For Discussion
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Legislative Council Panel on Health Services

Discharge Planning in Public Hospitals

PURPOSE

This paper sets out the various aspects of discharge planning in public hospitals and briefs members on recent cases involving discharge difficulties in public hospitals.

BACKGROUND

2. A patient, on completion of medical treatment and judged to be clinically fit to be discharged, and showing no further clinical indication for a need to remain in hospital, should be discharged from hospital. Returning home or to facilities in community setting facilitates a patient's social re-integration, hence assisting the patient's early rehabilitation.

3. Insofar as patient discharge is concerned, the Hospital Authority (HA) has in place a set of well-established procedures for assessing a patient's suitability for discharge from hospital after completion of medical treatment. The assessment adopts a multi-disciplinary approach, involving relevant doctors, nurses and allied health staff, including where necessary, medical social workers (MSWs). While clinical fitness for discharge is the main consideration, the views and social conditions of the patient and his carer(s) would also be taken into account as appropriate in determining whether a patient should be discharged and if so, the necessary post-discharge support. The hospital team will make a professional decision on whether a particular patient is ready for a full return to the community, or should be taken care of in a residential home. A determination will also be made on the support that the patient may need after his discharge from hospital (for example, community nursing service and financial assistance).

"DISCHARGE PROBLEM"

4. Early discharge of patients, especially those who have been staying in hospitals for comparatively long periods, will help them to reintegrate into the society early. Prolonged hospital stay beyond clinical indications may also cause unwanted institutionalisation of the patients and waste of limited and precious medical resources. However, in exceptional circumstances, there are cases where the discharge of patients is met with resistance and hence lengthening of the discharge process. While the reasons are many and may vary from one case to the other, they can be summarised largely as follow :

(a) patients or family members may perceive differently the medical illness of the patients from the clinical assessments;

(b) lack of confidence of the family members or patients in continuation of self care at home;

(c) financial and/or other social considerations e.g. patients having chronic diseases, long term disabilities and requiring care from others may tend to refuse to be discharged; and

(d) unavailability of family and social support etc after discharge.

5. According to the HA's experience, discharging patients with weaker social, family and financial support, and those receiving assistance from the Comprehensive Social Security Assistance (CSSA), is comparatively more difficult.

EXISTING MEASURES TO ADDRESS "DISCHARGE PROBLEMS"

6. The HA at present adopts a multi-facet approach in dealing with patients with discharge difficulties.

(a) the hospital staff will on the one hand continue communication with the patients/families to allay their concerns regarding possible difficulties from discharge of patients from hospitals. On the other hand, the hospital staff will try to understand the specific difficulties faced by the families/patients and work closely with relevant parties e.g. the Social Welfare Department in arranging for

the appropriate support and assistance for patients, as and where necessary, to facilitate their discharge from the hospitals;

(b) where medical care is needed, the HA has in place a system to provide comprehensive post-discharge ambulatory care, through outpatient clinics, day hospitals or ward follow-up facilities, as well as a range of medical outreach services. For example, the visiting medical service in many old-aged homes has been enhanced since 2003;

(c) for cases where follow up social services are considered necessary, social workers will interview the patients and their family members to assess the need and types of social services required and arrange for the provision of the services, ranging from long-term resident services or community care services to district-based support services; and

(d) for patients considered to be severely disabled, the MSWs will offer further assistance on applications for relevant government financial assistance schemes if need be.

7. In sum, "discharge problem" is a very complex matter that encompasses issues well beyond the arena of medical service provision. Actual cases that the HA encountered may help illustrate the complexities involved.

THE HA EXPERIENCE IN DISCHARGING PATIENTS FROM HOSPITALS

8. **Appendices 1 and 2** are case summaries of two actual cases happened recently in public hospitals. The first case involved a CSSA recipient, while the second involved a Non-entitled Person (NEP). The two cases are cited to illustrate the difficulties that have been faced by the HA in discharging long-term patients. We have no intention, nor do we have statistical evidence, to show that the discharging difficulties are a pervasive problem amongst CSSA recipients and NEPs. A brief summary of the cases is set out below.

<u>Case One</u>

9. The patient in Case One was a CSSA recipient. Numerous discharge options were offered by the hospital concerned, but refused repeatedly by the wife of the patient. The difficulties encountered by the hospital were :

(a) the family insisted on choosing some of the most "popular" subvented homes which had the longest waiting time, hence prolonged unnecessarily the discharge arrangements; and

(b) the level of medical care available in hospitals is higher than that can be offered by residential and old age homes. In addition, CSSA recipients receiving free hospital services are eligible to continue to receive the CSSA during the hospitalization period while awaiting placement. We have the impression that this discrepancy in benefits between remaining in hospital and transferring to a residential or old age home may well be one of the reasons for the patient's reluctance to be discharged.

Case Two

10. Case Two involved a NEP patient. With the anticipated increase of tourists from neighboring territories, the possibility of short-term visitors requiring admission to public hospitals may increase. Some of them may require longer-term care ultimately.

