Advance care planning in elderly care-concerted efforts through medical social collaboration

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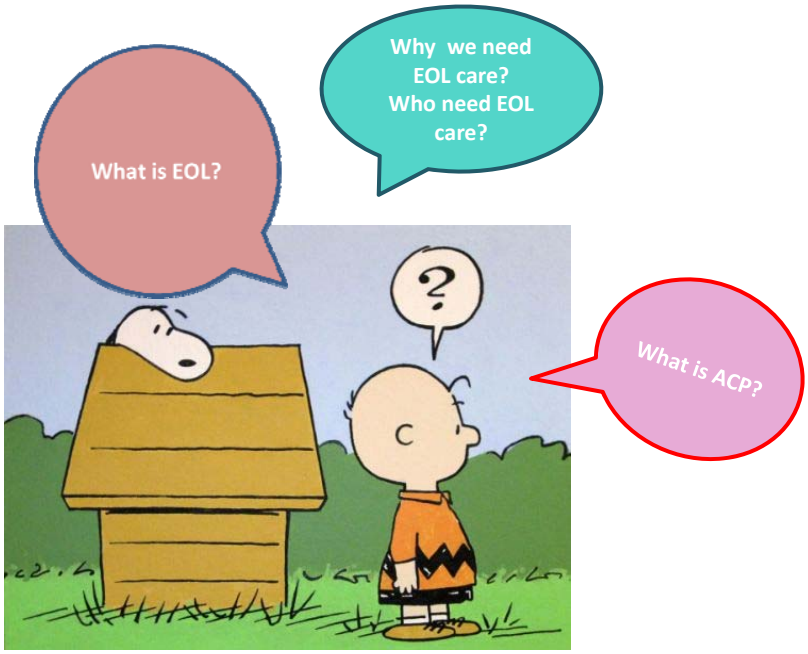


HA guideline

- ACP is a process of proactive communication to bring out a patient's wishes and preferences regarding end-of-life care,
- and is being recognized as an integral part of care for patients with advanced progressive diseases.

Components of ACP conversation

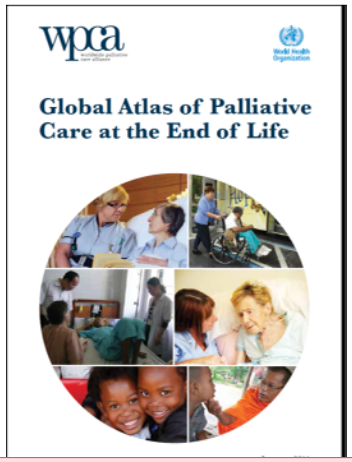
1. Clarify understanding of illness
2. Patient's values
3. Goals of care
4. Treatment options which are desired or not desired
5. Identify patient's wishes
6. Identify proxy health care decision maker

Benefits of ACP

- Communicate future wishes
- Improve patient and family satisfaction
- Alleviate anxiety in relatives
- Prepare for end of life care and death
- Avoid prolongation of dying
- Strengthen personal relationships
- Relieve burdens placed on family

ACP is key to good end of life care
It informs care plan and guides care delivery

Target groups for palliative care



Disease requiring palliative care for adults:

- Cancer
- Alzheimer's and other dementia
- Cardiovascular disease excluding sudden deaths
- Cirrhosis of the liver
- Chronic obstructive pulmonary disease
- Kidney failure
- Multiple sclerosis, Parkinson's disease
- Rheumatoid arthritis
- Drug-resistant tuberculosis

Elderly may be complex due to multi-morbidity, mostly with dementia

End of Life Care

Patient are likely to die within the next 12 months

1) includes imminent death
2) those with
   a) advanced incurable conditions
   b) general frailty and co-morbidity expected to die within 12 months
   c) existing conditions with risk of dying from a sudden acute crisis
   d) life-threatening acute conditions

