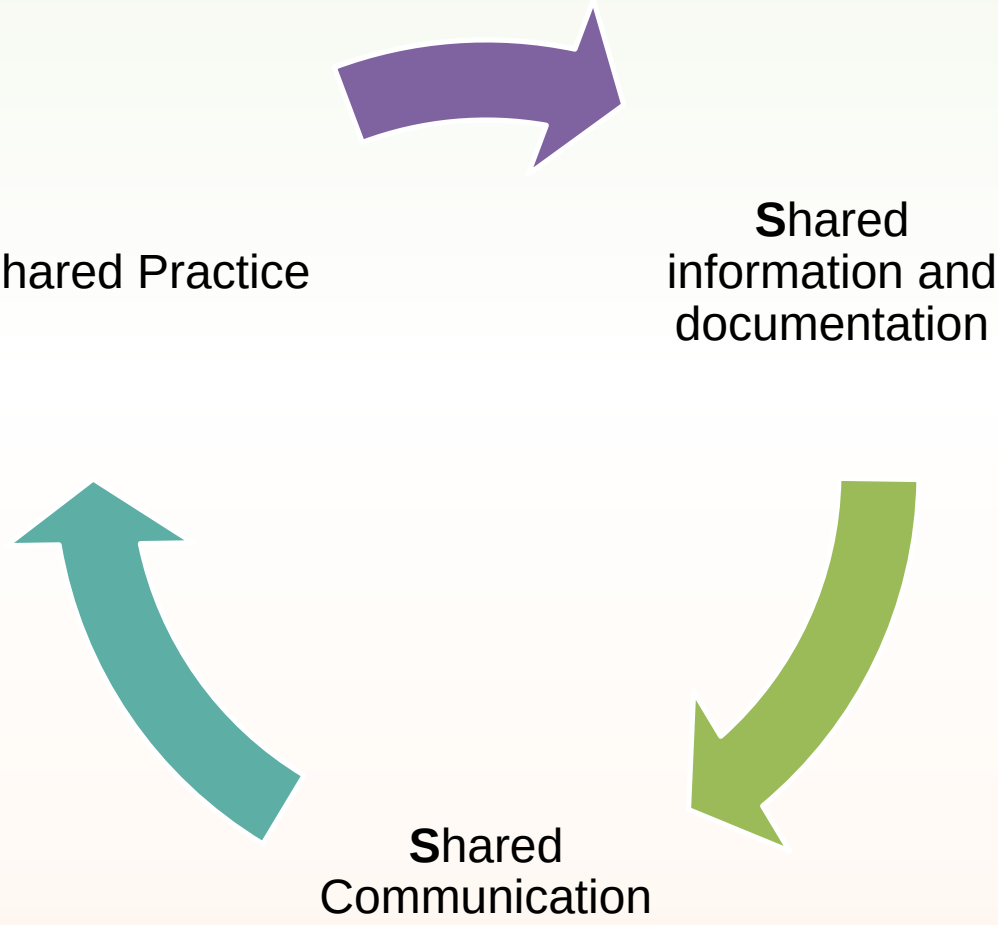

The Story of Ah Fa

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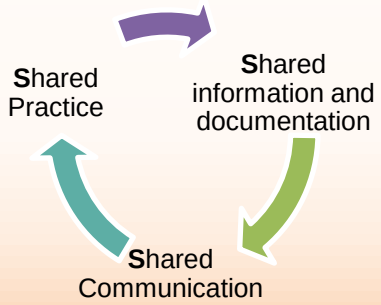
- Female, 90 years old
- Living at home with her daughter who is the main caregiver
- Diagnosed advanced dementia and heart failure
- Suffered from confusion, pain radiation and shortness of breathe
- Severely dependent on most of the activities of daily living
- Home bound
- With depressive mood due to low acceptance of her physical deteriorations



Case identification and referral

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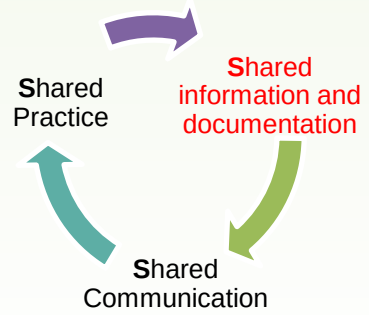
- Geriatric team in the Ruttonjee & Tang Shiu Kin Hospitals referred Ah Fa to the JCECC “Life Rainbow” End-of-life Service in Dec 2019.