11. For NEP patients with medical problems, discharge arrangements often require multi-agency involvements, thereby making the process of discharge even more complicated and difficult :

(a) Patients subject to Repatriation

Unlike discharge within Hong Kong, cross-border repatriation for patients requires much greater co-ordination with many cross-border agencies. The repatriation of patients with functional and self-care problems will require more careful consideration, as patient/family may have difficulty to obtain a similar level of rehabilitation or maintenance services after repatriation.

(b) Difficulties of Mentally Incapacitated Patients

It is a cardinal principle that social and welfare arrangements cannot be carried out without obtaining proper consent from a

patient. For mentally incapacitated persons who do not have capacity to give proper informed consent, their next of kin can take up the guardian role to act in the best interests of patients to agree on discharge and placement arrangements. However, in situations where the next of kin cannot be identified or refuses to liaise with the hospital to work out discharge planning arrangements, the hospital may need to apply to the Guardianship Board for guidance.

Experience tells that applying for a guardianship order when the patient's family is not in Hong Kong would be more time-consuming and that without proper consent from the patient or guardian, physical repatriation of the patient would be more complex and complicated.

(c) Entitlement of NEPs to Welfare and Community Facilities in Hong Kong

Except under emergency and short-term situations, social and community facilities are presently not available to non-Hong Kong residents as a matter of policy. This is to ensure that our limited resources would be used on Hong Kong residents. Therefore, if a patient is not able to be repatriated immediately, he will have to stay in a public hospital even though his clinical condition is judged fit for discharge.

THE WAY FORWARD

12. In sum, patients are admitted to hospitals for medical treatment and hospital discharge, as a matter of principle, is a clinical decision. A patient should be discharged from hospital when his clinical condition is judged fit for discharge by the hospital team. A patient should not stay in a hospital once he is fit for discharge. However, in actual practice, the HA encounters difficulties in discharging some of its patients, particularly those long-term staying ones, taking into account both human rights and humanitarian concerns.

13. Medical resources are limited. To ensure best use of the resources and in the light of the HA's experience, consideration may be given to the following issues :

(a) enhancing public awareness of the availability and choices of social and community services outside hospitals;

(b) whether CSSA recipients should continue be paid the allowance during their stay in a public hospital when all inpatient charges will already have been waived for such patients. There may be a case for this practice to discontinue, especially when the CSSA recipient has been judged to be fit to be discharged. This should however be balanced against the argument that the recipient may need some money to cover miscellaneous personal expenses during his hospitalisation. We may also need to take into account the impact of the recipient's hospitalisation on the level of expenditure by the remaining members of his family (e.g. additional travelling expenses in conducting hospital visits);

(c) the present long waiting list for some social institutions make access to service inconvenient to patients. This is despite the Government's efforts in increasing the relevant services to meet rising demands. Services in community institutions could be strengthened suitably to facilitate continuity of care upon discharge of patients from hospital settings, though the availability of resources is an issue; and

(d) enhancing cooperation with local consulates and other cross-border agencies in handling the repatriation of patients to their homeland.

ADVICE SOUGHT

14. Members are invited to note the content of this paper.

Hospital Authority
Health, Welfare and Food Bureau
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Appendix I

The HA's Experience in Discharging Patients from Hospitals
Case Summary One

1. Mr. X was admitted to Hospital A in October 2002 with right sided weakness due to acute ischaemic stroke.

2. He was transferred to Hospital B in October 2002 for stroke rehabilitation. He made good progress, with only mild cognitive impairment and was able to walk with quadripod.

3. By November/December 2002, he was clinically assessed to be fit for discharge : either back to his own home with Geriatric Day Hospital and/or social services support, or to a private old age home. Despite multiple meetings and case conferences with the clinical team, the patient's wife refused all discharge options.

4. Over the next two and a half years, the clinical team had repeatedly approached the patient and his wife to discuss his discharge from Hospital B. Below are some of the options offered and the wife's responses:

(a) February 2004 : Patient expressed a wish to go back home and live with his family, but the wife refused. She agreed to let him go to a subvented Care & Attention Home (C&A Home).

(b) March 2004 : Wife insisted on permanent placement in a Central Infirmary Waiting List (CIWL) Infirmary bed, either at Hospital B or Hospital C.

(c) July 2004 : A place became available at a private C&A Home place in patient's district. The patient had been on the waiting list since his stroke in 2002, and the place offered was under the Enhanced Bought Place Scheme. Prior to admission to such institutions, it is mandatory for a client to undergo the Minimum Data Set – Health Care (MDS-HC) assessment by a medical social worker (MSW). However, the patent's wife forbade the patient to sign the consent for the assessment, and strongly warned the clinical team not to attempt to do any assessment or send the patient to a C&A Home

without her knowledge. Therefore the application for C&A Home was cancelled.