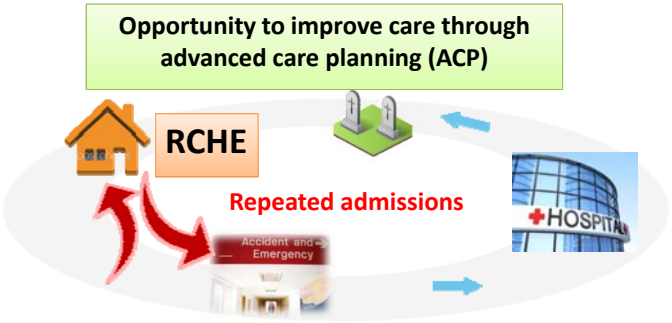
General Medical Council, UK 2010

Triggers for ACP discussion

1. Recent serious illness/major surgery
2. Worsening symptoms/functional decline
3. New diagnoses of life-limiting conditions
4. Irreversible deterioration in the patient's health status
5. Loss of response to complications from disease-specific treatments
6. Expressed desire of the patient or the family to discuss ACP

End of Life Care in Hong Kong

- 90% HK deaths in HA
- 50% who died in Medical beds from RCHE (old aged homes)
- Frequent hospital admission in last few months
- Lack of advance care planning



Slide courtesy of HAHO Geriatric Subcommittee

MEDICAL SOCIAL COLLABORATION FOR ELDERLY END OF LIFE CARE

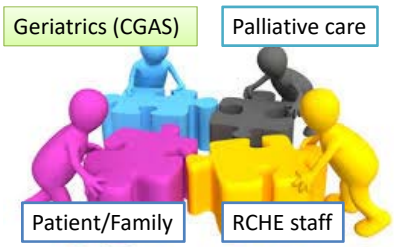
Medical Social Collaboration for Care of Elderly at End of Life

- Surprise question – life expectancy of 6 to 12 months
- Elderly at End of Life are characterised by Medical & Social (Care) Needs
  - Frail and functionally dependent
  - Dementia
  - Multi- morbidity
  - Recurrent hospitalisations
- Medical social collaborative care model from ACP to Care Delivery
  - Multi-disciplinary (with Palliative Care Team)
  - Inter-sectoral (with RCHE staff & NGOs)
- 2015 : HA's CGAT (community geriatrics assessment team)
  End of life program for elderly in residential care home for elderly
- 2019 : JCECC End of life program for those living at home

"Enhancement of CGAT Service for EOL Care in RCHEs"
安老院舍晚期醫護服務

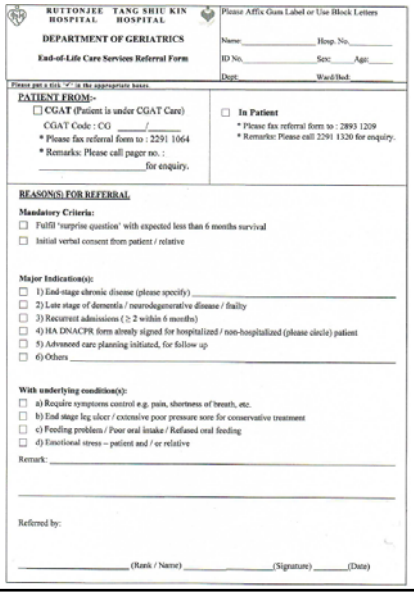
2015

- Objective
  - Provide coordinated & appropriate care to terminally ill residents in RCHEs
- Scope
  - Advance care plan
  - On-site support
  - Direct clinical admission
  - Psychosocial/spiritual support
  - Empower RCHE staff



HKWC CGAS

Case Identification & Clinical Referrals – Criteria



RUTTONJEE HOSPITAL TANG SHIU KIN HOSPITAL

DEPARTMENT OF GERIATRICS

End-of-Life Care Services Referral Form

Please Affix Gum Label or Use Block Letters

Name:_____ Hosp. No.:_____

ID No.:_____ Sex:____ Age:____

Dept:_____ Ward/Bed:_____

Please put a tick "✓" in the appropriate boxes.

PATIENT FROM:-

☐ CGAT (Patient is under CGAT Care)

CGAT Code : CG _____/_____

* Please fax referral form to : 2291 1064

* Remarks: Please call pager no. : _____ for enquiry.

☐ In Patient

* Please fax referral form to : 2893 1209

* Remarks: Please call 2291 1320 for enquiry.