Referral Form for Jockey Club End-of-Life Community Care Project (JCECC)

☐ TO: St. James Settlements (SJS) (Phone/Fax: 3974 4640/ 3104 3683 Email: eol@sjs.org.hk)	FROM: Palliative Care/ Oncology of ☐ PYNEH ☐ RTSKH (Phone/ Fax: ____ / ____ Email: ____)
☐ TO: HK Society for Rehabilitation (HKSR) (Phone/Fax: 2549 7744/ 2549 5727 Email: ecc@rehabsociety.org.hk)	FROM: Medical/ Geriatrics of ☐ PYNEH ☐ RTSKH (Phone/ Fax: ____ / ____ Email: ____)

Consent

1. Verbal consent of referral obtained from
   ☐ patient and/or
   ☐ family member: ____
   on ____(date) for patient referral to SJS or HKSR under JCECC and release of the information as listed in the referral form to SJS or HKSR for JCECC enrolment
2. Diagnosis known to patient: ☐ Y ☐ N ☐ Not sure
3. Diagnosis known to family: ☐ Y ☐ N ☐ Not sure

Patient's Personal Information
Name: ____ (Chinese preferred)
Gender: ____ Age: ____ Contact No. ____
Address: ____

Family Member Information
Name: ____ Relationship: ____
Contact No. ____

Medical Background

4. Diagnoses:	5. PPS (%, if any) ____
6. Current Infectious Disease ☐ Y: ____ ☐ N	7. HARRPE score (0-1, if any) ____
8. Mental Illnesses ☐ Y: ____ ☐ N	9. ACP Discussed: ☐ Y ☐ N ☐ Not sure AD Signed: ☐ Y ☐ N ☐ Not sure

Psychosocial Background

10. Psychosocial Spiritual Distress of Patient: ☐ Y ____ ☐ N	11. Psychosocial Spiritual Distress of Family member: ☐ Y ____ ☐ N
12. Suicidal Ideation of Patient ☐ Y ☐ N ☐ Not sure	13. Family Issues: ☐ Y ____ ☐ N ☐ Not sure

Recommended Services

Physical Care	Psychosocial – Spiritual Care	Practical Care
☐ Personal care	☐ For patients	☐ Escort
☐ Education on physical care	☐ For family	☐ ADL/Household chores
☐ Equipment loan	☐ Preparatory ACP	☐ Social Services Navigation

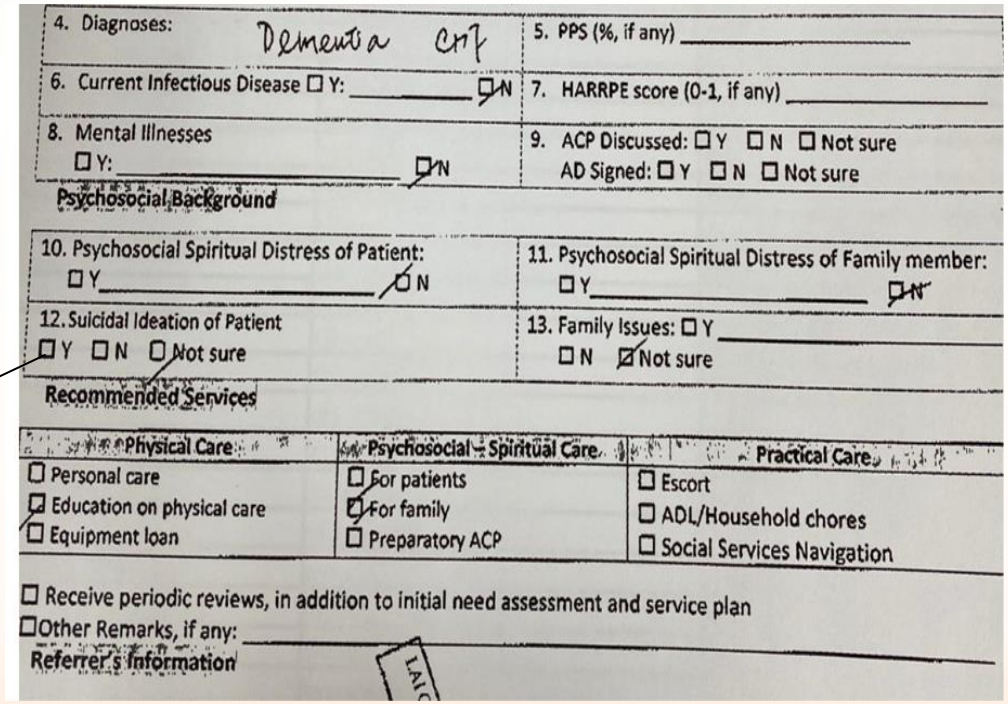
☐ Receive periodic reviews, in addition to initial need assessment and service plan
☐ Other Remarks, if any: ____

