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 The Hong Kong Jockey Club Charities Trust
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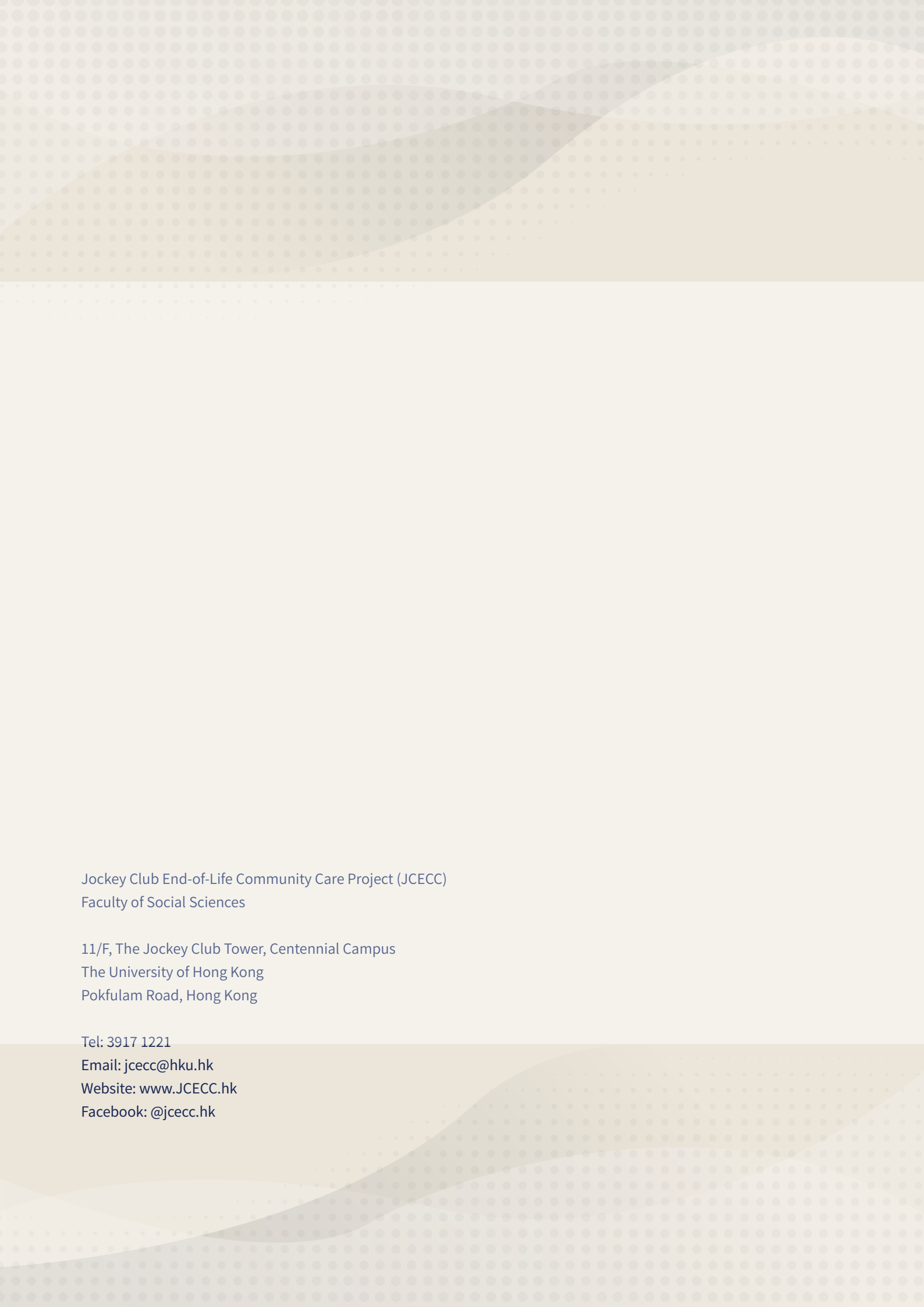
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Message from the Project Director

I am so grateful to the continuous trust and unfailing support of The Hong Kong Jockey Club Charities Trust in deputising me to direct the Jockey Club End-of-life Community Care Project. The project advances and extends for another three years. Amalgamating the strengths of the different models by the NGOs in the first half of the project, a new model of Integrated Community End-of-life Care Support Team (ICEST) is co-created. The focus of the second half of the project is to refine this unified model, hoping to serve more community-dwelling patients and families touched by terminal illness efficiently, effectively and with impact. Another arm of care model for patients in residential care homes for the elderly (RCHes) is developed by the Hong Kong Association of Gerontology. Utilising systematic and rigorous methods, the project is evaluated from a 360-degree perspective and expectantly develops the best-practice model for community end-of-life care in Hong Kong, if not around the world.

