

Collaborative Care Model for End-of-Life: Dying in Residential Care Home

Presentation No.: F8.6

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Introduction

- Amendment of the Coroners Ordinance in June 2024
- Death of residents in residential care home for the elderly (RCHEs) are no longer required to be reported
- Dying in RCHEs is challenging due to insufficient support
- Most of RCHE residents with terminal conditions die in hospital
- Strengthen the capacity of RCHEs through collaboration between hospital and RCHEs to facilitate dying in RCHEs

Collaboration for End-of-Life Care



- Since August 2024, collaboration among
 - Hong Kong East Cluster Community Geriatric Assessment Team (CGAT)
 - A residential care homes for the elderly (RCHE)
 - Jockey Club End-of-Life Community Care Project (JCECC) End-of-life team



Collaborative Care Model for EOL Care for RCHE Residents

Resident with advanced irreversible chronic medical illness under HKEC CGAT EOL care with ACP and non-hospitalized DNACPR order established

JCECC district based EOL team discusses with resident and family for DNACPR in RCHE, ACP, and option of dying in place

Care is provided by HKEC CGAT according to “needs-based coding system”:

- Green: relatively stable, regular follow-up + ad hoc consultation
- Yellow: deteriorating, at least 2 weekly follow-up + ad hoc consultation
- Red: final days of life

Regular assessment and communication are maintained among CGAT, JCECC, EOL team, RCHE, and the patient / family

During resident’s final days of life (Red code)

Preference for dying in hospital

Admission to a geriatric ward as arranged by CGAT

Preference for dying in RCHE

Care is provided in EOL room in RCHE

- CGAT transfers resident’s care to community doctor and nurse

Resident died

- Death is certified by the community doctor
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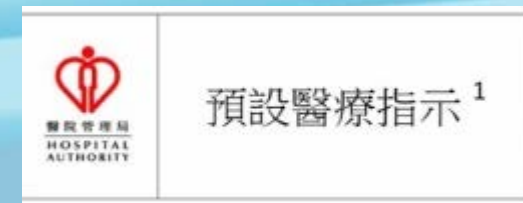
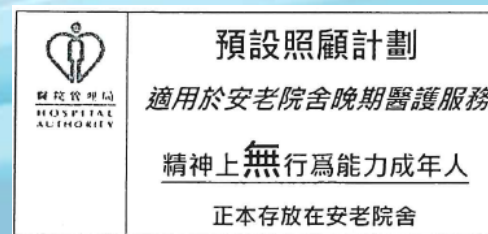
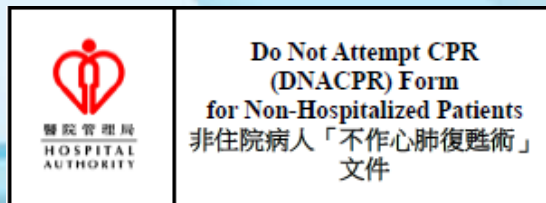
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Collaborative Care Model

Hong Kong East Cluster CGAT

- RCHE residents with advanced irreversible chronic medical illnesses and cancer for end-of-life (EOL) care
- Family conference
 - goal of care, psychosocial and spiritual needs
 - advanced care plan (ACP)
 - non-hospitalized Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)
 - advanced directive if cognitively intact



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Collaborative Care Model



- RCHE supported by JCECC EOL team
 - After CGAT EOL recruitment, discuss with patient and family for ACP, DNACPR in RCHE and option of dying in place
 - Assistance in logistic arrangement for funeral services
 - JCECC support medical and nursing care in the final days of life for residents dying in place

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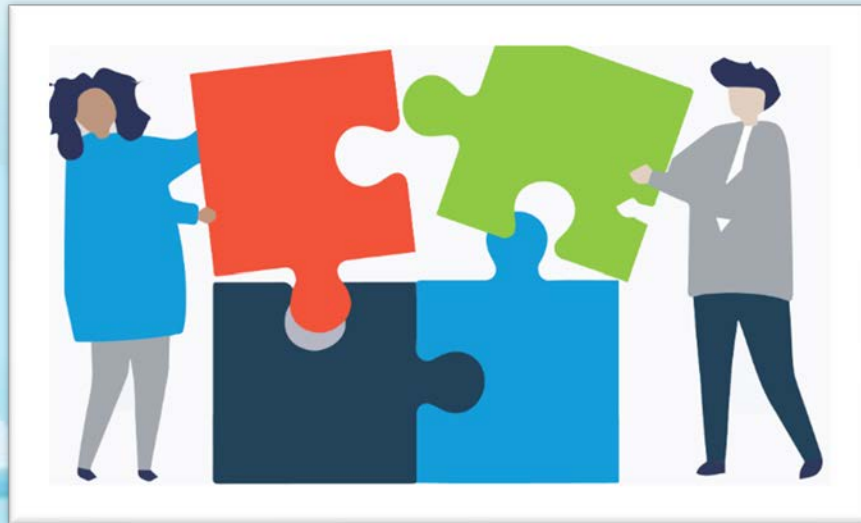