REASON(S) FOR REFERRAL

Mandatory Criteria:

☐ Fulfil 'surprise question' with expected less than 6 months survival

☐ Initial verbal consent from patient / relative

Major Indication(s):

☐ 1) End-stage chronic disease (please specify) _____

☐ 2) Late stage of dementia / neurodegenerative disease / frailty

☐ 3) Recurrent admissions (≥ 2 within 6 months)

☐ 4) HA DNACPR form already signed for hospitalized / non-hospitalized (please circle) patient

☐ 5) Advanced care planning initiated, for follow up

☐ 6) Others _____

With underlying condition(s):

☐ a) Require symptoms control e.g. pain, shortness of breath, etc.

☐ b) End stage leg ulcer / extensive poor pressure sore for conservative treatment

☐ c) Feeding problem / Poor oral intake / Refused oral feeding

☐ d) Emotional stress – patient and / or relative

Remark: _____

Referred by:

_____ (Rank / Name) _____ (Signature) _____ (Date)

- Prognostication
- Surprise question
- Challenging in elderly

- Any existing tools for screening we could use ?

- Hospital Admission Risk Reduction Program for the Elderly (HARRPE Score)

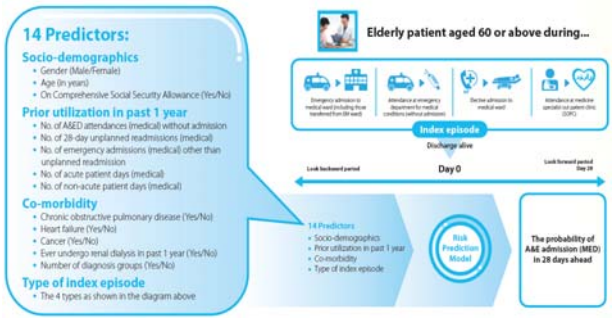
Risk Prediction Score

Hospital Admission Risk Reduction Program for the Elderly living in the community (HARRPE Score)

✴ Predicts probability of readmission eg 0.4 means 40% chance of readmission within 28 days

✴ Automated and available - Used for HA programs eg Integrated care model and Patient Support Call Centre.

✴ Clinical observation : suggested higher scores correlated with mortality



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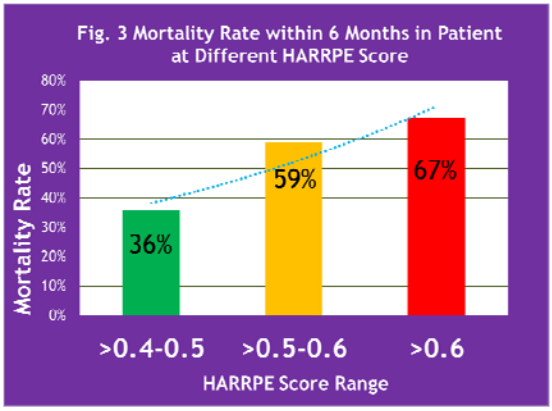
Hypothesis tested in Study by using HARRPE Score to identify High Risk Elderly for Advance Care Planning

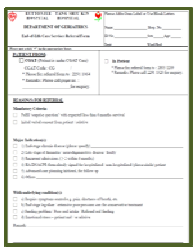
Objective (1) To correlate HARRPE scores with mortality



Objective (2) To test its practical use by CGAS Nurses in case identification for ACP and CGAS EOL Program in Residential Care Homes of the Elderly (RCHE)

Under HKEC CGAT cover

Check patient's medical history in CMS which under CGAT FU



Meet EOL criteria

Visit Patient at RCHE or ward

Contact RCHE and patient's relative for EOL introduction

ACP in RCHE setting – engage relative and RCHE staff

- Engage relative & RCHE carer to formulate the advance care plan
- Respect what patient would have chosen according to relative or best interest principle for medical treatment and other wishes

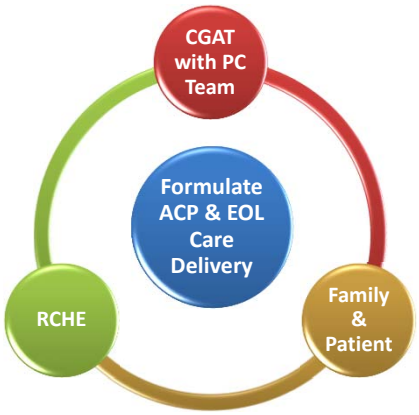
Medical social collaboration for CGAS End of Life Program

