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Case Discussion on Primary Care Physicians' Role in Partnership for End-of-life CareProvision in Residential Care Homes for Elderly

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Introduction:

Two cases and care profiles are shared in this discussion, illustrating the primary care physicians' role in developing and strengthening end-of-life care (EOLC) provision in residential Care Homes for the Elderly (RCHEs). This is achieved through direct patient/family care and by promoting multi-sectoral collaboration, with an emphasis on public-private partnerships.

Care Home & End-of-Life Care (EOLC) service:

Established in 2023, KSG Contract (Nursing) Home (HTE) is an RCHE serving 100 elderly residents requiring nursing-level care, with no visiting CGAT service. The Visiting Medical Practitioner (VMP), together with the privately-run subsidized residential home provider, aims to provide comprehensive EOLC for residents in need. This includes holistic care, good symptom management, and ongoing communication with elderly residents and their families through a shared decision- making approach. Effective partnerships were developed with various NGOs, including JCECC, the Society for the Promotion of Hospice Care, and the local HA hospital (Caritas Medical Centre) Geriatrics and Palliative Care Teams. Following sensitive discussions with families, ACP/DNACPR (non-hospitalised) orders were completed, respecting residents' wishes and minimising unnecessary suffering. The VMP and the elderly care home also provide continual training for care staff. Families have expressed their appreciation. Since its establishment two years ago, KSG Contract Home has completed 25 DNACPR (non-hospitalised) orders, following referrals to the CMC Team. Detailed clinical profiles of this cohort are shared below.

Results and Case Sharing:

Case 1:

Ms L, F/96, was admitted to KSG in February 2024.

History: Congestive heart failure, diabetes with renal impairment, and recurrent hospitalisations for heart failure, renal failure, pneumonia, or urinary tract infection.

Functional status: No speech, motor, or eye response. NG tube feeding; bed-bound and totally dependent, with limb contractures.

Discussions with family were conducted both in person and via phone to explain the resident's condition and prognosis. Patient and family wishes were addressed.

A DNACPR (non-hospitalised) order was referred to and completed by the CMC Geriatric Team in December 2024, citing irreversible coma/PVS.

Progress at KSG: Ms L remained stable with good symptom control for breathlessness. The family visited regularly. Gradual decrease in urine output and breathing effort were noted. The family requested EOLC provision in the care home. The JCECC team supported the EOLC provision.

Ms L remained at KSG until she passed away peacefully in early February 2025 during Chinese New Year. The family stayed by her bedside to say their final farewell. KSG staff accompanied the family, offering emotional and practical support during bereavement. Staff advised the family on death registration procedures. In later days, the family sent a thank-you card to the KSG staff, appreciating the humanistic care provided during Ms L's final journey.

Case 2:

Ms Y, F/86, was admitted to KSG in March 2023.

History: Diabetes, dementia, recurrent pneumonia.

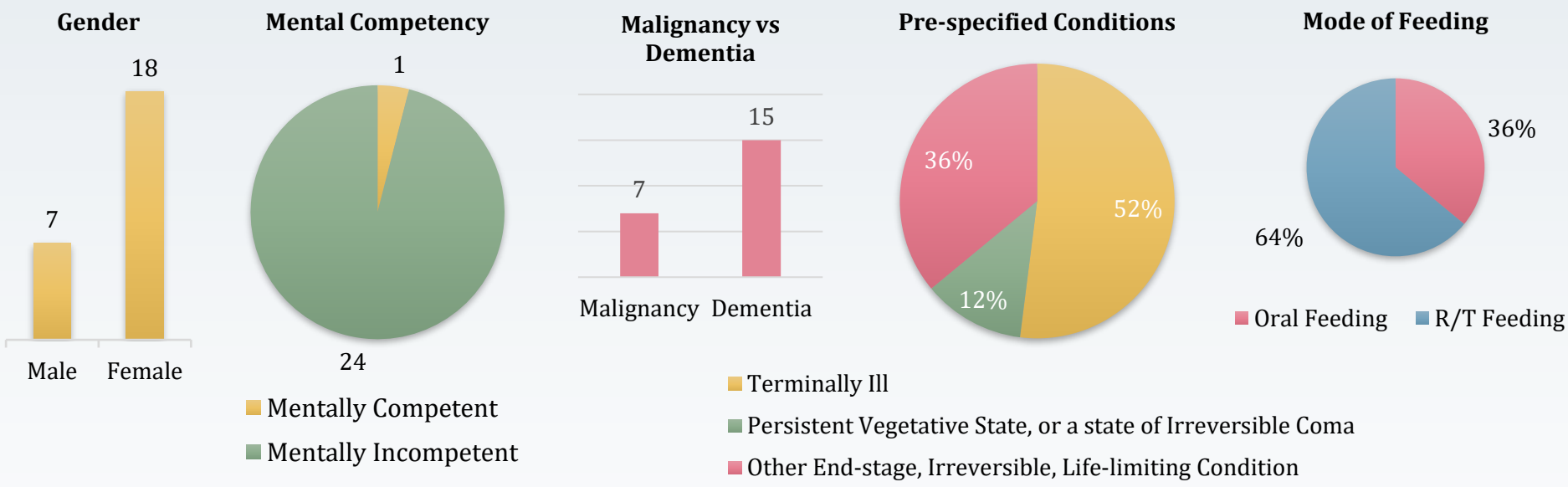
Functional status: Total dependency with NG tube feeding; no verbal response.

Multiple discussions took place with the family (husband, daughter, and grandson) regarding future health and social care planning since December 2023. The grandson, a medical student at Cambridge Medical School, supported the family's DNACPR decision.

A DNACPR (non-hospitalised) order was referred to and completed by the CMC Geriatric Team in January 2025.

Progress: The husband visits frequently; the daughter, who lives overseas, visits a few times a year. Ms Y remains relatively stable in the home, with only occasional brief hospitalisations for symptoms or infections that could not be managed in the residential home. The daughter and grandson sent a thank-you card to the KSG team, expressing their gratitude.

Clinical Profile:



Lessons Learnt and The Way Forward:

- Good end-of -life care (EOLC) for frail elders in RCHEs is feasible and is of paramount importance in providing comfort care and respecting elders and families choices. In addition, local and overseas studies showed that EOLC provision in RCHEs would reduce total health care cost by reducing hospital stay and minimizing unnecessary medical intervention for the terminally-ill elders.
- Holistic clinical care and ongoing, effective communication with residents, families, team members, and other agencies such as Hospital Authority, JCECC and other public/private organisations are essential in ensuring good EOLC provision in residential homes.
- There can be limitation on medical support during certain period of a day or time of year. In case 1, The body was sent to public Mortuary as medical doctor was not available during the holiday period.
- The cases illustrating the primary care physicians role in developing and strengthening the EOLC provision in RCHEs through providing direct patient/family care and promoting multi-sectoral collaboration emphasizing public-private- partnership.
- In future, primary care physicians may further strengthen EOLC provision in RCHEs by education to more public, local community and professionals. Liaison with local DHCs with network of interested parties enhancing the EOLC commitment can be the way forward.