Social Welfare Department

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong

Consultancy Study Report

30 December 2024

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Chapter 1 Introduction

1.1 Background

Currently, a majority of the residents of residential care homes (RCHs) for the elderly (RCHEs) and the RCHs for persons with disabilities (RCHDs) require health and rehabilitation services from RCH staff or visiting professionals, including nurses, health workers (HWs), care workers (CWs) and various types of therapists. As RCHEs and RCHDs often encounter difficulties in recruiting or retaining staff who provide health and rehabilitation services, the 2022 Policy Address announced that a holistic review of the skill and qualification requirements of RCH staff would be conducted to establish professional standards and a career progression path for them. The Government established the Steering Committee on Review of Manpower for Healthcare Services in RCHs (the Steering Committee) chaired by Dr. LAM Ching-choi, the former Chairman of the Elderly Commission and its membership comprised stakeholders from various sectors, including RCH operators/organisations, allied health professionals, trade union members, and representatives of relevant policy bureaux/departments. The Social Welfare Department (SWD) has commissioned Learning Resources & Technologies Limited (also known as LRT Consulting) (the Consultant) to conduct the Review and report to the Steering Committee on a regular basis. The Review covers the following aspects:

(a) reviewing the skill and qualification requirements for staff providing health and rehabilitation services in RCHs so as to establish professional standards and a career progression path for them;

(b) exploring the feasibility and implementation plans of establishing a new rank in RCHs, including its required qualifications, training, registration requirements, regulatory framework, as well as the division of labour and collaboration among staff providing health and rehabilitation services; and

(c) identifying factors conducive to the recruitment and retention of RCH staff.

1.2 Research scope of work

The consultancy study aims to conduct a holistic review of the skills and qualifications required for staff in RCHEs and RCHDs who provide health and rehabilitation services. The research scope of work included:

(a) Identify the health and rehabilitation services currently provided by RCH staff:

(i) Conducted sampling of 30 RCHEs and 22 RCHDs for fieldwork with reference to the type, nature, scale of the RCHs, etc.

(ii) Identify the average frequency and ratio of resident in each type of RCH receiving various health and rehabilitation services, alongside the working hours of various types of RCH staff.

(b) Review the skill, qualification, training, and statutory registration requirements for RCH staff (if applicable).

(c) Study the rationale and implementation details for establishing the rank of "Senior Health Worker (SHW)" (tentative title).

(d) Invite relevant stakeholders to express their views and suggestions:

(i) Introduce the work plan of the consultancy study to relevant stakeholders, and engage them in providing views and suggestions on the issues covered;

(ii) Collect and analyse the views from relevant stakeholders on the responsibilities, training required, regulations, etc. of the new rank; and

(iii) Seek views and consensus on supporting the establishment of the new rank and enhancing the career progression path of key RCH staff.

(e) Assess potential challenges in implementing the recommendations made, and propose corresponding measures to overcome the challenges.

In summary, the Consultant reviewed the skills and qualifications of RCH staff aiming to enhance recruitment, retention, professional standards, and promotion prospects.

1.3 Research methodology

1.3.1 Strategies to engage stakeholders

The Consultant engaged various stakeholders in the consultancy study in the following ways to increase the sector's acceptance and feasibility of the recommendations for the future:

(a) Project initiation workshop
(b) Partnership team meetings

(c) Fieldwork
(d) Individual interviews
(e) Focus groups
(f) Stakeholder opinion survey
(g) Strategy forum
(h) Consultations with relevant professional bodies and advisory committees

For details, please refer to section 4.1, "Methods for collecting data and opinions".

1.3.2 Key Factors for Consideration

(a) Manpower allocation

- Baseline of manpower allocation: Review the number of staff, staff structure, staff-to-resident ratio of various types of RCHs and compare them with the minimum staffing requirements of RCHEs or RCHDs to find out the baseline of manpower allocation.

- Responsibilities and workload: Review the current responsibilities and workload of various types of RCH staff to explore whether the new rank can help to alleviate the situation of tight manpower.

- Division of labour and collaboration: Define how the new rank will cooperate with other RCH staff to ensure a clear division of labour and effective collaboration.

- Career development: Consider the career development opportunities of various types of RCH staff, explore whether the establishment of the new rank of "SHW" can provide a clear promotion and career development path for RCH staff.

- Qualifications requirement: Review the current qualifications and skills of various types of RCH staff, and recommend the qualifications required for the new rank.

- Training and qualifications: Review the qualifications and responsibilities of key RCH staff to identify areas for skills upgrading, propose recommendation to promote professionalism within the industry and enhance staff competencies.

(b) Market demand

- Customer needs: Review whether the current services of RCHEs or RCHDs meet the customer needs (e.g. daily care, health and care).

- Service demand: Analyse the increasing demand for services to identify opportunities for improving service processes and meet service standards.

(c) Regulatory framework

- Review the regulatory framework for key RCH staff to ensure that any regulatory recommendations for the new rank are in compliance with and aligned to existing regulations.

In order to achieve the objectives of the consultancy study and fully consider the above factors, the Consultant adopted a variety of methods to extensively collect relevant information. Please refer to Annex 1 for details.

Chapter 2 Literature Research on the International Situation

To achieve the objectives of the consultancy study, in addition to taking a comprehensive and prudent approach to collecting data and information on local RCHs, the Consultant also conducted extensive literature collection and research on ageing and long-term care (LTC) services published in different regions for in-depth analysis. These include:

- Population ageing trend forecast reports and research literature published by international organisations;
- Policy papers and research reports on LTC services published by government departments and agencies in different countries and regions;
- Research reports and journal papers on staff recruitment and retention in the LTC sector published by relevant professional bodies, scholars, etc.; and
- News media coverage of the manpower situation in the LTC sector.

In line with the objectives of this consultancy study, the findings from the Consultant's desktop research are presented as follows.

2.1 The demand for LTC services due to the ageing global population continues to grow

According to the United Nations (UN), the global population aged 65 and above is projected to increase to 1.6 billion in 2050, rising from 10% in 2022 to 16%. By then, Hong Kong, South Korea, Japan, Italy, and Spain will be the world's most ageing areas[1]. Although this trend varies from area to area, it is generally indicating an accelerated upward trajectory. For example, individuals aged 65 and above accounted for 29.1% of Japan's total population in 2022, representing the highest proportion of elderly people in the world[2]. In Hong Kong, the proportion of the population aged 65 and above is expected to rise from 20.5% in mid-2021 to 36.0% by mid-2046[3].

The global population is ageing, leading to an increased emphasis on the importance of end-of-life care and gerontology. End-of-life care aims to provide holistic care and healthcare to patients in the advanced stage of their illness until the end of life. Different from geriatrics, which emphasises clinical applications,

1 United Nations. (2023) *World Social Report 2023: Leaving No One Behind In An Ageing World*.

2 走進日本（2024）「不斷老去的日本，總人口的 4 分之 1 為年逾古稀的老人」。

3 Census and Statistics Department of the Government of the Hong Kong Special Administrative Region, October 2023 issue of Hong Kong Monthly Digest of Statistics feature article "Hong Kong Population Projections for 2022 to 2046".

gerontology is dedicated to studying the phenomena of ageing, the ageing processes, the ageing issue, as well as the associated physiological, psychological and social challenges, etc.

These two areas are receiving increasing attention in the development of LTC services. UN member states are striving to promote comprehensive care and primary healthcare for the elderly, ensuring continuity of care. This includes fostering physical and mental well-being, disease prevention, treatment, rehabilitation, as well as palliative and hospice/end-of-life care services[4].

As the population ages, governments around the world are facing enormous challenges, especially the need for LTC services, which is one of the largest expenditure items in the budget. For example, in 2022-23, Australia's total expenditure on elderly services amounted to A$28.3 billion, of which RCHEs amounted to about A$16.3 billion, accounting for 57.7% of the total expenditure on elderly services[5]. The situation is similar in Hong Kong, where SWD's recurrent expenditure estimate for elderly services in 2022-23 was about HK$14 billion, of which about HK$8.1 billion was for residential care services for the elderly, representing an increase of about 10% as compared with the revised estimate of about HK$7.4 billion for residential care services for the elderly in 2021-22, and an increase of about 70% over the actual expenditure of about HK$4.8 billion for residential care services for the elderly in 2017-18[6].