Conjoint efforts in ACP

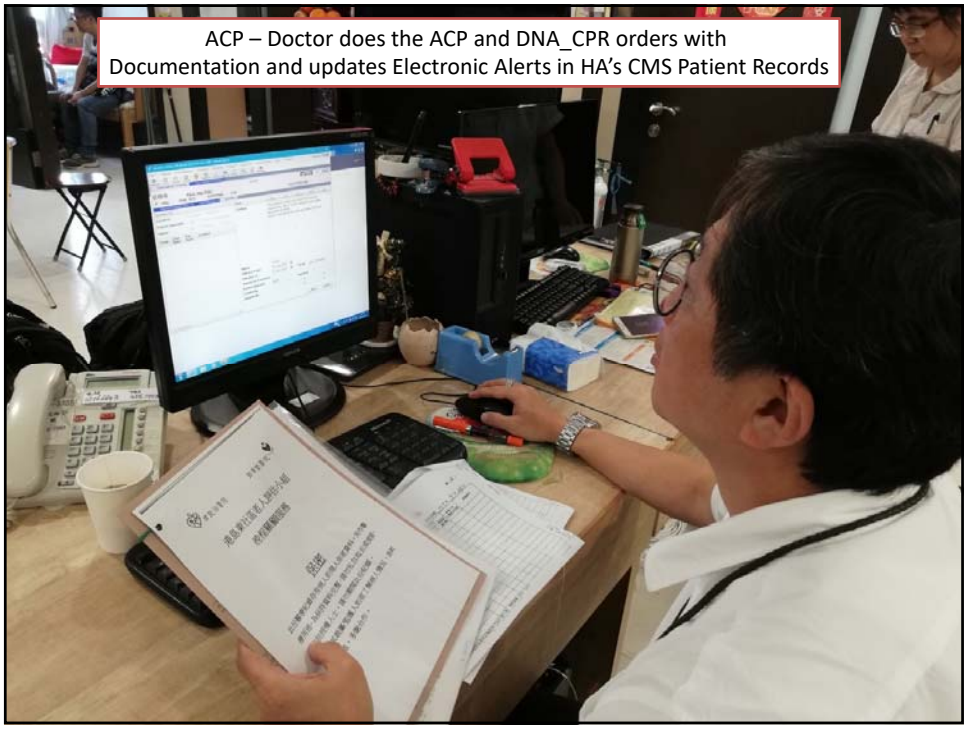
Symptom assessment

<u>RCHE staff help</u>

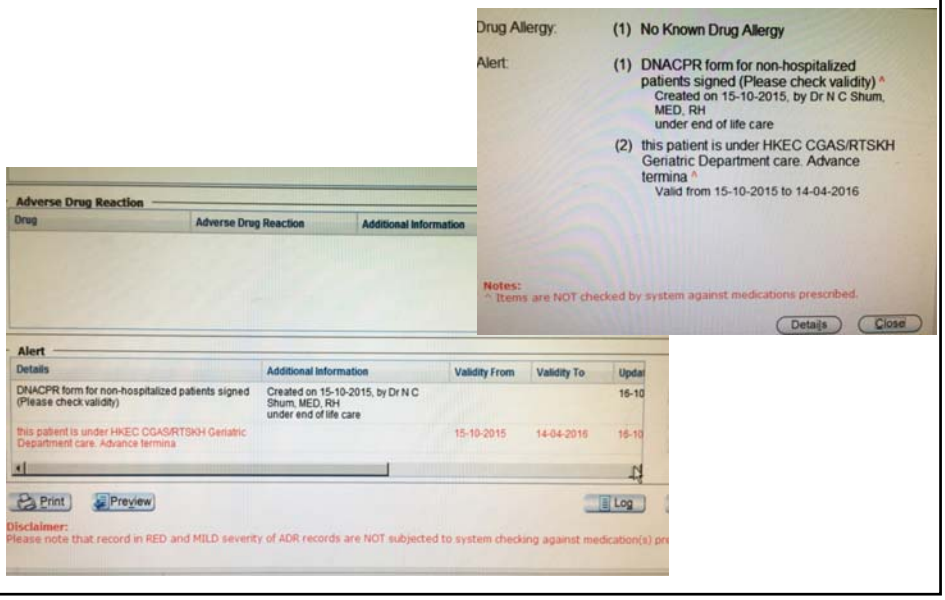
- Identify eligible patients
- Conjoint efforts in ACP
- Keeps ACP for resident
- Ensures ACP is brought to HA
- Monitor and alert CGAS for timely symptom management
- Contact CGAS EOL nurse & ward based EOL Hotline
- Facilitate communication with relatives