Human capital is the most essential asset and change agent in the community end-of-life care. The project is committed to building capacity of the healthcare and social care workers as well as the public in assembling an end-of-life friendly and competent community. The capacity building programmes evolve from classroom teaching to flipped classroom model by adding an online mode to accommodate the busy schedule of healthcare and social care workers. The content of the programmes is carefully crafted from evidence-based materials around the world and shaped within the local context. The project develops curriculum for our healthcare and social care workers-to-be to implant the end-of-life care seeds in our younger generation.

Since the extension of the project, we are facing unprecedented challenges. In particular, our lives are radically reshaped by the COVID-19 pandemic. While observing social distancing, we spent more time with our family members, surprisingly. We have meals at home more often and routinely watch the news reports of the pandemic together. Death is no longer a stranger and avoidable topic. This period is the most favourable moment for family members to address “the elephant in the room” and to share about preferences, values and wishes of end-of-life decisions. Looking back, the JCECC team’s education effort in 2019 is focused on end-of-life decisions. In response to the public consultation on End-of-life Care, the team collaboratively organised a series of public education programmes on End-of-Life Care and Advance Directives with the Food and Health Bureau (FHB). I hope all these initiate a timely impetus for family members to have meaningful communications on these crucial topics.

The teammates and volunteers of NGOs partners are not disheartened by the challenges induced by the social distancing policy. Instead, they flexibly found alternative ways to support families in the community in a timely and appropriate manner. I would like to salute to all the teammates in the project, for their contribution to the holistic well-being of families with patients in their end of life.

Death is an inevitable life event. Literally, everyone is or will be a recipient of end-of-life care. At the same time, everyone can be a provider of end-of-life care. Let’s join hands in building an end-of-life friendly and competent community to farewell those going to depart the same way as we welcome them to this world!

Professor Amy Chow

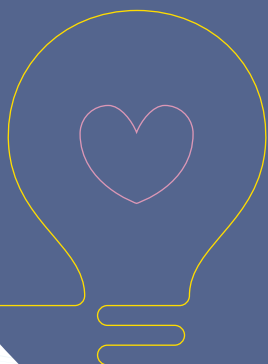
Project Director, JCECC

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Life is full of uncertainties but death is certain.

When death is anticipated in a foreseeable future, how can we plan for it? Do we want to learn about the prognosis, clarify options of treatments and their effectiveness and potential side effects? Do we have the autonomy over what treatments to take or to reject, especially those life sustaining treatments (LST) that cannot cure the irreversible illness but only to prolong the death process?



Before it's too late when we become mentally incapable or too frail to speak for ourselves, we need to communicate our wishes, values and preferences with our families and friends, as well as the healthcare team in advance. Not only are we exercising our autonomy over our own lives, but also we are excusing our loved ones from painfully guessing our preferences and avoiding potential conflicts among family members over these difficult end-of-life decisions.



Advance Directives (AD) and Advance Care Planning (ACP) in Hong Kong

The purpose of Advance Directives (AD) and Advance Care Planning (ACP) is to help patients, family members, related healthcare and social care professionals to communicate and plan for end-of-life care (EoLC). The term “advance” highlights that the plans or decisions are made in advance when the patient is mentally competent in preparation for the time when he/she is no longer mentally competent. AD is a written statement refusing futile LST; and ACP is a communication process, in which the patient can express values, wishes and preferences for future medical and personal care.

To be made in advance when patient is mentally competent in preparation for the time when he/she is no longer mentally competent

ACP

- ▶ Communication process with patients, family members and health social care professionals
- ▶ About values, wishes and preferences of care plan

AD

- ▶ Written document
- ▶ About medical treatments

According to the consultation document on EoLC (FHB, 2019), back in 2004, the Law Reform Commission of Hong Kong (“LRC”) kicked off public discussion on AD. In 2006, it recommended the Government to promote the concept of AD under common law framework instead of by legislation, and to review the issue again when the community is more widely familiar with the concept of AD. In response, the Food and Health Bureau (FHB) developed guidelines for medical and relevant professions on making and handling of AD in 2009. In 2010, Hospital Authority (HA) issued the Guidance for HA Clinicians on Advance Directives in Adults and in 2014 HA further included family members of mentally incompetent or minor patients in the ACP discussion. In the same year, HA extended the *Guidelines on Do-Not-Attempt Cardiopulmonary Resuscitation (DNACPR)* to seriously ill non-hospitalised patients. In 2019 June, HA revised the ACP forms to address patient’s psychosocial and spiritual needs. In September the same year, the Government launched a public consultation on EoLC regarding the legislative proposals on Advance Directives and Dying in Place.