2.2 International standards for LTC services

Internationally, LTC services are defined as providing a wide range of healthcare services, personal care, and social services to people who have lost part or all of their abilities to take care of themselves over a period of time[7].

Ensuring the quality of LTC services is a common topic for international research. After years of research, the average care hours per resident day (HPRD) is a key indicator to ensure service quality. This metric helps measure the amount of care time each resident receives to ensure their needs are being met[8].

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4 World Health Organization. *UN Decade of Healthy Ageing 2021–2030*.

5 Australian Institute of Health and Welfare. (2024) Spending on Aged Care.

6 The Legislative Council Panel on Welfare Services Subcommittee on Increasing the Provision of Residential Care Places for the Elderly "Overview of Subsidised and Non-Subsidised Residential Care Services for the Elderly".

7 National Institute of Aging, United States. What Is Long-Term Care?

8 Jutkowitz E, Landsteiner A, Ratner E, Shippee T, Madrigal C, Ullman K, Linskens E, Wilt TJ, and Duan-Porter W. *Effects of Nurse Staffing on Processes of Care and Resident Outcomes in Nursing Homes: A Systematic Review*. Washington, DC: Evidence Synthesis Program, Health Services Research and Development Service, Office of Research and Development, Department of Veterans Affairs. VA ESP Project #09-009; 2022.

According to the recommendations of the Centers for Medicare & Medicaid Services (CMS), the average HPRD is calculated by:

- Adding the number of hours worked by each healthcare professional who provides direct care within 24 hours [Note: CMS collects payroll data from agency employees through the Payroll-Based Journal (PBJ) system, which includes the number of hours worked per day by all salaried employees (whether full-time or not) in each quarter.]
- Dividing the total number of hours by the total number of residents for the day
- As a result, the average HPRD is obtained

Effective from 1 October 2023, all private elderly homes in Australia are required to provide an average of 3.33 HPRD, including 0.67 hours of direct care provided by registered nurses (RNs). It is expected that from the end of 2024, the average HPRD of the elderly services sector will increase to 3.58 hours, including 0.73 hours of direct care provided by RNs[9].

The United States (U.S.) also announced on 10 May 2024 that LTC facilities must provide at least 3.48 HPRD, including at least 0.55 hours of direct care provided by RNs and at least 2.45 hours of direct care provided by other healthcare professionals[10].

In New Zealand, it is recommended that elderly care facilities provide at least 2.0 HPRD, and dementia care facilities provide at least 2.5 HPRD[11].

2.3 Regulation of key healthcare professionals

Governments around the world are placing great emphasis on ensuring the professionalism and service quality provided by key healthcare professionals. As such, all countries have set up dedicated departments or statutory bodies to regulate them in accordance with the relevant legislations.

2.3.1 Nurses

In the U.S.[12] and Canada, state or provincial nursing boards are responsible for

9 Department of Health and Aged Care, Australian Government. Care Minutes in Residential Aged Care.

10 US Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting.

11 Ministry of Health: Minimum Indicators for Safe Aged Care and Dementia Care for New Zealand Consumers (2005).

12 National Council of State Boards of Nursing (NCSBN).

regulation, while in Singapore, Japan[13], and South Korea[14], nurses are regulated at the national level by the central authorities. Nurses are typically required to complete a recognised nursing degree or diploma programme and pass a national examination before obtaining a practising certificate.

The validity periods of nurses' practising certificates in these countries vary. In the U.S., Japan, and South Korea, practising certificates are generally renewed every two to three years and require the completion of a certain number of continuing education credits. Australia[15] and Singapore[16] require nurses to renew annually. Additionally, in Singapore, nurses who have not practised for five consecutive years are required to complete a specified refresher course before they can resume their practice[17].

If a regulatory authority or organisation receives a complaint against a nurse, an investigation will be launched. Once the complaint is formally lodged, disciplinary action may be taken against the nurse in question. The measures can range from a warning to a temporary or permanent suspension of their practising certificate, with the severity of the penalty determined by the nature and gravity of the violation.

2.3.2 Nurse Aides

For roles such as nurse aides or healthcare assistants, which are similar to the roles of HWs and CWs in Hong Kong, many countries have less stringent practice requirements compared to nurses. For example, in the United Kingdom (U.K.), Canada, Australia, and Singapore, nurse aides are not required to hold a practising certificate but must undergo specialised training.

However, some countries have stricter requirements for nurse aides. In the U.S., for instance, nurse aides must complete a standardised training course and pass a state-level certification examination to qualify for practice. Their practising certificates are typically valid for two years[18]. Once employed, nurse aides are also required to participate in regular on-the-job training. In the U.S., public complaints about nurse aides are primarily handled by state health departments. Specific disciplinary actions vary by state but generally include investigating complaints, reviewing the nurse aide's practice records, and imposing measures such as warnings, mandatory training, or suspension of practice credentials, depending on the circumstances.

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13 Ministry of Health, Labour and Welfare, Japan.

14 Ministry of Health and Welfare, South Korea.

15 Nursing Midwifery Board of Australia.

16 30th ASEAN Joint Coordinating Committee on Nursing.

17 The Singapore Nursing Board. Return-to-Nursing Programme.

18 RegisteredNursing.org. CNA Certification.

2.3.3 Physiotherapists, Occupational Therapists, and Speech Therapists

Physiotherapists (PTs), occupational therapists (OTs), and speech therapists (STs) are typically regulated by professional boards or relevant authorities in accordance with the law. To qualify for a practising certificate, these therapists must obtain a recognised professional degree, complete mandatory practical training, and pass a professional examination.

The Health & Care Professions Council (HCPC) in the U.K., the Australian Health Practitioner Regulation Agency (AHPRA) in Australia, and the Allied Health Professions Council (AHPC) in Singapore are the statutory bodies responsible for regulating these professions at the national level. In contrast, the U.S. and Canada regulate these professions at the state or provincial level.

In the U.K.[19], Singapore[20], and most states in the U.S., practising certificates are valid for two years. In Australia[21], however, practising certificates for various types of therapists are valid for only one year.

To maintain professional standards, most countries require therapists to renew their practising certificates periodically. The renewal condition typically involves completing a specified number of continuing education credits during their practice. These requirements are designed to ensure that therapists maintain their professional competence and continuously update their knowledge and skills during their practice.

If a complaint against a therapist is received, the regulatory authority or agency will investigate and take action depending on the complexity of the case.

In summary, the regulation of key healthcare professionals varies in detail across countries, but through government oversight, industry self-regulation, and public scrutiny, etc., all stakeholders are committed to fostering a safe, professional, and high-quality care environment in LTC facilities. This ensures that residents receive dignified and quality care services.

2.4 The impact of an ageing population on the job market

With the emphasis on end-of-life care and gerontology, the U.K. government has prioritised long-term infrastructure planning as well as the use of digital

19 Health & Care Professions Council (HCPC).

20 Allied Health Professions Council (AHPC).

21 Australian Health Practitioner Regulation Agency (AHPRA).

technology and data analytics to improve LTC services, aiming to meet the demand for such services[22]. These priorities have created a significant number of new job opportunities, particularly in technology-related fields.

The U.S. Bureau of Labor Statistics predicts that healthcare and social assistance will be the fastest-growing industry in terms of employment, with an annual growth rate of 1.0%. This growth is primarily driven by the rising demand for relevant services due to the increasing elderly population. As the industry expands, the demand for related occupations is expected to grow substantially. Specifically, from 2023 to 2033, the number of healthcare support workers (e.g. personal care workers (PCWs), OT assistants) is projected to increase by 15.2%, while the number of healthcare practitioners and technical staff (e.g. chiropractors, dentists, dietitians, pharmacists) is expected to increase by 8.6%[23].

Healthcare professionals providing these services are expected to possess a broad range of knowledge and skills, including the ability to provide comprehensive physical, psychological, spiritual, and interpersonal support to terminally ill patients, deliver palliative care, and demonstrate effective communication skills, etc.[24] These requirements are reflected in job advertisements for relevant positions.