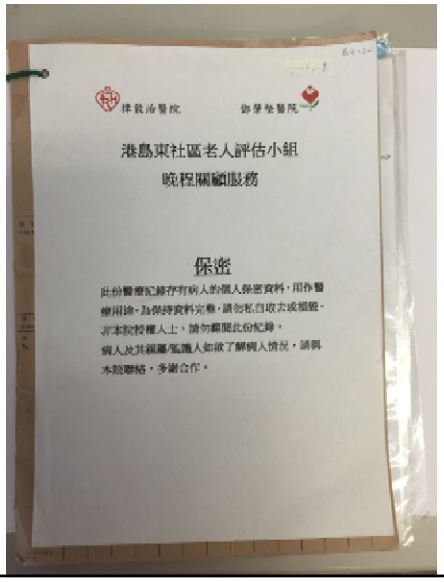

ACP - Nurse Provides Education to Inform Choice for Treatment Options
港島東社區老人評估小組
安老院舍晚期醫護服務
人生是不斷的取捨
取是一種本事
捨是一種哲學
放下自己是智慧
放下別人是慈悲
主要的醫療程序
心肺復甦術
心外按壓
第二章
提出田須急救指示前你不能不知的急救程序
人工輔助呼吸
非入侵性的「人工輔助呼吸」
第二章
提出田須急救指示前你不能不知的急救程序
心臟去顫術（電擊法）
血管加壓素

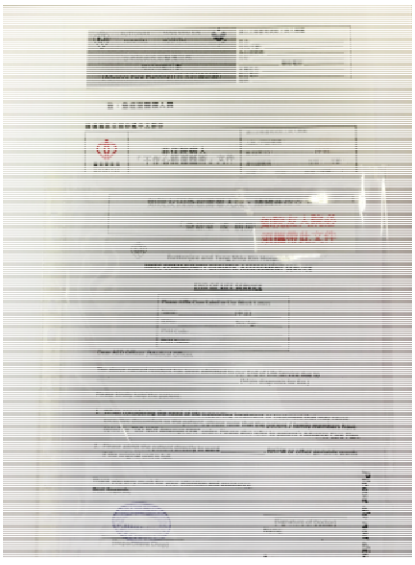

ACP – Doctor does the ACP and DNA_CPR orders with
Documentation and updates Electronic Alerts in HA's CMS Patient Records

CMS Alert



Documentation and EOL folder – communicated to hospital wards and A&E dept

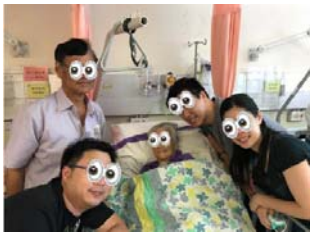




Subsequent to ACP – supporting relatives in ward setting

CGAS admission to designated EOL beds with trained staff

- Trained staff with expertise in geriatric care end of life
- Flexible visiting hours
- Life story book by Ward A3 & B3 at RTSKH



Future Enhancement
Medical Social Collaboration

- 2018-19 Government funded SWD – NGO led MOSTE (multi-disciplinary outreach support team for elderly) to RCHEs
- Engage MOSTE social worker to collaborate in CGAS EOL care

- Objectives
  - Arrange volunteers to visit RCHE EOL patients
  - Eg To facilitate life story book and better understanding of the person, assist in ACP process

Medical-social collaboration with MOSTE: Project On Life Story Booklet

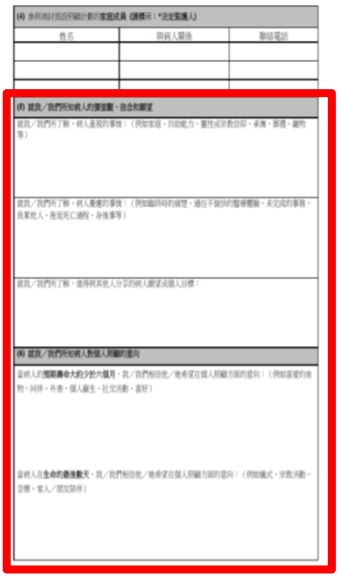
循道衛理中心安老院舍外展專業服務試驗計劃
(Methodist Center)