Food and Health Bureau (2019). End-of-Life Care: Legislative Proposals on Advance Directives and Dying in Place.



JCECC Synchronised Efforts to Promote ACP and AD

Riding on the public consultation to create momentum for ACP and AD discussions, JCECC initiated and organised a series of capacity building activities to raise public awareness and facilitate discussion among policy makers, healthcare and social care professionals on the topic.



For Professionals

October 24,
2019



JCECC held a symposium with HA as the supporting organisation.

Concerted Efforts in ACP – Regional and Local Experiences

The objectives are to understand the current landscapes, challenges and developments of ACP in Asia; and to explore the redefinition of ACP facilitation using an inter-disciplinary approach. A total of 260 people attended the symposium, of which 43% were healthcare professionals, 28% were social care professionals, 12% academics and 17% others including legal practitioners, financial planners and caregivers. The symposium was very well received as informative, inspiring and well organised.

Of the 84 evaluations received, 93% respondents were satisfied or very satisfied with the symposium, 95% agreed or highly agreed that speakers as knowledgeable and 92% respondents would recommend others to join JCECC activities in future. A number of participants showed interests in learning more about ACP implementation in the future.





Overseas speakers included Professor Deng Renli from Zhuhai and Ms Chee Wai Yee from Singapore. Local speakers included Ms Amy Yuen from FHB, Dr Sin Ngai Chuen and Dr CK Wong from HA and Professor Amy Chow from The University of Hong Kong (HKU). Panel discussion moderators were Professor Yeoh Eng Kiong and Dr Helen Chan from The Chinese University of Hong Kong (CUHK). Developments of ACP were looked into from different perspectives, including public policy, medical and social collaboration and public engagement. The three Chinese communities started promoting ACP at various speed, breadth and depth; and the symposium served as a platform for exchanging valuable experiences. Information of the symposium can be found at: www.JCECC.hk/sym2019. Ideas and the learnings of the symposium were summarised as follows:

1 From Medical AD to Holistic ACP

In Hong Kong, discussion on AD legislation went back to 2004. Although by then, the decision was to put AD under the common law framework. The government is now proposing making AD a legislation to encourage healthcare professionals to initiate discussion of AD with patients and to avoid conflicts with other legal statutory provisions including the Fire Services Ordinance and the Mental Health Ordinance. In Singapore, the Advance Medical Directive (AMD) Act was put in place in 1996. Realising AD mainly addresses the medical aspects, the care professionals saw the need to have good conversations to provide holistic care options. The concept of ACP was introduced and advocated. In 2011, Singapore rolled out the National ACP Movement and formed the ACP National Office to promote ACP using the framework of “Living Matters”. Professor Amy Chow too proposed an ACP facilitation model which emphasised to take care of the physical, practical and psychosocial-spiritual needs of patients. In particular, for psychosocial spiritual aspect, the concept of “Two Lives and Three Wills” was reiterated. “Two lives” mean “Life Review” and “Life Meaning”. “Three Wills” mean “Lasting Will”, “Living Will” and “Will”.

2 ACP Promotion: Right Thing, Right People, Right Time

People are often puzzled about the right time to initiate the ACP conversations. Although adults aged 18 or above can sign an AD, a healthy adult is not encouraged to do so because the EoLC decisions involve a lot of medical care decisions and vary according to personal experiences. Singapore defines ACP on a broad sense, which ranges from 1) the general ACP taking care of healthy adults to 2) disease-specific ACP for adults with progressive, life-limiting illness with frequent complications to 3) preferred plan of care for adults who may be expected to die within the next 12 months. In Hong Kong, ACP usually refers to the last one: the preferred plan of care. Although not exactly referring to the same thing, Professor Amy Chow also proposed a tiered-multistage model for ACP promotion, which built on the concept of three levels of disease prevention (Gordon, 1983; IOM, 1994) and the Transtheoretical Model (TTM) (Prochaska & DiClemente, 1983; Norcross, Krebs & Prochaska, 2011). The ACP discussion ranges from information provision and life and death education to intensive EoLC planning. In short, this is about doing the right thing and targeting the right people at the right time.