2.5 The LTC sector facing the challenge of human resource shortage

Despite the rapid growth of the LTC sector, many countries are facing widespread manpower shortages. During the pandemic, RCH staff in the U.S. experienced immense work-related stress and infection risks[25], leading to the loss of over 400 000 staff from LTC facilities (including nursing homes (NHs) and residential care institutions). This has resulted in the lowest labour supply levels since August 2007[26]. Similarly, the U.K. has faced significant challenges, with 165 000 vacancies in residential care roles (10.7%) in 2021-22, which is the highest vacancy rate among all industries[27].

The manpower shortages not only affect the availability of LTC services but also directly impact service quality. In the U.K., NHs have struggled to attract and

22 National Health Service in England. (2020) The NHS in England at 75: priorities for the future.

23 US Bureau of Labor Statistics. New Release on 29 Aug 2024: Employment Projections 2023-2033.

24 American Nurses Association. (2016) Position Statement: Nurses' Roles and Responsibilities in Providing Care and Support at the End of Life.

25 Heiks Cheryl, Sabine Nicole. "Long Term Care and Skilled Nursing Facilities" in Delaware Journal of Public Health. 2022 Dec.

26 American Healthcare Association / National Center for Assisted Living. (2022) *BLS March 2022 jobs report*. [Fact Sheet]

27 The King's Fund in England. (2024) Social Care 360: Workforce and Carers.

retain RNs, forcing some NHs to discontinue care services. This has led to the transfer of services to community care teams or the relocation of residents to other facilities[28]. The situation in Japan is equally severe, prompting the Ministry of Health, Labour and Welfare to consider expanding the scope of duties for overseas healthcare professionals to address the manpower shortages in the LTC sector[29].

2.6 Measures to address the human resource shortages and ensure the service quality

Facing the challenges posed by an ageing population, governments around the world are actively seeking solutions. Some countries have implemented measures such as improving remuneration packages for healthcare professionals, enhancing working environment, and strengthening training, etc., to attract more talent to the LTC sector.

Another strategy to address manpower shortages is the recruitment of overseas workers. For example, since 1997, the U.K. government has recruited a large number of non-locally trained nurses from various countries (e.g. the Philippines, India, South Africa)[30]. These nurses now account for over 14% of the total nursing workforce in the U.K., a proportion similar to that in countries like Australia and New Zealand[31]. In addition to nurses, the U.K. government has also imported overseas workers to fill other roles, contributing to a reduction in the vacancy rate for residential care positions to 9.9% in 2022-23, with 152 000 vacancies[32].

Alternatively, some countries employ a large number of non-permanent staff (including part-time and temporary staff) for LTC [Note: This refers to paid staff, including nurses and PCWs, who provide LTC services in facilities and RCHs outside hospitals.] to address manpower shortages. For instance, in 2019, 42% of LTC professionals in member countries of the Organisation for Economic Co-operation and Development (OECD) were part-time, while approximately 17% were temporary[33]. Although hiring non-permanent staff can replenish vacancies, their inconsistent attendance affects team collaboration and the efficiency of

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28 Care Quality Commission in England. (2023) State of Care 2021/22: Workforce.

29 The Asahi Shimbun. National Report: Japan mulls easing foreign caregiver rules to fill labor crunch by Shinichi Sekine on 25 July 2023.

30 Ayaka Matsuno, Nurse Migration: The Asian Perspective. *ILO/EU Asian Programme on the Governance of Labour Migration Technical Note*. January 2008.

31 Vari M Drennan, Fiona Ross, Global nurse shortages—the facts, the impact and action for change, *British Medical Bulletin*, Volume 130, Issue 1, June 2019, Pages 25–37.

32 The King's Fund in England. (2024) Social Care 360: Workforce and Carers.

33 OECD (2021). *Health at a Glance 2021: OECD Indicators*. OECD Publishing, Paris, France.

residential care services[34].

Adequate staffing ensures that RCHs are equipped with sufficient qualified staff to provide high-quality daily care services to residents. Although there is no international standard for establishing baseline of manpower allocation, it is a common practice to adjust staffing level based on the number of residents in RCHs[35].

The adoption of technology has also emerged as a way to enhance the efficiency and quality of LTC services. The Japanese government promotes the "Society 5.0" initiative, which encourages the use of artificial intelligence and robotics to assist the elderly in their daily lives, thereby improving care efficiency[36].

To further enhance service quality, the Japanese government has set up an incentive scheme to reward LTC facilities that exceed the minimum requirements in specific areas. Facilities with staff numbers above the minimum standard receive additional bonuses, while those offering ongoing training opportunities are granted financial incentives[37].

2.7 Career development and career progression path for staff in LTC facilities

In LTC facilities worldwide, the same roles may have different job titles in different regions. Please refer to Table L 5 for details. For example, nurse aides or healthcare assistants typically serve as frontline staff, with responsibilities and rank similar to those of CWs and HWs in Hong Kong.

After accumulating a certain amount of practical experience, nurse aides can obtain a higher level of practising certificate and promotion opportunities through continuing education. One of the popular options is to further education as licensed nursing practitioners (e.g. Licensed Practical Nurses/Licensed Vocational Nurses)[38]. This generally requires completing a one-year vocational or community college programme and passing an examination. They have a higher level of professional competence than nurse aides and can independently perform more complex nursing tasks such as administering medication and performing wound

[34] Webinar: Training of human resources for long-term care: learning from the Korean experience by Sang-Baek Chris Kang.

[35] Skills for Social Care. (2020) "Tips to help you to decide safe staffing levels for your service".

[36] 遠見 12 月號/2019 第 402 期（電子雜誌）「直擊日本社會 5.0」。

[37] The Research Office of the Legislative Council Secretariat (FS01/2023) "Residential long-term care services for the elderly in Japan".

[38] Finger Lakes Performing Provider System. (2023) Long-term Care.

care, etc. Their role is comparable to that of ENs in Hong Kong.

With additional clinical experience, licensed nursing practitioners can further their education and obtain an RN practising certificate. Becoming an RN typically requires completing a two- to four-year university degree programme. RNs can then advance to managerial or specialised roles, such as Nurse Supervisor, Nurse Manager, or Advanced Practice Nurse, etc.

In addition to clinical care nursing career paths, LTC facilities also offer administrative career progression path, such as Administrator and Assistant Administrator roles, etc. These positions are typically filled by individuals with a master's degree in healthcare administration or a related qualification.

Career development paths for key RCH staff vary across countries and regions, influenced by factors like cultural backgrounds, social needs, and policy support, etc. For example, Singapore has established clear and diverse career paths for the LTC sector. From frontline roles to executive positions, there are well-defined promotion pathways across different levels and areas of expertise (e.g. clinical, administrative, educational). The Singapore government places a strong emphasis on talent cultivation and provides support such as on-the-job training and further education opportunities to help LTC professionals continue to develop[39].

2.8 Responsibilities and qualification requirements for staff in LTC facilities

More than two-thirds of OECD member countries do not have specific academic requirements for the education and training of PCWs. On the other hand, in more than three-quarters of OECD member countries, nurses working in the LTC sector typically have higher education qualifications, though they may not necessarily have completed specialised aged care training. Half of OECD member countries require nurses to hold a bachelor's degree, while only a few (Iceland, Israel, Estonia, Poland, and Sweden) have integrated geriatric nursing training into their general curricula or mandate such training for nurses on the job[40]. In LTC facilities, nurses primarily perform case management duties.

In Mainland China, Elderly Care Workers have responsibilities similar to those of PCWs in other economies. Generally, their primary responsibility is to provide daily personal care for residents in RCHs. In order to attract more individuals to work in elderly care, the National Occupational Skills Standards for Elderly Care Workers (2019 Edition) relaxes the entry requirements for Elderly Care Workers. The academic requirement for practitioners was adjusted from "junior high

39 SkillsFuture, Singapore. (2018) *Skills Framework for Healthcare: Career Pathways*.

40 OECD. (2020) *Who Cares? Attracting and Retaining Care Workers for the Elderly*. OECD Health Policy Studies, OECD Publishing, Paris, France.

school graduation" to "no academic requirements". Additionally, the eligibility criteria for Level 5/junior workers were revised from "continuous apprenticeship in this occupation for more than two years" to "cumulative work in this occupation or related occupations for more than one year (inclusive)". Furthermore, candidates without a primary school graduation certificate are permitted to take an oral examination for the theoretical knowledge test, which assesses the basic and relevant knowledge required for the profession[41].