社會福利署銅鑼灣綜合家庭服務中心
(Integrated Family Service Center)

Medical
- ACP / EOL care
- Training
- In-patient

Social
- Volunteer network
- Home visit
- Community

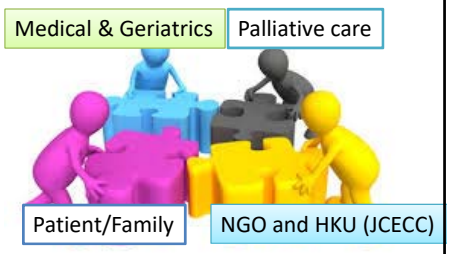
Values and personal wishes - ACP Form



End of Life for Elderly living at Home
cal social care with JCECC and HK Society of Rehabilitation

2019

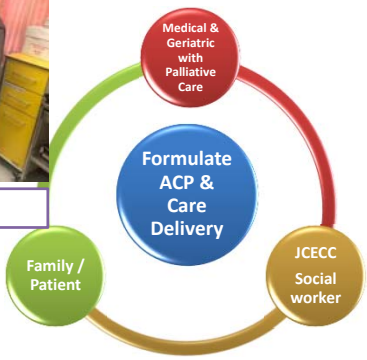
- Objective
  - Provide coordinated & appropriate care to terminally ill elderly living at home
- Scope
  - Advance care plan
  - On-site support
  - Home personal care
  - Psychosocial/spiritual support
  - Practical support eg transport
  - Respite care



HKWC CGAS

Medical social collaboration for Elderly living at Home (JCECC)

Conjoint ACP



Social worker from HKSR (JCECC) visit elderly in ward

JCECC Referral Form

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

☐ TO: St. James Settlements (SJS) (Phone/Fax: 3974 4640/ 3104 3683) FROM: Palliative Care/ Oncology of ☐ PYNEH ☐ RTSKH (Phone/ Fax: ____ / ____)

☐ TO: HK Society for Rehabilitation (HKSR) (Phone/Fax: 2549 7744/ 2549 5727) FROM: Medical/ Geriatrics of ☐ PYNEH ☐ RTSKH (Phone/ Fax: ____ / ____)

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

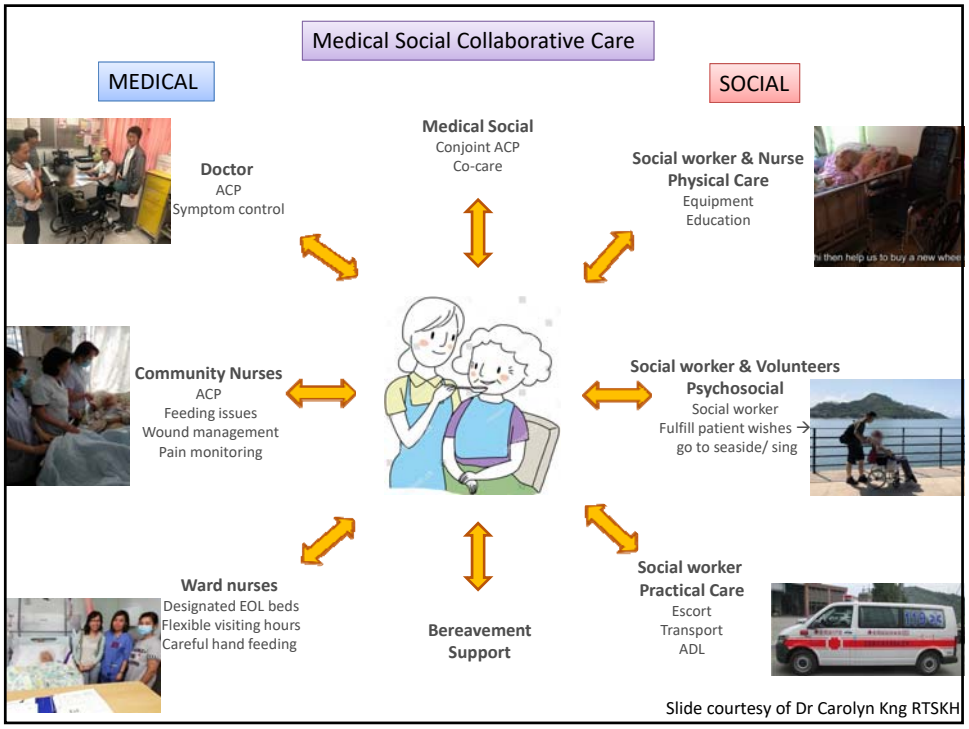
EOL Care– Only one chance to get care right