- Gordon, R. (1983). An Operational Classification of Disease Prevention. *Public Health Reports* (1974), 98(2), 107-109.
- Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology*, 51(3), 390-395.
- Norcross, J.C., Krebs, P.M., Prochaska, J.O. (2011). Stages of Change. *Journal of Clinical Psychology*, 67(2):143-54.



Concerted Efforts in ACP – Regional and Local Experiences

3 Inter-disciplinary Collaboration

Since EoLC should provide holistic care, a good inter-disciplinary collaboration is needed. Dr CK Wong, Geriatrician of Ruttonjee and Tang Shiu Kin Hospital demonstrated how they provide EoLC through medical-social collaboration to care for the elderly living at RCHes and their own homes. Starting in 2015, HA set up Community Geriatrics Assessment Teams (CGATs) providing onsite support, direct clinical admission for the terminally ill RCHes residents as well as empowering the staff to provide appropriate EoLC. In 2018, they further collaborated with the Social Welfare Department-funded MOSTE (Multi-disciplinary Outreach Support Team for the Elderly) social workers to engage the terminally-ill patients in ACP conversations. In 2019, medical-social collaboration was further extended to elderly patients living at home by doctors, hospital and community nurses, social workers and volunteers in the community. A conjoint ACP in collaboration with one of the JCECC NGO partner, The Hong Kong Society for Rehabilitation (HKSR) was showcased. Professor Amy Chow also proposed different levels of medical-social collaboration and division of works at different stages.



4 ACP is About Family Relations in Chinese Culture

ACP advocates respect for patient's autonomy. In Chinese culture, ACP is also about family relations. It is not uncommon that patients with advanced disease make ACP because they care about the burdens to their families. In Singapore's End-of-Life programme "Living Matters", they are shifting the locus of ACP away from hospitals and physicians into the community and specifically to the family unit. Also, rather than asking a patient what he or she wants, they reframe the question as, "How can you guide your loved ones to make the best decisions for you?"

5 Integrated Health and Social Care System

Singapore adopts a national approach to promote ACP as part of its integrated health care initiatives. The Ministry of Health funded the Agency for Integrated Care (AIC) to set up the ACP National Office in 2011. Its responsibilities include 1) engaging and coordinating stakeholders from hospitals to community, 2) providing training for ACP facilitators and public education; 3) developing an IT system to maintain a central registry, and 4) developing national standards and guidelines to ensure service qualities. Although the same approach may not be applicable in Hong Kong, concerted and coordinated efforts are necessary to providing people-centered EoLC. During the panel discussions, it was opined that alignment for healthcare professionals across specialties and between public and private medical settings, as well as enhancement of healthcare and social care professionals' EoLC competency are needed to provide good quality EoLC in Hong Kong. In addition, a good IT system to facilitate timely exchange of patients' information is also a key to the successful implementation of ACP.

ACP in Practice: A Post-symposium Workshop

October 25,
2019



The workshop consisted of two parts:

In the first part, Professor Deng Renli introduced the “VIP for future Care” model in a hospital setting used in Zhuhai. VIP means Video, Illness Experience, Preferences. Videos were shown to patients and family members to ease into the tabooed conversation on death and dying, which is portrayed as a normal and natural life process. Concepts of ACP was further introduced to patients referencing their unique illness experiences. Through role play, Professor Deng’s students demonstrated how to step-by-step engage the patients and their family members in the ACP process.

In the second part of the workshop, Mr Andy Sim, Principal Medical Social Worker of Singapore General Hospital and Ms Chee Wai Yee, Programme Director of Singapore Hospice Council expanded on the country-wide initiatives on ACP introduced in the Symposium. Examples in the “Inaugural National ACP Week in 2019 and Facilitating ACP Conversation Through Artwork” were shown on how social workers reached out to the community and raised public awareness on ACP using fun, lively and participatory activities. In collaboration with local artists, creative production companies, art studios, charitable organisations and tertiary institutions, creative platforms such as theatres, movies, life story exhibitions, artworks, photography, experiential learning and social media are established to engage the general public to consider, reflect and talk about EoLC wishes and preferences. Valuable experiences and challenges in launching these projects were also shared.



For Professionals



JCECC Synchronised Efforts to Promote ACP and AD

For Public

Dr Welgent Chu, a medical and social work consultant shared his views on the challenges that Hong Kong is facing, such as Chinese cultural barriers, misconception of palliative care, fragmented medical care provisions and limited availability and accessibility to EoLC services. However, with recent heightened support from government and advocacy from the public sector, we should grasp the opportunity to enhance the EoLC developments in Hong Kong.