2.9 Key factors influencing staff recruitment and retention in LTC facilities

Recruiting and retaining staff in LTC facilities face multiple challenges.

2.9.1 Lack of social recognition

A study conducted in Nordic countries, including Denmark, Finland, Norway, and Sweden, revealed that insufficient recognition for elderly care by government leaders, the media, and the general public has led to feelings of being "undervalued" among healthcare professionals, exacerbating their desire to quit their jobs[42].

In fact, the average tenure in the global LTC sector is two years shorter than that of the overall manpower. High staff turnover not only reduces the quality of care but also increases operational costs. Staff turnover necessitates re-hiring or hiring replacements, generating issues like additional recruitment and on-the-job training costs as well as productivity losses, etc.[43]

2.9.2 Lack of competitive compensation and benefit plans

Many LTC facilities report manpower shortages, primarily attributed to an inability to offer competitive salaries and benefits, making it challenging to attract sufficient qualified candidates.

A "LTC staffing study" in Ontario, Canada, found that 63% of respondents indicated manpower shortages have worsened since the COVID-19 outbreak. There is a particularly acute shortage of Personal Support Workers, Registered Practical Nurses (who are not authorised to handle medications without permission), and RNs. The manpower shortages hamper the provision of essential

41 《養老護理員國家職業技能標準（2019 年版）》中華人民共和國人力資源和社會保障部及中華人民共和國民政部合制。

42 BMC Health Services Research. (2021) 'Lack of recognition at the societal level heightens turnover considerations among Nordic eldercare workers: a quantitative analysis of survey data'. Article number: 747.

43 A. Llena-Nozal, E. Rocard and P. Sillitti. (2022) "Providing long-term care: Options for a better workforce", Organisation for Economic Co-operation and Development, Paris, France.

personal care (e.g. bathing, feeding), emotional support, and assisting bedridden residents in changing their positions regularly, etc.[44] These issues not only disrupt the RCH operations, but may also prevent some from accepting new residents due to manpower shortage.

Moreover, factors such as workplace culture, team cohesion, as well as diversity and inclusion, etc., also have a direct impact on staff satisfaction and retention.

2.9.3 Inadequate vocational and staff training

Inadequate vocational and staff training profoundly impacts recruitment and retention in LTC facilities. First, a lack of adequate training (e.g. work ethics, understanding service user's needs, communication skills, infection control) prevents new hires from quickly adapting to the work environment, thereby increasing turnover rates. Furthermore, existing staff feel that their career prospects are limited due to insufficient professional development opportunities, prompting them to seek other job opportunities. This situation not only exacerbates the issue of manpower shortage but also affects the quality and stability of LTC services. Research indicates that a lack of skilled staff is one of the main reasons why LTC manpower problems are faced in Australia and South Korea[45].

2.10 Staff recruitment and retention methods

2.10.1 Policy support and planning

When adopting the "Decade of Healthy Ageing" ("Decade"), UN member states requested UN partners and the World Health Organisation to report to the UN General Assembly and the World Health Assembly in 2023, 2026 and 2029 on the progress of its implementation. Despite global challenges since 2020, the progress has been made during the first phase of the "Decade". Between 2020 and 2022, the implementation rate of four indicators increased by more than 20%: legislation against age discrimination (e.g. Singapore, Finland), legislation supporting access to assistive devices for older persons, national programmes for age-friendly cities and communities (e.g. studying and addressing social isolation and loneliness in India and Japan, responding to humanitarian emergencies in South Africa, promoting "age-friendly" initiatives in Ireland), and the development of national policies to comprehensively assess health and social care needs (e.g. establishing dementia learning centres in New Zealand, developing a charter of sexual rights for older persons in the U.K., training healthcare professionals in Chile and the

[44] Ontario Health Coalition (2020) *Long-Term Care Staffing Survey Report*.

[45] Lee, H.Y., Short, S., Lee, MJ. et al. Improving the quality of long-term care services in workforce dimension: expert views from Australia and South Korea. *Arch Public Health* 80, 112 (2022).

Maldives, and reintegrating older people such as retired nurses and healthcare professionals into the workforce in Romania)[46].

2.10.2 Enhancing career development

In response to the growing shortage of healthcare staff, the Health and Social Care Committee in the U.K. House of Commons published its third report in 2022. Key recommendations include:

- By the beginning of the next decade, it is expected that an additional 475 000 jobs will be needed in the health sector and an additional 490 000 jobs in the social care sector. The U.K. should develop a long-term manpower plan for LTC.
- Launch a new bursary scheme covering full tuition fees, a non-means-tested loan of at least £1 000, and means-tested loans.
- Improve retention conditions, such as improving work facilities, developing flexible work models, etc.;
- Establish a national retirement and reinstatement system to encourage senior staff to continue contributing;
- Improve the treatment of ethnic minority staff and eliminate racial discrimination; and
- Provide more training opportunities to upskill staff and encourage career development[47].

2.10.3 Vocational-based training programmes

Some countries have improved retention rates among frontline staff by offering training tailored to career advancement. Examples include in Denmark and Germany, where self-motivated staff can progress to managerial positions, while nurse aides can enrol to a diploma in nursing. In France, a recent report recommends incorporating frailty detection into the formal training of PCWs. South Korea plans to provide more training for PCWs in the future to provide them with the opportunity to advance to managerial roles[48].

Countries such as the U.S., the Netherlands, Ireland, the U.K., and Sweden, etc., have introduced Advanced Nurse Practitioners for case management. After receiving specialised training, they are equipped to handle critical tasks in LTC (e.g. monitoring care plans for the elderly; managing interactions with older

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46 World Health Organization. (2023) *Progress report on the United Nations decade of healthy ageing, 2021-2023: executive summary*.

47 House of Commons, UK. (2022) *Workforce: recruitment, training and retention in health and social care (Third Report of Session 2022–23).*

48 OECD. (2020) *Who Cares? Attracting and Retaining Care Workers for the Elderly*. OECD Health Policy Studies, OECD Publishing, Paris, France.

people, informal care providers, community caregivers, and health workers; identifying signs of lost autonomy in the elderly)[49].

2.10.4 Staff recruitment and retention methods at the RCH level

LTC facilities worldwide typically use the following methods to recruit and retain staff:

- Creating a positive culture: Create a work environment where staff can thrive and build trust by recognising their accomplishments.
- Fostering team cohesion: Encourage teamwork, reduce burnout, and emphasise the importance of teamwork to improve job satisfaction.
- Promoting diversity, equity and inclusion: Implement fair practices, provide learning opportunities to learn about each other's cultures, and make staff feel valued.
- Providing plans for future development: Ensure staff understand the organisation's strategy, mission, and future plans, making them feel part of the organisation's future.
- Effective communication: Maintaining open and adequate communication about policies, work arrangements, strategies, and changes is an important part of staff retention.
- Technology adoption: Applying technology to align with staff communication preferences can increase staff engagement and satisfaction[50].

These methods help to increase staff satisfaction, thereby improving recruitment and retention outcomes.

[49] B. Ljungbeck and K. Sjögren Forss. (2017) "Advanced nurse practitioners in municipal healthcare as a way to meet the growing healthcare needs of the frail elderly: a qualitative interview study with managers, doctors and specialist nurses" in *BMC Nursing*, vol. 16.

[50] VoiceFriend. (2022) *Staff Retention Strategies for Senior Care Organizations*.

Chapter 3 Overview of the Local Industry

As Hong Kong's population continues to age and the average life expectancy of persons with disabilities increases, there is a growing demand for residential care services for the elderly and persons with disabilities. The Government has adopted a multi-pronged strategy to increase the supply of residential care services, including reserving 5% of the gross floor area of public housing developments for welfare purposes, purchasing additional places through the "Enhanced Bought Place Scheme (EBPS)" and the "Bought Place Scheme (BPS) for Private RCHDs", implementing the "Special Scheme on Privately Owned Sites for Welfare Uses", etc. The Government expects to gradually increase additional 6 200 subsidised places for RCHEs and 1 900 subsidised places for RCHDs by the end of 2027[51].

