Ethics of Care Transition

Diana Lee
Chair Professor of Nursing

The Nethersole School of Nursing
Faculty of Medicine
The Chinese University of Hong Kong

Care Transition

Goals:

- To transfer care responsibility from one agency to another
- To plan for patients' continuing health and social care
- To promote QOL for both patients and carers

Care Transition

High risk frail elderly persons with poor social and care support :

- Live alone/ live with an aged spouse
- Lack of a ‘proper’ carer
- Unable to arrange the necessary community care services

Ineffective Care Transition

- Sub-optimal assessment of readiness for transition
- Incomprehensive and fragmented planning
- Breakdown in communication and information transfer
- Inadequate post-transition care and follow-up

Care Transition

Local scene:

- No systemic policy-driven care transition practices
- Lack of a proactive and multidisciplinary approach to care planning and delivery

Care Transition

Local scene:

- Examples:
  - Integrated Discharge Support Programme
  - Nurse-coordinated transitional support
  - Transitional residential care for elderly patients discharged from hospital

Care Transition

Local barriers to effective care transition (eg. Chan and Pang 2007, Lee 1999, Leung et al 2010, Wong et al 2011 etc)

- Disease focused
- Patients' preference/ choice seldom considered
- Carers' needs highly neglected
- Health care professionals especially physicians have low awareness about patients' psychosocial needs

Care Transition

Local barriers to effective care transition (eg. Chan and Pang 2007, Lee 1999, Leung et al 2010, Wong et al 2011 etc)

- Poor communication between care units
- Service availability: waiting time, patients' affordability
- Other social factors: transportation issues, time gap


01 3 20

Transition to Residential Care

- A life event that challenges elderly people

  → feelings of abandonment, stress and uncertainty, loss of a home and the opportunities for contact with families and friends (eg. Lee et al 2002, Lee et al 2002, Lee 1999, Lee 1997)

  → transition is usually unplanned and accompanied by deterioration of medical condition and functional abilities

Transition to Residential Care

- In most circumstances, elders' have no choice and are not involved in decision making
  (eg. Lee et al 2002, Lee et al 2002, Lee 1999, Lee 1997)

- For Chinese elders

  → a sense of parental failure and loss of respect

  → loss of face (own face and that of the family's)

Transition to Residential Care

- Quality of life concerns (Chan & Pang 2007)

  → existential distress: meaning and purpose in life – hopelessness, helplessness and powerlessness

  → value of life

  - unable to achieve a sense of integrity
  - indulge in despair

Improving Care Transition Practices

A shift from management of the disease to a communicative and ethical approach that promotes quality of life for both the patients and the carers

→ re-orientation to a biographical, person-centered approach

→ a collaborative partnership to actively engage the patients and their families/ carers

Improving Care Transition Practices

→System change: manpower, service availability for post-transition service

→ Professional education: communication and ethical issues re transition; patients' and carers' psychosocial needs

Acknowledgement

- Competitive Earmarked Research Grants
  - CUHK 4376/00H
  - CUHK 4241/03H
- United Board for Christian Higher Education in Asia Faculty Research Grant