**October 25,
2019**

**Let Elderly's Voices Be Heard:
Promoting Public
Understanding of ACP—
A Public Seminar**

Ms Chee Wai Yee, Programme Director of Singapore Hospice Council and Mr Andy Sim, Principal Medical Social Worker of Singapore General Hospital shared the challenges that Singapore has been facing in promoting ACP in public and also within their medical system; and their valuable experiences and learnings to overcome the obstacles. Some of the challenges, for example, striking a balance between safeguards of patients' rights and medical liabilities, and the longstanding curative medical concepts, were shared. To help the audience to experience the common dilemmas and the considerations on EoL decisions, participants were also invited to participate in a role play activity.



The meaning of the word “SAY” in the title “End-of-Life Care: You have a SAY!” is of two-folds. The first meaning is to emphasise that patients’ autonomy on EoLC should be respected. The second meaning is to emphasise the importance of communications among patients, family members and the medical-social care teams as well as the documentation of the conversation such that patients’ autonomy and choices are to be honoured.



**October to December
2019**

**“End-of-Life Care:
You have a SAY!” —
Public Seminar Series**

Health and social care professionals from JCECC’s project partners as well as Tung Wah Group of Hospitals accompanied their service recipients to share their personal experiences in signing the ACP/AD: the considerations, the dilemmas, the psychological struggles, the communication process and the benefits of doing ACP/AD. Representatives from FHB were also invited to introduce the key elements of the public consultation on “End-of-Life Care: Legislative Proposals on Advance Directives and Dying in Place”. At the end of each seminar, a senior medical consultant from HA joined the Q&A session. In the Q&A sessions, government officials and HA representatives were able to address the public enquiries and to explain the rationales, considerations and details of the proposed legislations. What’s more important is that many valuable and thoughtful comments on the operability and future developments of ACP/AD were collected. The questions and opinions collected in these Q&A sessions, with participants’ verbal consent, were sent to FHB to aid their formulation of related legislation and policy.

The areas that the public is most interested in:

- 1) accessibility of signing AD in both public and private medical settings
- 2) readiness of the medical system to handle the increasing demands
- 3) streamlining the process of storing and presenting AD documentation when needed
- 4) measures to better facilitate the special clienteles to make EoLC decisions
- 5) resource implications to make “dying in place” feasible
- 6) public education to raise EoLC awareness

To sum up, advocacy of end-of-life care, advance care planning and advance directive cannot be done by a single party. A multi-disciplinary collaboration between the government, healthcare sector, social sector, academics and the community is extremely vital.

Jane (71 years old), we first met her in the hospital. At that time, her husband slowly fed her with soup while she was lying on the bed. After we have introduced ourselves to Jane and her husband, she broke down in tears and held us tightly, “I have a tough life, why not let me pass away earlier?” After Jane was discharged from the hospital, we visited her home and she presented us with her diaries, from which we were able to get a glimpse of her life. “God was never fair to me by making me live with a disability. I have lost my dignity and status and I have already given many burdens to my husband and daughter.” – Extracted from Jane’s diaries. Jane suffered from a stroke in 1996 and she has to rely on her husband since then. A few years ago, she was also diagnosed with advanced chronic kidney disease and was receiving therapy services in hospital.

Stories from Jockey Club
End-of-Life Community Care Project
“Life Rainbow”
End-of-Life
Care Services

When
we
first
met...



Plan End-of-Life Care Services As Soon As Possible to Bring More Reliefs



Helping patients and family members to plan EoLC services as soon as possible will offer them more reliefs in future care arrangement. Therefore, after Jane regained the “Three Wills” in life and built trust towards social workers, social workers started to discuss and record her desires via end-of-life service planning manual, including her wishes, places to receive medical treatment in later stages and ways of commemoration. When asked about her wishes, Jane said that “I miss my grandchildren the most and hope that they can still remember me when they grow older”. In order to realise her wish, our team decided to create more memories for Jane and her grandchildren, such as arranging visits to the Peak and yum cha. Jane has no more regrets in life and is able to face death without fear.