3.1 Types of RCHs

RCHs in Hong Kong are mainly classified into RCHEs and RCHDs. As of 30 September 2024, there were 817 RCHEs providing more than 77 000 places; and 344 RCHDs providing more than 19 000 places in Hong Kong.

According to Section 3 of the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A), RCHEs can be classified into four types:

- A "nursing home (NH)", i.e. an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years, and who are suffering from a functional disability to the extent that they require personal care and attention in the course of daily living activities, and a high degree of professional nursing care, but do not require continuous medical supervision.

- A "care and attention (C&A)" home, i.e. an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are generally weak in health and are suffering from a functional disability to the extent that they require personal care and attention in the course of daily living activities but do not require a high degree of professional medical or nursing care.

- An "aged home", i.e. an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are capable of observing personal hygiene but have a degree of difficulty in

[51] The Legislative Council Panel on Welfare Services. "Encourage Developers to Provide Residential Care Homes for the Elderly and Residential Care Homes for Persons with Disabilities in Private Development Projects". LC Paper No. CB(2)535/2023(04)

performing household duties related to cleaning, cooking, laundering, shopping and other domestic tasks.

- A "self-care hostel", i.e. an establishment providing residential care, supervision and guidance for persons who have attained the age of 60 years and who are capable of observing personal hygiene and performing household duties related to cleaning, cooking, laundering, shopping and other domestic tasks.

According to Section 3 of the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A), RCHDs can be classified into three types:

- A high care level home, i.e. an establishment providing residential care for persons with disabilities who are generally weak in health and lack basic self-care skill to the extent that they require personal care, attention and assistance in the course of daily living activities but do not require a high degree of professional medical or nursing care.

- A medium care level home, i.e. an establishment providing residential care for persons with disabilities who are capable of basic self-care but have a degree of difficulty in daily living activities.

- A low care level home, i.e. an establishment providing residential care for persons with disabilities who are capable of basic self-care and require only minimal assistance in daily living activities.

In addition to the above classifications based on the levels of care, RCHs can generally be classified by their operating modes into subvented homes, contract homes, self-financing homes operated by non-governmental organisations (NGOs), and private homes. RCHs with different operating modes have varying fees, eligibility criteria, etc., offering citizens a range of choices.

The aforementioned Residential Care Homes (Elderly Persons) Regulation and Residential Care Homes (Persons with Disabilities) Regulation set out the requirements for the operations, staffing, management, as well as monitoring of RCHEs and RCHDs respectively. The Residential Care Homes Legislation (Miscellaneous Amendments) Ordinance 2023 (Ord. No. 12 of 2023) (the Amendment Ordinance) was gazetted on 16 June 2023 to strengthen monitoring and enhance the quality of RCHs. Except for some provisions related to staffing and per capita floor area, which will be implemented in phases, most of the provisions of the Amendment Ordinance have come into effect since 16 June 2024.

3.2 Regulation of RCH staff

As of 30 September 2024, there were 44 264 RCH staff in Hong Kong, with a rough distribution as follows:

Type of Home	Home Manager (HM)	Nurse	Health Worker (HW)	Care Worker (CW)	Ancillary Worker (AW)	Total
RCHEs	876	4 226	4 267	13 152	9 686	32 207
RCHDs	318	1 010	1 137	4 398	5 194	12 057
	1 194	**5 236**	**5 404**	**17 550**	**14 880**	**44 264**

A post of HM is established in RCH responsible for the overall administration and staff matters of the RCH. The main provisions of the Amendment Ordinance introducing a registration system for HMs came into effect on 16 June 2024. RCH operators are required to employ a registered HM or registered HM (provisional) as HM from 16 June 2025. The registration system for HMs is managed and implemented by the Director of Social Welfare (DSW). It aims to enhance HMs' professionalism, strengthen the management of RCHEs and RCHDs, and ensure their service quality.

In terms of the regulation of RCHs, the Licensing Office of RCHEs and the Licensing Office of RCHDs under the SWD each has four professional inspectorate teams. Among these teams, the Health Inspectorate Teams (HITs) are responsible for handling complaints related to care procedures, etc.

Once a complaint is received, the SWD will arrange to visit the RCH as soon as possible to conduct a multi-faceted investigation, including inspections, checking records and documents, interviewing staff and residents, etc., in order to collect comprehensive evidence. Upon completion of the investigation, an investigation report will be written; if necessary, an advisory letter or warning letter will be issued to the institution/unit involved, and the RCH involved in the complaints will be monitored to ensure that remedial measures are taken. The SWD will also prepare a written reply to the complainant explaining the investigation findings and follow-up actions. Under normal circumstances, the complainant will receive a formal reply within one month after the SWD receives the complaint.

This mechanism, implemented by professional teams, not only ensures that every complaint is handled promptly and investigated thoroughly but also explains the investigation results to relevant stakeholders in accordance with established procedures to maintain a high degree of transparency. In addition, the SWD has also established a review mechanism, allowing complainants or institutions to apply for a review if they disagree with the investigation results.

In addition to the SWD's monitoring of the overall operation of RCHs, the Nursing Council of Hong Kong (NCHK), the Physiotherapists Board, and the Occupational Therapists Board are responsible for monitoring nurses, PTs, and OTs respectively.

Upon receiving a complaint, the three statutory bodies will have their secretariats refer the complaint to the chairperson of the Preliminary Investigation Committee for review to determine whether there are grounds for further investigation. If an investigation is decided, the Preliminary Investigation Committee will review the complaint, the explanation provided by the respondent, and any other relevant information before making the following decisions:

- Dismiss the complaint; or
- Refer the whole or part of the complaint for an inquiry.

After the inquiry is completed, the relevant statutory body will make a decision based on the findings:

- Dismiss the complaint if the person complained against is not guilty of the offence charged; or
- Make an order against the person being accused if he is found guilty of the offence charged.

These statutory bodies may reprimand or warn the person against whom the complaint is made, or remove the person's name from the register permanently or for a specified period.

In general, the complaints and disciplinary procedures of the three statutory bodies are similar, all of which aim to properly handle complaints, uphold relevant professional ethics, as well as ensure fairness through open and transparent procedures.

At present, there is no statutory body to regulate STs in Hong Kong.

3.3 Current qualifications and statutory registration requirements for RCH staff

Currently, there are certain differences in the qualifications and professional credentials of RCH staff, reflecting the diverse service demands of RCHs.

3.3.1 Registered/Enrolled Nurses

According to Section 8 of the Nurses Registration Ordinance (Cap. 164), eligibility for full registration:

(1) A person with special registration is eligible for full registration if—

(a) the person has, within a period of time specified by the Council, served as a person with special registration in one or more specified institutions for at least 5 years in aggregate;
(b) the institution, or each of the institutions, certifies that it is satisfied with the person's performance by reference to the criteria specified by the Council; and
(c) the Council is satisfied that the person is of good character and has good professional conduct.

(1A) Any other person is eligible for full registration if—
(a) either—
(i) the person has completed the prescribed training and has passed the examinations as may be required by the Council; or
(ii) the person possesses a valid certificate to practise nursing issued by a certifying body recognized by the Council from time to time as constituting sufficient evidence of the person's competency to practise nursing; and
(b) the Council is satisfied that the person is of good character.

(2) Despite subsection (1A), the Council may require an applicant for full registration to prove the applicant's competency in nursing by examination conducted by examiners appointed by the Council and, if required, to undergo such further training as the Council may specify.

According to Section 14 of the Nurses Registration Ordinance, eligibility for full enrolment:

(1) A person with special enrolment is eligible for full enrolment if—
(a) the person has, within a period of time specified by the Council, served as a person with special enrolment in one or more specified institutions for at least 5 years in aggregate;
(b) the institution, or each of the institutions, certifies that it is satisfied with the person's performance by reference to the criteria specified by the Council; and
(c) the Council is satisfied that the person is of good character and has good professional conduct.