(d) March 2005 : The MSW approached the patient again for the MDS-HC assessment and asked the patient to sign the consent, but the patient refused. He said that his wife told him not to sign anything or cooperate with any assessment, but just to remain in Hospital B for as long as possible.

(e) April 2005 : Case conference held with clinical team. Wife understood that the patient did not fulfill the criteria for infirmary placement, but nonetheless strongly urged the doctors to facilitate a transfer to Hospital C. The standard of C&A Homes, in her opinion, were inferior to Hospitals B and C, so she would not consider this option as all.

5. May 2005 : Intensive discharge program started by Hospital B which included sending notice to patient's family that Mr. X was clinically fit for discharge and invited them to discuss discharge arrangements with the hospital. Hospital team subsequently held interviews with family members and the wife finally gave consent to conduct the MDS-HC assessment, but she said she would not agree to result of assessment if not to her liking.

6. June 2005 : Assessor from SWD conducted the MDS-HC assessment for Mr. X and 'nursing home' level of care was recommended.

7. July 2005 : Mr. X's wife appealed to the SWD office against the assessment result, and to members of the Legislative Council and District Board on the discharge arrangement.

8. July 2005 : MDS-HC reassessment conducted by SWD office. Assessment result reconfirmed that patient was fit for home with community support while waiting for 'nursing home'. Hospital informed family that they planned to discharge Mr. X on 2 August and would offer alternatives to him for discharge :

(a) private Old Age Home; or
(b) home with community support while awaiting Nursing Home placement.

9. August 2005 : Discharge timings fixed. The family did not take either option (a) or (b) above. In circumstances where the family did not make their own arrangements, he or she would have to be taken over by SWD with special emergency arrangement. The wife accepted Mr. X to be taken over by SWD. Mr. X also accepted the arrangement and was directly transferred to an emergency placement in a subvented nursing home.

Appendix II

The HA's Experience in Discharging Patients from Hospitals
Case Summary Two

1. Mr. Z was a tourist from Mainland China. In October 2004, he was knocked down by a truck and was admitted with severe head injury into Hospital A for emergency care. Emergency operation with appropriate treatment was done uneventfully.

2. The patient was transferred to Hospital B in February 2005 for medical rehabilitation and his condition remained stable since then. After the incident, the patient had sustained a severe brain injury resulting in total loss of functional ability and loss of cognitive function despite a prolonged course of active rehabilitation. The residual disability of Mr. Z was most likely to be permanent in nature and the medical rehabilitation team and doctor-in-charge had certified that his medical condition was stable and fit for transfer back to Mainland China for maintenance care by his family.

3. During the patient's stay in Hong Kong, his wife (also a two-way permit holder) visited Mr. Z occasionally. The two-way permit of the patient had already expired on the date of the accident i.e. October 2004 and therefore the patient became theoretically an overstayer in Hong Kong. Hospital B informed Immigration Department of the case.

4. Repeated discussions were made with the patient's relative and wife on the discharge plan and several registered mails were also sent to his wife from April to August 2005 on the discharge plan. Hospital B was then informed that the wife had successfully applied for Hong Kong SAR legal aid for a civil suit claim for compensation against the driver.

5. During the wife's visit to Hospital B in December 2005, the hospital staff had explained to her in detail the patient's stable condition and fitness for discharge. The hospital also mentioned that arrangements for an escort service to facilitate the discharge of Mr. Z with the details of a free medical escort service back to Mainland China offered to the patient by a charitable Non-Governmental Organization (NGO) on special compassionate grounds. Nevertheless, the wife stressed that she had great financial difficulties and would only consider the discharge of the patient if damages were awarded

in the civil suit. In December 2005, a letter was received from the wife that she would not take the patient back to the Mainland.

6. Since then, from December 2005 to February 2006, the hospital liaised with relevant Government departments to work out the possible measures that could be taken for the discharge of the patient from the hospital. Discussions covered the following :

(a) whether the Immigration Department could issue a removal order and the repatriation procedures of a Mentally Incapacitated Patient person like Mr. Z;
(b) how to establish linkage with relevant Mainland authorities like the Ministry of Public Security and the Ministry of Civil Affairs on the arrangement of receiving Mr. Z upon his return to Mainland;
(c) continue to notify the wife and relatives on the discharge arrangement of Mr. Z by registered mails and phone;
(d) the need and procedures for application of Guardianship Order, in the situation that Mr Z's wife and relative did not turn up or refuse to take Mr. Z back to Mainland;
(e) how to solicit resource from charitable NGO for arranging Mr Z's travel documents and escort service to Mainland;
(f) if nobody took care of Mr Z, whether the Social Welfare Department could provide temporary shelter for Mr Z as he was medically fit for discharge;
(g) to keep contact with Legal Aid Department on Mr. Z's insurance claim status.

7. The patient's wife refused to contemplate any discharge arrangements until she was awarded an interim compensatory payment from the insurers of the driver in March 2006, when she finally agreed to allow her husband to be taken back to the Mainland.