“Life Rainbow” Allows Patients to Regain “Three Goods” in Life

When facing irreversible illness, it is vital to have a companion and to change one’s lifestyle, in order to help stabilise the condition. In terms of physical health, JCECC Project Team hopes to improve the symptom management ability of patients and their caregivers. When the nurses visited their homes, they taught Jane and her husband methods to manage oedema and pain. Besides, the nurses also set personal goals for them, such as increasing their amount of exercise and setting timetable for blood pressure measurement. These will help them to regain their life goals. Now, Jane is capable of doing exercise with cycling machine thrice a day, and her husband is able to go for a 30-minute walk every day, making a big change from his highly dependent life. Spiritually, Jane was very upset with her illness and the family burden she has created. Social workers tried to perform life review with Jane by discussing on the highs and lows in her life. Through sharing, it is important to listen to and tender care to her. Meanwhile, we are strengthening her positive experience and continuing to discuss on her strengths in life so that she is able to realise her contribution in life. In order to cheer her up further, we also gave a gratitude diary and invited her to record her mood and things she is grateful of every week. Jane is working very hard to complete her gratitude diary in at least an hour per day. We have seen that her life was full of grievances, and now she is able to talk about the good things and nice people she encounters. In terms of living, our team aspires to help patients and caregivers to overcome difficulties in life. Jane’s husband has been plagued with chronic neck and back pain, thus is incapable of pushing Jane’s wheelchair daily. Social workers have arranged volunteers to assist Jane on her regular visits to hospital and outdoor activities. These lessened her husband’s burden and created opportunities for Jane to interact with volunteers, expanding her social circle as a result.

Stories taken from Jockey Club End-of-Life Community Care Project **Hospice at Home**



Mr Yeung (60 years old plus), he is single and very independent. He has been diagnosed with terminal lung cancer in December 2017. As the lung tumour continues to worsen, he develops symptoms such as shortness of breath and coughing. In March 2019, he joined JCECC: Hospice at Home. In fact, he was worried that he would become a burden to his family, especially to his beloved niece when his illness reaches the final stage. Having learned about Mr Yeung's plan to arrange his end-of-life treatment in advance, JCECC Project Team introduced him to the idea of advance care planning. Not only did it help him to get a clearer sense of his situation and how the illness would develop, it also unfolded his psychological needs, fear towards death and his expectations in treatment and care in later stages.



Advance care planning

Peaceful Mind – Peaceful Home

Just like Mr Yeung, when one faces with irreversible illness and reaches his final stages in life, he/she usually cares for their family members most and also their quality of life conditions. Making advance care plan and advance directive require excellent and honest communications; otherwise, both patients and their family members can hardly reach consensus. Thus, establishing good communication between patients and family members is a key to open discussion about end-of-life arrangement, and this is essential to achieve the true meaning of “peaceful mind - peaceful home”.

Advance Directive

Besides, Mr Yeung expressed that he wanted to pass away painlessly and peacefully. He clearly expressed the thought of not receiving cardiopulmonary resuscitation (CPR) when dying. The team then introduced him with Advance Directive, arranged Mr Yeung and his niece to meet and discuss about his wishes and needs. His family members understood and respected Mr Yeung's decision, and finally he signed the Advance Directive. Mr Yeung was initially worried and scared of death, but with the care of his family members, the team's support and his faith in Christianity, he found peace and was relieved. Eventually, he peacefully passed away in palliative care ward. Mr Yeung's niece was a Christian chaplain at a hospital and felt grateful that her uncle passed away in peace.



JCECC Community Psychosocial End-of-Life Care Course



Basic Module

JCECC Community Psychosocial End-of-Life Care Course - Basic Module has been officially launched on September 10, 2019 and has received over 1,500 registrations of participants, including stakeholders from medical and social work fields, such as doctors, nurses, social workers, clinical psychologists, teachers, physical therapists, etc. The course analyses and compares competency frameworks of EoLC services all around the world. By combining related local studies and local experts' clinical experiences, we identified seven core competency domains of end-of-life holistic care services, forming the seven chapters of the module. These chapters are closely related, and they elaborate the seven core capabilities from the perspectives of cognition, value and technique. In addition, the chapters emphasise continuous communication, evaluation and review based on different illness conditions with patient-oriented and family-oriented approaches in an interdisciplinary team. In December 2019, the basic module of all seven chapters have been launched and are all available online. In 2020, the team will continue to develop the intermediate and advanced modules online.

Course features:

1. The module covers the holistic needs of terminally-ill patients and their family members, based on psychological, community and spiritual needs.
2. The modules are taught by different experts based on theories, research results and frontline experiences.
3. Online learning allows participants to learn at their own pace and convenience. Videos, self-reflective exercises, quizzes, interactive discussion forum are used to enhance the learning and interactions among participants.
4. Participants who have completed all 7 chapters in the course will be given a certificate of attendance and are eligible to apply for CNE and CME points.