(1A) Any other person is eligible for full enrolment if—
(a) either—
(i) the person has completed the prescribed training and has passed the examinations as may be required by the Council; or
(ii) the person possesses a valid certificate to practise nursing issued by a certifying body recognised by the Council from time to time as constituting sufficient evidence of the person's competency to practise nursing; and
(b) the Council is satisfied that the person is of good character.

(2) Despite subsection (1A), the Council may require an applicant for full enrolment to prove the applicant's competency in nursing by examination

conducted by examiners appointed by the Council and, if required, to undergo such further training as the Council may specify.

3.3.2 Health Workers

According to Section 4 of the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A), a person who has completed a course of training approved by the DSW in writing either generally or in any particular case; or by reason of the person's education, training, professional experience and skill in health work, satisfies the DSW that the person is a suitable person to be registered as a registered HW, is qualified to be registered as a registered HW for the purposes of employment at a RCHE.

On the other hand, according to Section 4 of the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A), a person who has completed a course of training approved by the DSW in writing either generally or in any particular case; or by reason of the person's education, training, professional experience and skill in health work, the DSW is satisfied that the person is a suitable person to be registered as a registered HW, is qualified to be registered as a registered HW for the purposes of employment at a RCHD.

According to the new provisions of the Amendment Ordinance, the validity period of a registration or renewed registration as a HW must not exceed five years. The DSW may impose on the registration any condition that the DSW considers appropriate, including any condition relating to continuous learning. Registered HWs are required to report whether they have been prosecuted or convicted of any offences in Hong Kong or overseas.

3.3.3 Physiotherapists

There are three ways for any person to register as a PT.

1. Registration under Section 12(1)(a) of the Supplementary Medical Professions Ordinance (SMPO) (Cap. 359)

   A person who holds the following qualification as prescribed in Section 4 of the Physiotherapists (Registration and Disciplinary Procedure) Regulation (Cap 359J) shall be qualified for registration as a PT:

   - A Bachelor of Science degree in Physiotherapy awarded by the Hong Kong Polytechnic or The Hong Kong Polytechnic University;
   - A Professional Diploma in Physiotherapy issued by the Hong Kong Polytechnic on or before 1 January 1995;

- A certificate issued by the Hong Kong Government School of Physiotherapy of the Medical and Health Department on or before 1 January 1981; or
- A certificate from the Board that he has passed an examination relating to physiotherapy conducted under Section 15A of the Ordinance for the purposes of Section 12(1)(a) of the Ordinance.

2. Registration under Section 12(1)(b) of the SMPO

A person who holds a qualification which is not prescribed under Section 4 of the Physiotherapists (Registration and Disciplinary Procedure) Regulation shall be qualified for registration as a PT if a person:

i. holds an entry-level degree in physiotherapy awarded by a tertiary institute recognised by the local physiotherapy governing body. The degree must follow a programme equivalent to full-time duration of no less than three years for undergraduate or two years for post-graduate courses. The programme curriculum should be recognised by the SMP Council which include at least 800 supervised clinical hours of physiotherapy practice;
ii. holds a current registration status with a physiotherapy governing body (i.e. the governing body is defined as Government or a professional licensing body) and with a current practising right in that jurisdiction; and
iii. produces a recent letter of good standing from the academic institution or the employer or a professional body.

Applicant who has fulfilled the criteria (i) – (iii) above, but failed to satisfy completely the requirement regarding the curriculum as recognised by the SMP Council will be invited to sit for the Physiotherapists Board's registration examination which consists of two parts – written assessment and practical assessment. Candidate who has passed the written examination will be admitted to take the practical part. Anyone who has passed both parts of the examination is qualified for registration under Section 12(1)(a) of the Ordinance.

3. Registration under Section 12(1)(c) of the SMPO

A person who, on the date on which Section 12 of the SMPO commenced to apply to the physiotherapy profession (i.e. 1 April 1997), is practicing physiotherapy but who do not possess any formal qualifications may apply for registration under Section 12(1)(c) of the Ordinance. The Supplementary Medical Professions Council and Physiotherapists Board will consider each application and determine in which part of the register the name of the successful applicant shall be entered based on the applicant's education, training, professional experience and skill. Each application will be considered on its own merits.

The register of PTs consists of two parts, namely Part I and Part II. Part I is further divided into Part Ia and Part Ib. Provisional registration in the Part II register under Section 15 of the SMPO had concluded on 30 September 1997.

Applicant holding not less than one year of post-qualification 'recognised experience' may apply for registration in Part Ia Register. Applicant who does not possess that experience may apply for registration in Part Ib of the register. Section 5(2) of the PT Regulation provides that 'recognised experience' refers to an experience in the practice of physiotherapy acquired by the applicant other than in the course of practising physiotherapy:

- as a sole proprietor; or
- in any other capacity at a profit-seeking establishment at which no other PT who has experience of not less than one year in the practice of physiotherapy practises physiotherapy.

3.3.4 Occupational Therapists

Under the SMPO (Cap. 359) and the Occupational Therapists (Registration and Disciplinary Procedure) Regulations (Cap. 359B), any person is eligible for registration if a person has:

- a Professional Diploma in Occupational Therapy issued by the Hong Kong Polytechnic before 1 January 1994, or a Bachelor of Science Degree in Occupational Therapy issued by the Hong Kong Polytechnic or The Hong Kong Polytechnic University on or after 1 January 1994; or *(L.N. 517 of 1994; L.N. 643 of 1994; L.N. 436 of 1996)*
- *(Repealed L.N. 436 of 1996)*
- a certificate from the Board that he has passed an examination relating to occupational therapy conducted under Section 15A of the Ordinance for the purposes of Section 12(1)(a) of the Ordinance.

According to the above regulations, the following qualifications and experience requirements are required for inclusion in different parts of the Register:

1. Those who possess the qualifications referred to in regulation 4 and have not less than one year's relevant experience, or other experience acceptable to the Board, will be included in Part I of the register.

2. Those who only possess the qualifications referred to in regulation 4 but do not have the above experience will be included in Part II of the register.

3. If a certificate of provisional registration has been issued under Section 15, it will be entered in Part III of the register.

4. If they are eligible for registration under Section 12(1)(b) or (c), they will be included in a part of the register as determined by the Board under Section 12(1A) of the Ordinance.

An OT shall not practise without supervision unless his name has been entered in Part I of the register. A person whose name is included in Part II or III of the register may practise only under the supervision of an OT registered in Part I of the register.

3.4 Current skills and training requirements for RCH staff

The consultancy study focuses on the provision of health and rehabilitation services by RCH staff, including their required skills, training, qualification, and statutory registration requirements. Good interdisciplinary collaboration is essential to provide holistic and quality care. Therefore, it is necessary to clarify the skills and training requirements of RCH staff providing various relevant services.

3.4.1 Registered/Enrolled Nurses

The primary responsibilities of a nurse are to assess and monitor the health conditions of residents, develop and implement care plans, be responsible for drug management and emergency care, provide professional nursing services, as well as guide and train other healthcare staff.

The skills and training requirements for nurses can be categorised into the following aspects:

Specialised clinical care

- Assess the health condition, personal hygiene, nutrition and medical care, and formulate appropriate individual care plans for residents
- Responsible for technical nursing care services (e.g. providing dressing for wounds, insertion of nasogastric tubes and indwelling urethral catheters)
- Responsible for meal management (including special meal arrangements)
- Conduct health checks (including body temperature, blood pressure, pulse, and/or blood oxygen levels) for residents who require special care, specifically those who are completely unable to care for themselves and cannot effectively express their needs (e.g. residents with intellectual disabilities, cognitive impairments, or those who have suffered a stroke and are bedridden for extended periods), as well as for residents needing to be quarantined or as directed by medical authorities

Drug management, emergency care, and special care

- Check, distribute, and follow up on residents' progress after taking drugs, addressing any special circumstances immediately
- Dispose of expired and surplus drugs
- Provide first aid to those in need in the event of an accident or emergency
- Assess the use of restraints based on individual needs and risk factors of each resident, as well as any factors that may pose a risk to the resident or other residents

Document processing

- Record and keep various types of medical records (including log book and drug management)

Staff training

- Manage and guide healthcare staff, provide them with basic healthcare knowledge, and provide relevant health education and guidance to residents and their family members according to individual needs, so as to achieve professional nursing standards
- Instruct healthcare staff on the use of simple medical instruments and disinfection methods

3.4.2 Health Workers

According to paragraph 11.2 of the Code of Practice for Residential Care Homes (Elderly Persons) June 2024 (Revised Edition) and paragraph 11.2 of the Code of Practice for Residential Care Homes (Persons with Disabilities) June 2024 (Revised Edition), the main duties of a HW are to provide health and care services to residents.