Referrer's Information

Contact Person Name/ Post
(if different from referrer) : ____ Contact Number: ____
Referrer's Name/Post: ____ Signature: ____ Date: ____

For Office Use Only Received on: ____ Case No. ____

1



Referral form filled by doctor

Mutual communication on case intervention plan

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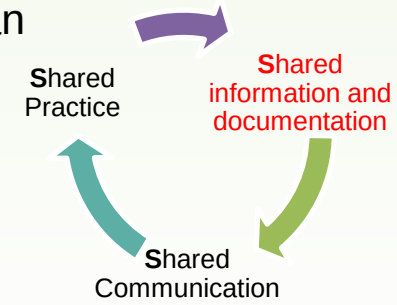
- After conducting case assessment, the case assessment and service plan was sent to Geriatric team in the Ruttonjee & Tang Shiu Kin Hospitals by community social worker.



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Initiated and Funded by: 香港賽馬會慈善信託基金 The Hong Kong Jockey Club Charities Trust

Initial Assessment and Service Plan

☐	TO: Palliative Care/ Oncology of ☐ PYNEH ☐ RTSKH (Phone/ Email: _____ / _____)	FROM: St. James Settlements (Phone/Email: 3974 4640 / eol@sjs.org.hk)
☑	TO: Medical/ Geriatrics of ☑ PYNEH ☐ RTSKH (Phone/ Email: _____ / _____)	FROM: HK Society for Rehabilitation (Phone/ Fax No: 2549 7744 / TBC)

Name of Patient: _____ Case Number: HKSR01-21291

Care Area	Need Level	Service Content			
Physical:	☑Hi ☐ Lo	☑ Personal Care	☑ Patient/ family education on physical care	☑ Equipment Loan	☐ Others: _____
Psychosocial Spiritual:	☐ Hi ☑ Lo	☐ Professional counselling for patients	☐ Education on caring skills & stress management for family members	☐ Facilitation of family communication/ reconciliation	☐ Befriending volunteer support for patients and family
		☑ Preparatory ACP	☐ Others: _____		
Practical:	☑Hi ☐ Lo	☑ Escort	☑ ADL/Household chores	☑ Social services navigation	☐ Others: _____
Service Referral: ☐ Y: _____ ☑ N					

Other remarks:
Contacted daughter for on going caregiving support . Nurse visitation arranged.
Subsidy provided for escort service.
Wheel chair, bathing chair bought for patient.

Care Area	Need Level	Service Content			
Physical:	☑Hi ☐ Lo	☑ Personal Care	☑ Patient/ family education on physical care	☑ Equipment Loan	☐ Others: _____
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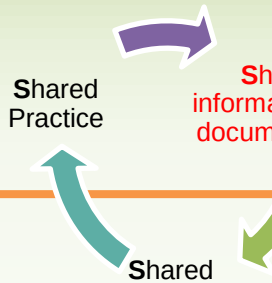
		☑ Preparatory ACP	☐ Others: _____		
Practical:	☑Hi ☐ Lo	☑ Escort	☑ ADL/Household chores	☑ Social services navigation	☐ Others: _____
Service Referral: ☐ Y: _____ ☑ N					

Other remarks:
Contacted daughter for on going caregiving support . Nurse visitation arranged.
Subsidy provided for escort service.
Wheel chair, bathing chair bought for patient.

