

# Transitional residential care for elderly patients discharged from hospital

EMF Leung<sup>1</sup>, YK Tsoi<sup>2</sup>, MP Li<sup>3</sup>, A Au<sup>3</sup>

<sup>1</sup> Department of Medicine and Geriatrics, United Christian Hospital, Hong Kong

<sup>2</sup> Medical Social Service, United Christian Hospital, Hong Kong

<sup>3</sup> United Christian Nethersole Care Home, Hong Kong

Correspondence to: Dr Edward MF Leung, Consultant Geriatrician, United Christian Hospital, 130 Hip Wo Street, Kwun Tong, Hong Kong.  
E-mail: emfleung@ha.org.hk

## BACKGROUND

With ageing of the population, the need of long-term care is a major concern for most of developed countries. For these economies, the proportion of institutionalised patients varies from 5% to 8%. The rising rate of institutionalisation creates a heavy financial burden on society and also compromises the quality of life of older people. This has raised concerns of Hong Kong academics and government, as there were over 72 000 residential home places in 2009, of which two thirds were in private old age homes. Policy initiatives that provide community care alternatives to reduce recourse to institutional care have been proposed.

Factors causing placement into residential care homes include deteriorating health, mobility problems, impairment in activities of daily living, the need of constant nursing care, and the lack of supportive care at home. The most important factors are acute deterioration of functional abilities and the lack of supportive care at home. Both render elderly people unable to cope in their home environment. These problems occur when an old person with weak social support (living alone or only with an older spouse) is admitted to hospital for an acute medical condition that results in deterioration of functional abilities. Thus, hospitalisation is a major contributing factor to admission into nursing homes. Common major acute medical problems include acute stroke, hip fracture, post major surgery and malignancy; all of which could cause impairment of functional abilities in older people and precipitate institutionalisation.

In Kwun Tong district, the proportion of older people aged over 65 years is 15.4%, which is one of the highest in Hong Kong. The median monthly domestic household income of such individuals is below HK\$15 000. Most such individuals are either from low income families or on comprehensive social security assistance (CSSA), and a high proportion live alone or just with an aged spouse. They have weak social support and lack other means of care at home, once they experience any form of acute deterioration in functional abilities.

Most older people prefer living in their own community upon discharge from hospital, but lack the necessary functional ability and support from carers, especially when they are living alone or just with an aged spouse. In most situations they either enter into low-cost private old age homes or stay for longer periods in hospital until they are able to cope with their daily lives at home. They apply for CSSA to top up their expenses in these private old age homes. Hence further unwanted long-term institutionalisation results in a slim chance of returning home thereafter. The institutionalisation of elderly people not only causes a financial burden on the elderly and their families, it also incurs a social cost for our society to maintain them in institutions. The situation worsens with the increasing number of elderly in the population. Unnecessary admission of socially deprived older people into old age homes is common among older subjects admitted to hospital for major disabling illnesses. Some may need to stay in subacute hospitals for a prolonged time, pending for their placement in institutions. Tackling this

problem helps hospitals reduce unnecessary use of resources and improves the quality of life for the socially deprived older people.

### **ESTABLISHMENT OF TRANSITIONAL RESIDENTIAL CARE PROJECT**

In view of the ageing population in Hong Kong, Mr Simon KY Lee and his family has established a Simon KY Lee Fund for the Elderly in 2007 and invited applications from hospitals and non-governmental organisations for innovative projects to cater to the needs (including transitional care) of older people. In view of the need of transitional care for socially deprived older people in Kwun Tong, the United Christian Hospital together with the newly established United Christian Nethersole Care Home applied to the Fund for the establishment of the Transitional Residential Care Project for Elderly Patients discharged from United Christian Hospital. Funding of HK\$3 million was allocated to the United Christian Medical Service to set up the Transitional Residential Care Project in 2008 for a period of 2 years. This project aimed to alleviate premature institutionalisation because of social reasons with a view to improve the health and quality of life of older people discharged from hospital and minimise the social and financial cost resulting from institutionalisation.

Transitional residential care aims to (1) provide a caring place for those who have no carer available upon hospital discharge, (2) enhance the capability of elderly patients to return to the community with a higher level of physical functioning after a short period of rehabilitation during transitional care, and (3) prevent premature/inappropriate admission to long-term institutional care.

Some older people suffered from acute stroke or hip fractures, after finishing a course of medical treatment, could not be discharged to their community or return home immediately, owing to inability to perform daily activities like bathing, dressing, toileting, etc. Also they may lack confidence or practical skills to stay alone or only with an aged spouse. Thus, many require care from others before they can go home. With the high proportion of older people living alone or only with their spouses, most could not receive the necessary care upon hospital discharge. They either stayed in hospital for a

prolonged period of time, making it more difficult to return home or enter private old age homes. Some patients are nevertheless able to regain their ability to stay independently, provided they can get care and support for a short period of time (4 to 6 weeks). Yet, there is no transitional care facility available in Hong Kong to bridge this service gap. This project aimed to address this service gap, which requires future government attention and social policy direction in terms of resource allocation.