Building capacity through co-care for a good death

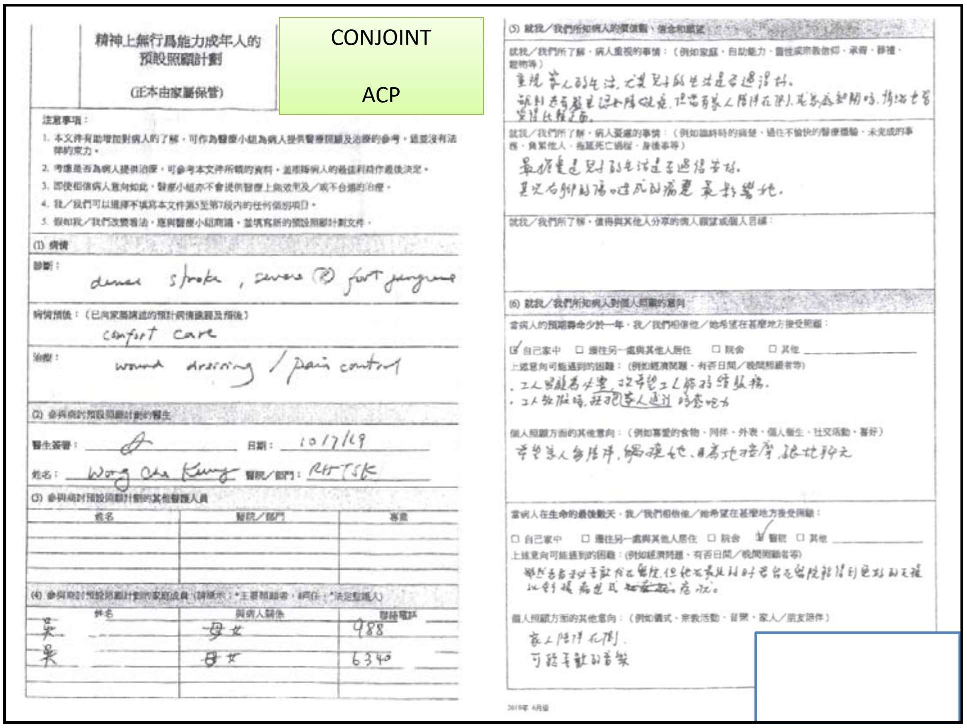
- Background - Mdm Chan has advanced dementia, gangrenous left foot along with multi-morbidity and is totally care dependent. This year, she had 4 admissions for infected foot with cumulative hospital stay of 155 days. Her daughter declined operation for amputation with each hospitalisation. A community nurse provided care of her foot
- Seen at geriatric outpatients, she agreed to an advance care plan (ACP) and referral to NGO providing home based end of life support.