Local Experts



Details and registration
www.JCECC.hk/onlinelearning

Intermediate Module

JCECC Community Psychosocial End-of-Life Care Course - Intermediate Module is specifically designed for professionals who frequently serve end-of-life patients and their families, and to equip them with more in-depth knowledge and skills. Upon completion of this intermediate module, participants could provide a more comprehensive and holistic care to the patients and families. Unlike the Basic Module, Intermediate Module adopts a “Flipped Classroom” teaching mode. Participants will watch teaching videos and do assigned readings in advance. Then, in the subsequent face-to-face tutorials and workshops, participants will have a chance to discuss each topic in more details. Their competence levels will enhance through inter-disciplinary exchanges.

JCECC Community Psychosocial End-of-Life Care Course - Intermediate Module has been rolled out in June 2020. Please visit our Project website for the latest information!

Remarks: Completion of Basic Module is the pre-requisite of applying for the Intermediate Module



Details and registration
www.JCECC.hk/onlinelearning

了解照顧方面的選擇權
將焦點放在疾病以外、病人認為重要的事

自我反思問題

自我反思問題

共同的資訊內容

資訊

源頭

接收者

跨平台

多媒體教學

全時段學習

網上自學

CNE CME

Capacity Building and Education Programmes on End-of-Life Care

Under JCECC project, the CUHK Jockey Club Institute of Ageing (IoA) has worked closely with the hospital network in the Hospital Authority (HA) New Territories East Cluster (NTEC); RCHes; Community Organisations and Patients' Association. From January 1, 2020 to March 31, 2020, 15 information sessions and workshops for healthcare staff, patients and public were organised with almost 200 attendees. Leaflets were also published with the goal of enhancing public awareness of the project. Please visit online version at https://www.ioa.cuhk.edu.hk/images/content/others/Eol/Leaflet/JCECC20Leaflet_Eng_Final.pdf.



香港中文大學
賽馬會老年學研究所
CUHK Jockey Club Institute of Ageing



End-of-Life Care in Residential Care Homes for the Elderly

The JCECC: End-of-Life Care in Residential Care Homes for the Elderly are now serving 43 subvented RCHes in Kowloon East, Kowloon Central and Kowloon West to deliver quality EoLC together with their RCHE staff.

From January 2019 to March 2020, 195 training sessions were provided to 647 staff of participating RCHes. A total of 12 EoLC training sessions were conducted to train Visiting Medical Officers of RCHes and 51 doctors attended the training. During this period, a total of 314 residents joined the project and 46 residents were arranged to sign Advance Directives. In total, 542 residents and 1,119 family members received EoLC service in this period. The project arranged 15 public talks joined by 594 participants promoting life and death education and thus arouse their awareness in advance care planning and its importance.

A professional seminar on EoLC in advanced dementia for social and health care professionals was held in August 2019 with 200 attendees. Geriatrician, Psychiatrist and Nursing experts shared the challenges and their experiences in EoLC for elders with dementia. The seminar was well received by the audience and positive feedback was received.

Hospice at Home

The JCECC: Hospice at Home has served more than 450 end-of-life patients and their family caregivers as at March 2020. The Haven of Hope Sister Annie Skau Holistic Care Centre's Palliative Home Care Department strives to provide holistic medical care, rehabilitation, spiritual care and support to patient's daily activity to people suffering from advanced illnesses and their family, and also to bring palliative care support to patients' homes and enable them to embrace the last journey with love. From February to April 2019, 50 family doctors participated in the Certificate Course on End-of-Life Care for Primary Care Doctors co-organised by the project and the Hong Kong College of Family Physicians. We explored the important role of family physicians in the end-of-life community care and fostered exchanges and collaborations between palliative and family medicine. The project also promoted end-of-life care, Advance Care Planning and spiritual care through public education, talks and trainings with more than 1100 attendees as at December 2019.



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Project Partners



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for Rehabilitation



“Life Rainbow” End-of-Life Care Services

The JCECC: Life Rainbow End-of-Life Care Services provide quality community end-of-life care to people with late stage chronic illnesses and their family members living in Wanchai and Eastern Districts. The project has served more than 560 end-of-life patients and their family members up to March 2020. The project successfully mobilised more than 120 community volunteers and members of self-help organisation to care for and contribute to the EoLC service development. In July 2019, the service has worked closely with the Geriatric Team of Ruttonjee Hospital to provide advance care planning for terminally-ill patients and their families. It demonstrated the effectiveness and efficiency of medical and social collaboration in promoting holistic End-of-Life Care service for EoL.