Care by CGAT

- “Needs-based coding system” from Gold Standard framework for EOL care (UK)
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- Guidelines for management of common symptoms in RCHE
 - Feeding difficulties, shortness of breath, pain, delirium

Collaborative Care Model

- Counselling and spiritual support to prepare for dying process are reinforced
- Regular assessment and communication among resident's family, CGAT, RCHE, JCECC EOL team are maintained



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Collaborative Care Model

After resident died

- Bereavement support and care for the family are provided



Evaluation of Collaborative Care model

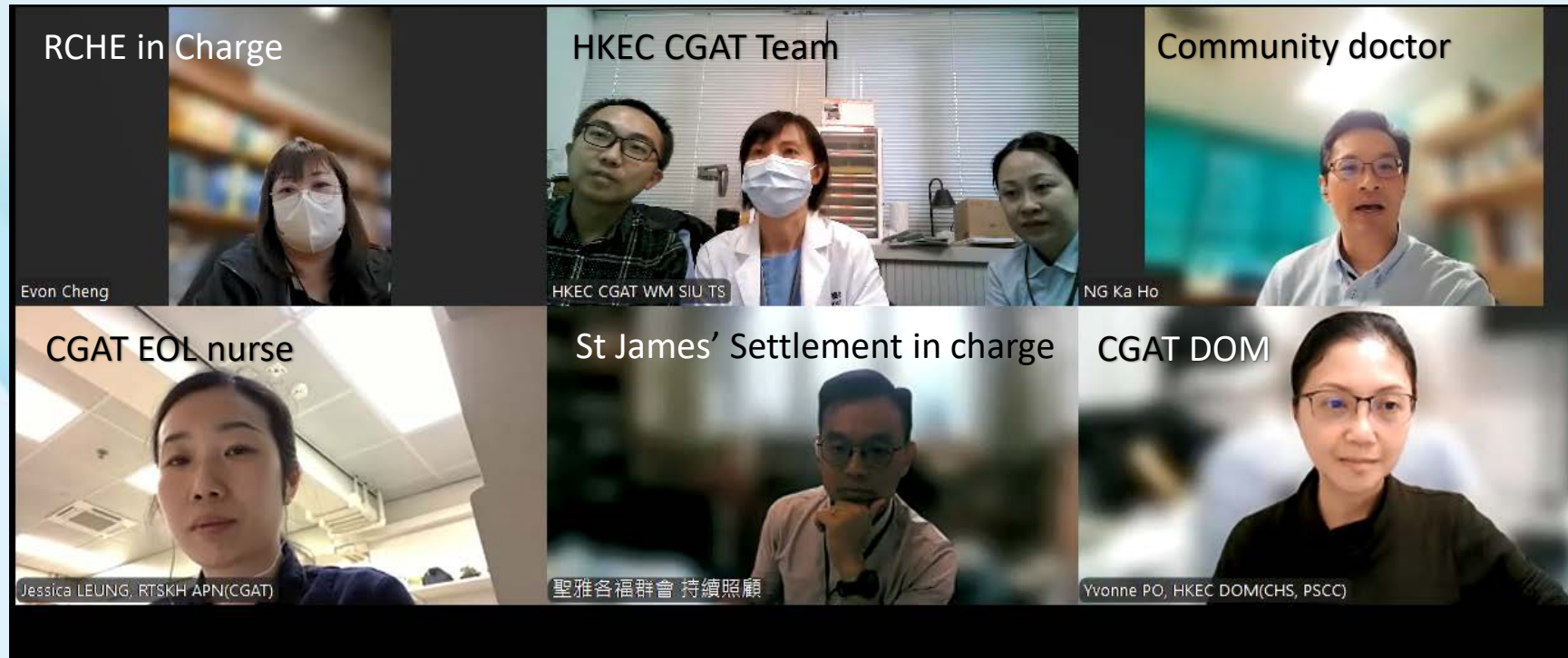
Up to 31st March 2025 since collaboration in August 2024

- Total 5 residents died
 - 4 at RCHE
 - 1 in hospital
- No. of hospital admission prior to death since collaboration in August 2024
 - 3 residents had no admission
 - 2 residents had one admission
- No. of residents under EOL care at present
 - 24 residents and 9 of whom opted for dying in RCHE



Evaluation of Collaborative Care Model

- An evaluation meeting with CGAT, JCECC an RCHE staff



Conclusion

- Collaboration between hospital and community sectors in EOL care makes dying in RCHE a viable option for residents with terminal illness
- Implementation of EOL care with dying in place facilitate a good death while reducing AED attendance and hospitalization



Thank you