With reference to the Vocational Qualifications Pathway (VQP) of the Elderly Care Service Industry under HKQF and the information collected from fieldwork, the skills and training requirements for HWs can be categorised into the following areas:

Basic knowledge

- Concept of health
- Concept of ageing
- Psychological and physical changes of residents
- Assisting residents in adapting to RCH living
- Overview of residential care services in Hong Kong

- The rights of residents and the legal responsibilities of healthcare staff under Residential Care Homes (Elderly Persons) Ordinance, Residential Care Homes (Elderly Persons) Regulation, and Code of Practice for Residential Care Homes (Elderly Persons)
- The rights of residents and the legal responsibilities of healthcare staff under Residential Care Homes (Persons with Disabilities) Ordinance, Residential Care Homes (Persons with Disabilities) Regulation, and Code of Practice for Residential Care Homes (Persons with Disabilities)

Care and human anatomy

- Objectives, principles and procedures of caring (including formulate, assess, and review individual care plans), as well as structure and function of the human body
- Skills in observing, measuring, and recording vital signs (including body temperature, blood pressure, pulse, respiration, body weight, calculating Body Mass Index)

Physiological condition and care of residents

- Understand diseases and treatments related to the circulatory system (including heart and vascular diseases, peripheral vascular diseases, cerebrovascular accidents, hypertension), and acquire proficiency in related care and skills
- Understand respiratory diseases and treatments (including tuberculosis, chronic obstructive disease, pneumonia, bronchitis, lung cancer), and acquire proficiency in related care and skills (including understanding of oxygen therapy, tracheostomy suction, tracheostomy stoma)
- Understand eye, ear, nose, and throat diseases and treatments, and acquire proficiency in related care and skills (including oral care)
- Understand related diseases and treatments, acquire proficiency in related care and skills in the use of assistive devices, understand peritoneal dialysis, master incontinence care (including the application of PAUL's tube), and understand the treatments of urinary larynx (including Foley catheter and suprapubic catheter)
- Understand diseases and treatments related to the endocrine system (including diabetes, thyroid diseases), and acquire proficiency in related care and skills (including blood glucose testing, urine glucose, insulin injection)
- Understand diseases and treatments related to the musculoskeletal system (including osteoporosis, foot diseases, joint diseases, etc.)
- Master skin care, pressure ulcer prevention and care and understand the care and treatments of common skin diseases (including eczema, psoriasis, scabies, dry skin, etc.)
- Master the skills of nursing and the use of assistive devices, the concept of wound care and disinfection, master the methods and skills of disinfection and wound care (including stoma care and the use of various wound care products)

- Master the handling of disposal of contaminated articles (including sharp objects, used syringes)
- Understand diseases and treatments related to the digestive system (including cirrhosis, liver cancer, gallstones, gastric ulcers, gastric cancer, constipation, gastrointestinal bleeding, etc.)
- Master the skills of nursing and the use of assistive devices (including understanding of the care of gastrostomy feeding tube and general feeding tube)

Psychological and psychiatric condition and care of residents

- Understand common mental health issues among residents (including depression, suicide among the elderly)
- Understand psychiatric disorders and treatments, and how to handle patients in RCHs
- Understand treatments and care of dementia and how to handle patients in RCHs (including behavioural problems such as screaming, wandering, etc.)
- Hospice services
- Rest and sleep, management of insomnia
- Sexual needs and management

Others

- Master activities of daily living and care (including compilation of daily living schedules)
- Master knowledge of special diets (including low sugar, low salt, etc.) and menu design
- Master the skills of assisted in serving food and the use of assistive devices, and feeding skills (including the use of coagulant powder and assisting residents with dysphagia, etc.)
- Facilitate leisure and social activities
- Manage RCH operations (including handling of special incidents)
- Maintain health records of residents and understand its importance
- Supervise healthcare staff
- Concepts of communication and master skills in interacting with residents and their family members
- Demonstrate the proper attitude of RCH staff
- Understand elder abuse (including neglect, physical abuse, emotional abuse, misappropriation of property, and sexual abuse)
- Acquire basic first aid knowledge and master procedures for calling an ambulance in common accident scenarios (including internal bleeding, concussion, fractures, falls, etc.)
- Master the handling, recording, and observation of accidents, as well as prevention methods (including the principles, methods, and procedures to avoid using restraints as far as possible)

- Understand commonly used drugs (including English names, common side effects, and precautions) in drug handling (management, storage, distribution, verification, and record-keeping)
- Master how to handle disposal of drugs
- Master the use of rehabilitation appliances and equipment (including mobility aids and wheelchairs) and physiotherapy techniques (including passive movement)
- Master occupational health and safety for healthcare staff (including proper lifting techniques)
- Working relationship with the Community Geriatric Assessment Team (CGATs), Community Nursing Service (CNS)/Community Psychiatric Service of the Hospital Authority, and the Visiting Health Teams of the Department of Health in order to follow up residents' discharge plan
- Master the measures to maintain environmental hygiene, control and prevent outbreaks of infectious disease in RCHs (including fever records)
- Master common infectious diseases affecting the elderly and RCHs and their care
- Master the responsibilities of the Infection Control Officer
- Master the reporting procedures for infectious disease outbreaks
- Master the appropriate use of isolation rooms, storage and use of personal protective equipment

3.4.3 Care Workers

The main duties of a CW are to provide personal care to residents and to deliver daily care services according to the care schedule designed by a nurse or HW.

Depending on the operating situation, different RCHs may use alternative titles for this position, such as Personal Care Worker or Rehabilitation Care Worker.

With reference to the "VQP" of the Elderly Care Service Industry under the HKQF and the information collected from fieldwork, the skills and training requirements for CWs can be categorised into the following areas:

Personal care

- Activities of daily living and care skills for residents (including body cleaning, dressing and changing, grooming, skin care, toileting, incontinence care, assisting with food intake and feeding, and escort skills)
- Physical conditions and needs of the elderly and persons with disabilities (including patients with dementia, patients with terminal illness, attention deficit/hyperactivity disorder, autism, hearing impairment, intellectual disability, mental illness, physical disability, specific learning difficulties, speech impairment, organ disability, and visual impairment)
- Proper use of commonly used equipment and assistive devices

- Knowledge on occupational safety and health (including physical manipulation, infection control)
- Content and requirements of individual care plans
- Measures to protect personal privacy during care

Oral care

- Skills for oral care
- Measures for caring for the oral cavity of different residents (including self-care residents, long-term bedridden residents, denture residents, residents with intellectual disabilities and special needs)
- Common oral health problems and treatment for residents on different care needs

Foot care

- Common foot problems among the residents and ways to handle (including skin abrasion, fungal infection (onychomycosis), tinea pedis, ingrown toenails, corns and calluses, sweaty feet)
- Prevention of foot problems

Vital signs

- Reasons and importance of observing vital signs
- Skills for observing, measuring, and recording vital signs (including body temperature, blood pressure, pulse, respiration, blood oxygen level, pain level)

Lifting and transfer

- Principle of correct lifting and transfer, various techniques of grip for lifting and transfer
- Common assistive devices for lifting and transfer and their methods of use
- Safety measures for lifting and transfer

Communication skills

- Common communication difficulties among the elderly and persons with disabilities
- Principles and attitudes of communication with the elderly and persons with disabilities
- Principle of communication with residents' family members and the proper attitudes

Awareness and prevention of assault and abuse

- Basic understanding of abuse (including its definitions, types, risk factors of abuse and signs of abuse)
- Implementation of relevant guidelines on the prevention of abuse (including handling of suspected abuse cases)

Relevant Ordinances and Codes of Practice

- Ordinances relevant to RCHEs and RCHDs, Code of Practice for Residential Care Homes (Elderly Persons) and Code of Practice for Residential Care Homes (Persons with Disabilities)
- Service code of practices and internal guidelines of the institution

3.4.4 Therapy/Rehabilitation Assistants

The main duties of a TA/RA are to assist in the implementation of physio/occupational therapy services, and to provide training and care to residents under the guidance of a PT/OT.