Case assessment & service plan filled by community social worker

Joint ACP discussion



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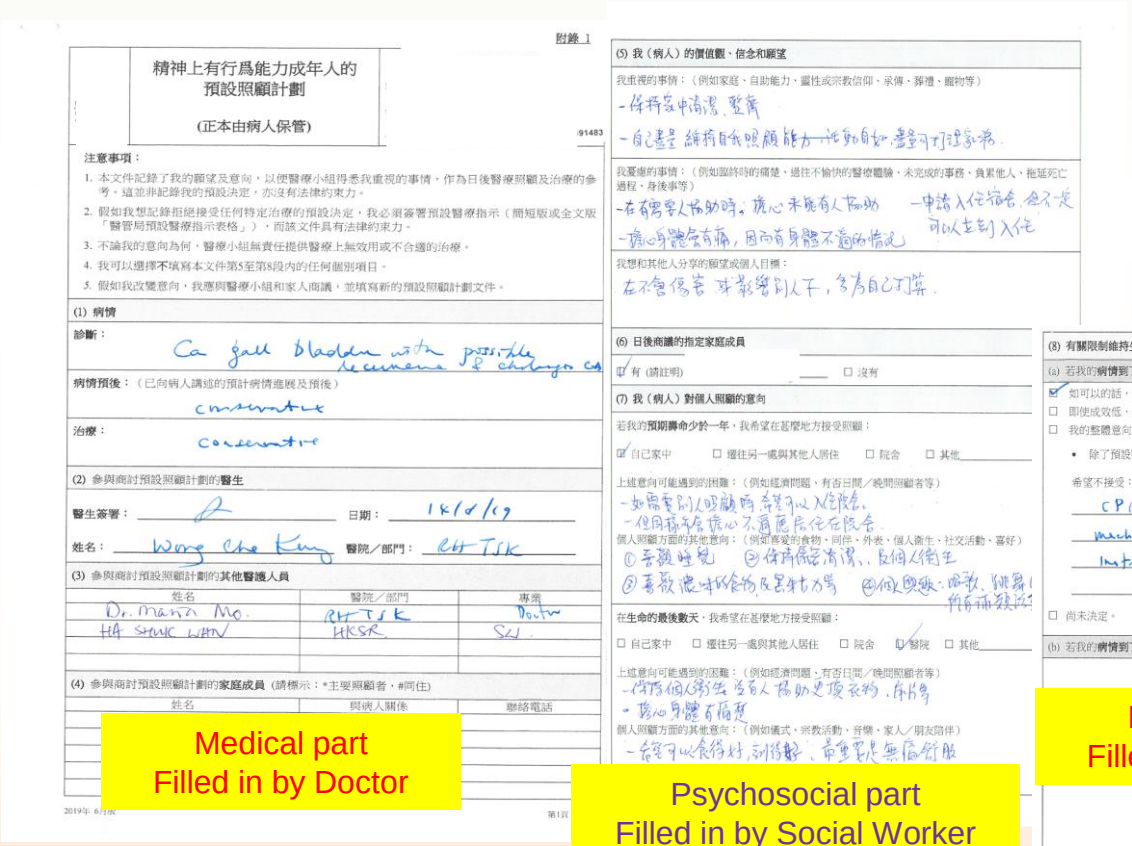
- A holistic completion of ACP discussion was executed with the clear division of work with doctors focused on medical parts and social workers focused on psychosocial parts.