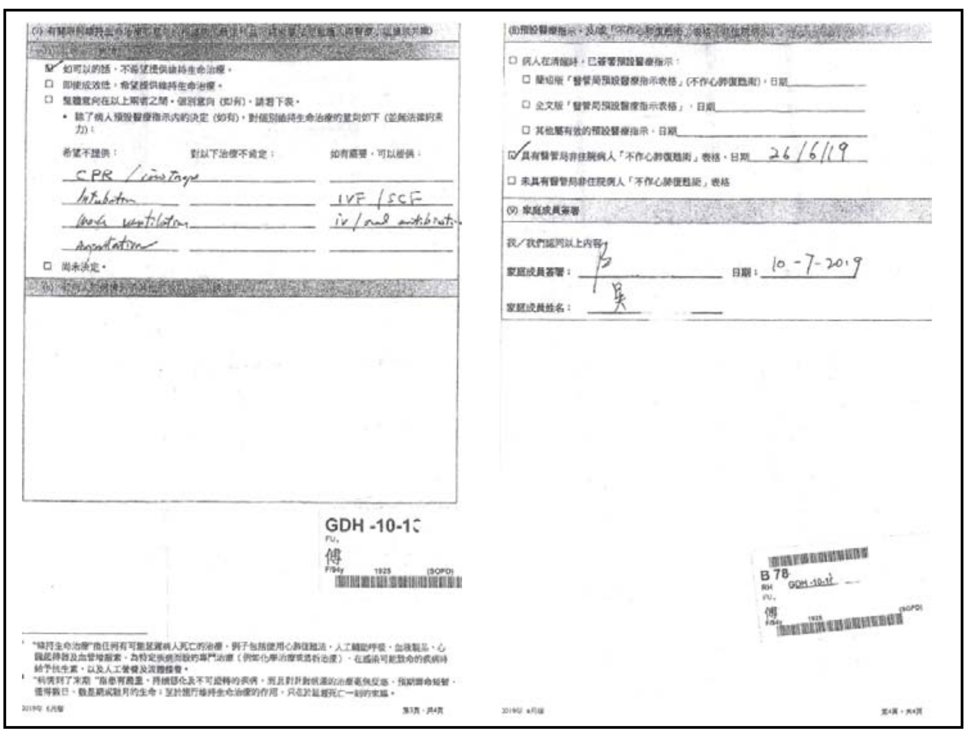
- Co-care begins with conjoint ACP
  - NGO social worker and HA geriatrician conjointly completed the ACP with her at GDH. Social worker could explore values and geriatrician explain treatment options
- Care delineation
  - **Medical**
  - titration of pain relief and foot care by geriatrician and community nurse, working closely with NGO. Community nurse contacted the geriatrician for symptomatic treatment such as infection or pain.
  - Coordinated Admission to designated bed, where flexible visiting and other end of life care protocols, access to psychosocial and spiritual care for appropriate care.
  - **Social** - NGO's nurse and social worker provided home care, transport and psychosocial support at home
- Multidisciplinary input at interdisciplinary palliative care and geriatrics case conference. Her daughter appreciated deeply the end of life care support for her to care for her mother, without recourse to admissions.

Slide courtesy of Dr Carolyn Kng RTSKH



Slide courtesy of Dr Carolyn Kng RTSKH


精神上無行為能力成年人的
預設照顧計劃
(正本由家屬保管)
CONJOINT
ACP
注意事項：
(1) 病情
診斷：
病情預後：
comfort care
治療：
wound dressing / pain control
(2) 參與商討預設照顧計劃的醫生
醫生簽署：
日期：
10/7/19
(3) 參與商討預設照顧計劃的其他醫護人員
(4) 參與商討預設照顧計劃的家庭成員
(5) 就我／我們所知病人的價值觀、信念和願望
(6) 就我／我們所知病人對個人照顧的意向
自己家中
院舍
其他


如可以的話，不希望提供維持生命治療。
即使成效低，希望提供維持生命治療。
尚未決定。
CPR / Cardiac massage
Intubation
Mech ventilation
IVF / SCF
(8) 預設醫療指示，及或「不作心肺復甦術」表格
26/6/19
(9) 家庭成員簽署
家庭成員簽署：
日期：
10-7-2019
家庭成員姓名：
GDH -10-1

Video sharing

- https://drive.google.com/open?id=1LBmfoHzRH6HSCo6k4wBMHVnYFeqC54aY
- https://drive.google.com/file/d/15jesnLvKrkBTHDCQuA404XSuxg_ecdyD/view?usp=drivesdk

Summary

1. Right patient
2. Right time
3. Individualized
4. Realistic care goal
5. Integrate relevant services and resources
6. Balance from 'over- medicalising' EOL care
7. Innovate with care models bridging medical social interface
8. EOL care – only one chance to get it right

Acknowledgements

- All our patients and relatives who consented to share their stories and photos
- HKEC CGAS and RTSKH Geriatrics Teams
- JCECC & HKU – Prof Cecilia Chan, Dr Amy Chow and Diane Yat
- HK Society of Rehabilitation
- HKEC RCHE operators
- Dr Shum NC (private geriatrician)


港島東醫院聯網醫社合作研討會
14th HKEC Symposium on Community Engagement 2019