“Hospice in Family” Home Care Support Services

The JCECC: Hospice in Family Home Care Support Services aims to provide home-based palliative and hospice care service to support end-of-life patients and their caregivers to live in the community with dignity and respect. Till March 2020, the service has served over 300 patients and family members. Our social workers and nurses have also provided over 1,600 visits to the family for advance care planning discussion and health consultation. In addition, our volunteers have provided over 2,000 service hours to our users. Besides home-based support, the project team has also organised outdoor activities, such as family photo-taking and relaxation activities, as well as monthly mutual support activities in Tuen Mun Hospital. From June to December, 2019, two drama performances titled ‘The Red Sky’ and ‘Oh! Touchwood!’ , attracting more than 8,000 audiences were conducted.



聖公會聖匠堂長者地區中心
S. K. H. HOLY CARPENTER CHURCH
DISTRICT ELDERLY COMMUNITY CENTRE
(由香港聖公會福利協會有限公司營運)



聖雅各福群會
St. James' Settlement



Cheering@Home End-of-Life Care Services

The JCECC: Cheering@Home End-of-Life Care Services provides end-of-life care to patients suffering from life-threatening illnesses and their families, and also support patients' need while staying at home as their preferred place of care. The programme has served more than 510 patients and family members in the reporting period. In 2019, our team was invited to introduce the content and theory of our services to The University of Hong Kong, The Chinese University of Hong Kong, Hong Kong Baptist University, Hong Kong Shue Yan University and Hong Kong Institute of Vocational Education. Over 170 persons participated in the sharing sessions. They have shown great interests in our “Cheer up activity” organised for end-of-life elderly patients. Apart from service introduction, we also provided valuable life and death education to the youngsters, aiming to increase their knowledge about death, understanding the emotion of end-of-life elders and the stress of the caregivers, as well as improve their communications skills with their families.





Professional Training Workshops

A series of professional training workshops were held in 2019, which covered the topics of psycho-social assessment and intervention, palliative care for dementia patients and theory and practice integration of cognitive behavioral therapy. Professional local experts in the field were invited to deliver presentations and coordinate interactive activities, discussions and case sharing.

**September 20,
2019**



Engaging Family in EoL Stage:
Case Conceptualisation,
Assessment and Intervention
Using Family Centred Approach

**October 4,
2019**



Working with Patient with
Advanced Cancer: Psycho-social
Assessment and Intervention

**October 25,
2019**



Post-symposium Workshops on
Concerted Efforts in ACP: Regional
and Local Experiences – Advance
Care Planning in Practice

**November 9,
2019**



Forget Me Not: Palliative Care
for People with Dementia

**December 10,
2019**



Working with End-of-Life
Patients and Family: Theory and
Practice Integration of Cognitive
Behavioural Therapy

**December 12,
2019**



(Re-run)
Engaging Family in EoL Stage:
Case Conceptualisation,
Assessment and Intervention
Using Family Centred Approach

Past Events

To align with the commencement of the second phase of the JCECC Project, the JCECC Phase II Launch Ceremony *cum* symposium was organised in May 2019. It marked a new start of the extension of the Project and introduced our new service model and its components and enhancement areas to the stakeholders in the field.

In the beginning of the second phase, JCECC Project Team set a public education theme "End-of-Life Decision Making" with an aim to enhance public understanding about the choice for EoLC. A series of public education activities including seminars and a regional symposium around the theme were organised from January to November 2019. Stakeholders and speakers were invited to share their views on EoLC and related decision making.



Public Education

May 7,
2019



JCECC Phase II Launch Ceremony *cum* Symposium on Improving End-of-Life Care Outcomes for Older Adults at a System Level: Opportunities and Challenges

October 24,
2019



Symposium on Concerted Efforts in Advance Care Planning: Regional and Local Experiences

October 25,
2019



Let Elderly's Voices Be Heard:
Promoting Public Understanding of ACP—
A Public Seminar

October
to
December
2019



"End-of-Life Care: You have a SAY!" —
Public Seminar Series



Volunteer Training

The 2019 volunteer core and elective course trainings were organised by JCECC in collaboration with Haven of Hope Christian Service, The Hong Kong Society for Rehabilitation, SKH Holy Carpenter Church District Elderly Community Centre, and St James' Settlement.

May to June 2019

Volunteer Core course

In the 4-session core course, dedicated volunteers learned core knowledge and skills for serving end-of-life patients in the community. Topics included background and basic concepts of end-of-life care, psychosocial and spiritual care, communication, symptom management, self-reflection and self-care, end-of-life decision making, and bereavement care.

July 2019 to January 2020 Volunteer Elective course

Nine sessions of elective courses followed the core course, which provided additional training in special issues for interested volunteers. Topics included home safety, religious views on life and death, legal knowledge for end-of-life, funeral practices, and self-reflection.