On-Point medical support through medical and social synergy

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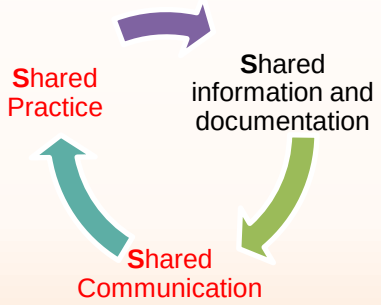
- Home visit by community team can obtain up-to-date information on Ah Fa's conditions and acts a critical role in early problem detection.
- Communication channels was built between medical and community teams. Via phone and online channels, Ah Fa could receive prompt medical support and admission advices from the geriatric team.
- Fast track clinic and admission by appointment could be arranged when necessary to minimize hassles in the A&E.
- Community social worker arranged transport and escort service from home to hospital.



First time going out after years of homebound!

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- Special consultation session was arranged with doctor to assess whether Ah Fa was suitable to go on an outdoor day trip with family and reminders of what needed to be pay attention to during the trip.

- Community team pre-arranged barrier free transport and planned a fun and suitable route. Ah Fa enjoyed the trip a lot and it was an unforgettable memory for her and her family.

Shared Practice

Shared information and documentation

Shared Communication

Living as Ah Fa!

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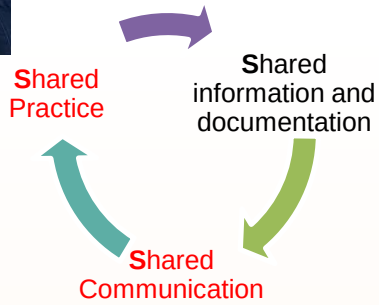
Ah Fa made new friends with volunteer.

Arranged music therapist to sing with Ah Fa!

Bought a geri “armchair” for Ah Fa to relax in safety.

Ah Fa brushing her teeth on her own.



Shared goals to assist Ah Fa to lead a life with happiness and safety through joint signing of ACP in hospital

Farewell Ah Fa

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According to her wish, no intrusive treatment was implemented during her last moments. She died peacefully and in comfort, surrounded by her beloved family.

致 ： 律敦治醫院老人科及香港復康 賽馬會安寧頌生命彩虹計劃

本人的媽媽（ ）剛於最近離逝，而走時也很安祥，非常感恩。

自從媽媽參加了"晚程"計劃後，得到黃醫生、各護士、復康會何姑娘等社工的支援及體貼關顧，包括音樂治療、探訪、物資支援等等，使我媽媽不論在心理或生理都得到很大的舒緩及幫助。

當人去到人生的最後階段，時常要面對心理上及生理上的不同問題，包括孤獨.空虛.身體機能衰退.病痛等等，因此非常渴望處於此階段的能安舒地走完最後一程。

衷心感謝黃醫生、何姑娘及各位的努力及付出，希望"晚程"計劃可以得到更大的推廣，使更多的長者可以受惠！

祝：工作順利，身體健康！

Ho Mei Kuen

女兒-何 敬上

2021年6月7日

Thank you and appreciation letter from Ms.Leung's daughter

Other beautiful stories of medical social collaboration

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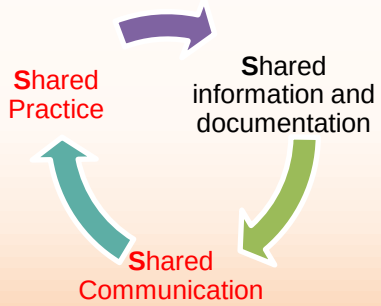
Wish Fulfillment: A patient in hospital was able to attend and witness his favorite daughter's wedding via live broadcast with the joint arrangement of community social worker and ward nurse.



"Having a **life celebration party**" was mentioned in the ACP discussion by a patient who is single. The geriatric team from hospital and community service team co-organized the party for her to farewell her beloved family and friends.

Prerequisite of Medical Social Collaboration

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- Clear shared mission and common goal
- Regular and continuous communication platform and channel
- Engagement in both management and operational levels
- Professional training for both medical and community staffs




Future Prospect

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- Formalize community EoL care as a regular social service in Hong Kong
- Establish a standardized medical social collaboration system in local EoL care
- Improve community engagement in EoL care and empower patients with the rights of “good death”