The Transitional Residential Care Project aims to provide support for 80 to 100 hospitalised older people identified by medical social workers and clinical team members in the United Christian Hospital each year. The project targets older people who live alone, live with an aged spouse, lack a proper carer, are unable to arrange the necessary community care services immediately upon discharge from hospital, or are awaiting availability of a full time carer. Transitional residential care places were established with the collaboration of the United Christian Nethersole Care Home, which is a self financing nursing home launched in 2007 and located next to the United Christian Hospital. 12 to 15 beds within the United Christian Nethersole Care Home were reserved to serve the project. Older people identified for transitional residential care were provided with 4-to-12-week stay in the facility. The Transitional Residential Care Project was catered for those who lacked the financial means to purchase places in high-quality self-financing homes. The intended recipients were CSSA and non-CSSA elderly relying on their own savings or meager financial support from children. The monthly family income of the recipients had to be below the median monthly domestic household income, and assets that could be liquidated had to accord with predefined criteria for waiving medical fees and charges. The cost per bed for transitional residential care in the United Christian Nethersole Care Home was HK\$10 000 per month and each older person needed to pay a fee of HK\$70 per day, which is equal to respite bed charges of the Social Welfare Department. Thus, each patient needed to pay HK\$2100 per month and the Simon KY Lee Fund contributed the remaining HK\$7900 per month to the United Christian Nethersole Care Home. After assessment by a medical social worker and the patient's agreement for admission to the transitional residential care facility, the service manager of the United Christian Nethersole Care

**TABLE 1**  
**Demographics of the 72 elderly persons who received transitional residential care**

Demographics	No. (%) of elderly persons
Age (years)	
60-69	13 (18)
70-79	27 (38)
80-89	28 (39)
90+	4 (6)
Sex	
Male	27 (38)
Female	45 (63)
Living arrangement	
Live alone	32 (44)
Live with spouse	13 (18)
Live with family	26 (36)
Live with relatives	1 (1)
Type of accommodation	
Public housing	61 (85)
Home ownership scheme	1 (1)
Self-owned flat	10 (14)
Financial support	
Welfare recipient	38 (53)
Own savings	8 (11)
Family support	26 (36)
Medical problem	
Stroke	27 (38)
Fracture	24 (33)
Cardiac problem	6 (8)
Post-surgery	6 (8)
Severe back pain	5 (7)
Others	18 (25)

Home conducted a nursing assessment while the potential recipient was in the United Christian Hospital. During their stay in the care home, the patients continue to receive rehabilitation in the geriatric day hospital, physiotherapy or occupational therapy in outpatients departments, with a view to facilitate return to their own home after discharge from transitional residential care.

## OUTCOMES

The project commenced from July 2008. In the 12 months period ending in June 2009, 72 elderly

patients aged 60 to 98 years (65% aged 70 to 85 years) from United Christian Hospital were referred for transitional residential care; 44% lived alone and 18% with a spouse only. Nearly half relied on CSSA for their livelihood, and most lived in public housing estates. 74% of the admitted elderly had sustained acute medical conditions, 44% from acute stroke and 33% from fractures. After completion of transitional residential care, these elderly patients showed significant improvements in their mobility, walking ability and activities of daily living. Out of 72 elderly patients discharged, 5 were able to live independently, 38 returned home with carer support,

**TABLE 2**  
**Destination of elderly persons after transitional residential care**

Destination	No. (%) of elderly persons
Home with independent living	5 (7)
Home with carer support	38 (53)
Home with support from home care services	16 (22)
Private old age home	8 (11)
Self-finance or subvented homes	3 (4)

**TABLE 3**  
**Status of elderly persons before and after transitional residential care (TRC)**

Parameter	No. (%) of elderly persons	
	Before TRC	After TRC
Mobility		
Walk independently	1 (1)	7 (10)
With aids	32 (44)	37 (51)
Poor with aids	35 (49)	12 (17)
Wheelchair indoor	3 (4)	2 (3)
Chairbound	1 (1)	6 (8)
Modified functional ambulation category		
Sitter	4 (6)	5 (7)
Dependent walker	7 (10)	2 (3)
Assisted walker	46 (64)	25 (35)
Supervised walker	11 (15)	12 (17)
Indoor walker	4 (6)	13 (18)
Outdoor walker	0 (0)	12 (17)
Indoor walking		
Freehand	0 (0)	9 (16)
Stick	15 (21)	28 (49)
Quad	12 (17)	5 (9)
Frame	29 (40)	11 (19)
With support	16 (22)	4 (7)
Independence in activities of daily living		
Bathing	2 (3)	21 (29)
Dressing	8 (11)	34 (47)
Toileting	4 (6)	43 (60)
Transfer	8 (11)	47 (65)
Continence	30 (42)	48 (67)
Feeding	61 (85)	69 (96)
Grooming	54 (75)	64 (89)
Mean relative stress scale	26.1	20.7

16 returned home with community support services, 8 were admitted to private old age homes, and 3 were admitted to government subvented homes, due to health deterioration resulting from other medical conditions. The demographics and outcomes of

these older patients are summarised in **TABLES 1 to 3**.

### CONCLUSION

The Transitional Residential Care Project enabled

high-risk elderly persons with poor social and care support to benefit from a short period of residential care after a stroke or hip fracture. It reduced their need to be transferred to convalescence purely for social care, reduced the chance of their long-term admission to residential care homes, and enabled them to return to their own homes either independently or with the care and support of carers and community support services. It showed a new model in tackling the issue of an ageing population with a failing social supporting system, which enhanced the ability of older patients with new disabilities to return to their own homes with a reduction in the need of long-term

institutionalisation and unnecessary hospital stays. This project has served as a new model for planning of services of the Hospital Authority, the Social Welfare Department, and residential care homes catering for the emerging needs of older people in the future. The one-year experience of transitional residential care as a collaborative project between private funding, the hospital, and a residential home enabled the identification of persons in need for such services. The outcome of providing transitional care for patients discharged from acute hospital was favourable.