Based on the information collected from fieldwork, the skills and training requirements for TAs/RAs include:

Direct service

- Implement rehabilitation programmes under the guidance of PT/OT, record the training progress of residents, and review the effectiveness of training regularly
- Assist PT/OT in leading activities and training for residents
- Prepare venues for activities and implement follow-up work

Administration and management

- Assist in the procurement of training equipment, recreational supplies or medical supplies
- Assist in the management and inspection of training equipment or rehabilitation equipment, and perform simple repairs when necessary
- Assist in the production of training guidelines and equipment usage guidelines
- Write and submit training records, activity reports and annual review reports on time

3.4.5 Physiotherapists

The main responsibility of a PT is to provide professional services to residents in need to help them restore their mobility and daily functions, thereby enhancing their quality of life and functioning.

Based on the information collected from fieldwork, the skills and training requirements for PTs include:

Direct service

- Assess the treatment needs of residents, formulate, and implement relevant programmes (e.g. limb stretching, cardiopulmonary therapy, walking balance, and coordination for bedridden residents)
- Assess and record the health condition of residents, assist in applying for and procuring appropriate assistive devices (e.g. wheelchairs, bed exit alarms)
- Arrange daily exercises for residents to help them restore mobility and daily functions (e.g. improving the function of joints, muscles, or tendons)
- Design and make appropriate assistive devices
- Inspect physiotherapy equipment and arrange for maintenance if necessary

Administration and management

- Write assessment reports, case progress reports, and referral reports for residents in need
- Compile statistics on training and services data of service users
- Participate in special case meetings
- Apply for social resources for residents in need
- Assist in the management of treatment equipment and supplies (including procurement proposals, storage, procurement, production and simple maintenance) in the RCH/unit

3.4.6 Occupational Therapists

The main responsibility of an OT is to provide professional services to residents in need to help them maintain their daily functioning, thereby enhancing their quality of life and functioning.

Based on the information collected from fieldwork, the skills and training requirements for OTs include:

Direct service

- Assess residents' self-care abilities and provide training in areas that are impaired but with rehabilitation potential
- Assess the physical fitness, mental condition, and cognitive ability of residents as well as design appropriate dementia and occupational therapy services for them
- Help residents adapt to the residential lifestyle and maintain their daily living functions (e.g. cognition, self-care, fall prevention)

- Plan, implement and guide supporting staff in assisting residents with dementia and occupational therapy services
- Make or procure suitable assistive devices for residents in need to enhance the impaired physical functions
- Slow down ageing or problems caused by disease
- Enhance the range of motion of joints (e.g. teach patients to use assistive devices, make suitable braces for them to rest, prevent and correct joint deformity)

Administration and management

- Write assessment reports, case progress reports, and referral reports for residents in need
- Compile statistics on training and service data of service users
- Participate in special case meetings
- Serve as the Occupational Safety and Health Officer of the RCH/unit, and be responsible for related planning, supervision, and training
- Apply for social resources for residents in need
- Assist in the management of treatment equipment and supplies (including procurement proposals, storage, procurement, production and simple maintenance) in the RCH/unit

3.4.7 Speech Therapists

The main responsibility of a ST is to provide professional services to residents in need to enhance their communication and swallowing ability, thereby enhancing their quality of life and functioning.

Based on the information collected from fieldwork, the skills and training requirements for STs include:

Direct service

- Assess, diagnose, rehabilitate, and prevent communication and swallowing disorders caused by oral, laryngeal, resonance, respiratory, esophageal, or neurological functions
- Optimise residents' communication and swallowing ability through reasonable, safe, and cost-effective speech therapy programmes
- Use instrumental techniques to manage communication and swallowing disorders
- Measure and record treatment progress and outcomes

Administration and management

- Write assessment reports, case progress reports, and referral reports for residents in need
- Compile statistics on training and services data of service users
- Participate in special case meetings
- Apply for social resources for residents in need
- Assist in the management of treatment equipment and supplies (including procurement proposals, storage, procurement, production and simple maintenance) in the RCH/unit

3.5 Training to support the skill enhancement of RCH staff and to alleviate the staff shortage in the welfare sector

At present, there are many training courses in Hong Kong to support the continuous training of RCH staff and to alleviate the staff shortage in the welfare sector.

3.5.1 Training to support the skill enhancement of RCH staff

SWD has launched a five-year Training Subsidy Scheme for RCH staff (the Scheme) since 2019 to provide full subsidies for HMs, HWs and CWs of RCHs to enrol in QF-based training courses, including the "Training for Home Managers", "Advanced Training for Health Workers" and "Training for Care Workers", to continuously enhance the service quality of RCHs. All RCHs shall nominate their staff for enrolment in relevant courses with available quota. Once the trainees have been issued graduate certificates by the Training Institutes (TIs) upon completion of the relevant courses, the RCHs concerned may apply to SWD for full reimbursement of the course fees already paid.

After assessing the effectiveness of the Scheme and considering the views of the sector, SWD had obtained additional resources and extended the Scheme by three years (from 1 April 2024 to 31 March 2027) to subsidise more RCH staff to enrol in the related training courses.

Except from the Scheme mentioned, according to Qualifications Register (QR) established under the Accreditation of Academic and Vocational Qualifications Ordinance, a number of relevant training courses for RCH staff recognised under the QF are available as of September 2024:

- At least 108 courses related to TAs/RAs are organised by 33 operators[52] or assessment agencies[53].

  For example: "Certificate in Basic Rehabilitation Training for Occupational Therapy and Physiotherapy Assistants", "Certificate in Advanced Rehabilitation Training for Occupational Therapy and Physiotherapy Assistants".

- At least 104 courses related to CWs are organised by 33 operators or assessment agencies.

  These include "Certificate in Progression Training for Care Workers" – a bridging course for HWs who do not possess academic qualifications at Secondary 5 or above, but have completed the Secondary 3 curriculum and have worked as CWs in RCHEs or RCHDs for not less than three years. Upon completion of this bridging course, the person is qualified to enrol the "Health Worker Training Course (HWTC)" approved by the DSW.

- At least 59 courses related to HWs are organised by 31 operators or assessment agencies.

  These include "Combined Health Worker Training Course" – any person who has successfully completed this training can apply for registration as a HW under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) and the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A) for employment in RCHEs and RCHDs.

  "Training Course for Health Workers in RCHEs" – Upon successful completion of this course, a person may apply for registration as a HW under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) for employment in RCHEs.

  "Training Course for Health Workers in RCHDs" – Upon successful completion of this course, a person may apply for registration as a HW under the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A) for employment in RCHDs.

  "Bridging Course for Health Workers of RCHDs (Course A)" – for HWs registered under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) who are not currently working in RCHDs. Upon successful

[52] An operator is a person, school, institution, organisation or other body which provides and operates a learning programme.

[53] An assessment agency appointed by the Secretary for Education under the Accreditation of Academic and Vocational Qualifications Ordinance (Cap. 592) to conduct assessment of skills, knowledge or experience of an individual and to grant qualifications recognised under the QF (currently only on Recognition of Prior Learning (RPL)) upon successful completion of the assessment.

completion of this course, a person may apply for registration as a HW under the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A) for employment in RCHDs.

"Bridging Course for Health Workers of RCHDs (Course B)" – for HWs registered under the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) who are working in RCHDs. Upon successful completion of this course, a person may apply for registration as a HW under the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A) for employment in RCHDs.

- At least 6 courses related to HMs are organised by 3 operators or assessment agencies.

  These include "Certificate in Training for Home Managers (Course A)" – for HMs working in RCHE or RCHD, or other staff nominated by RCH, and relevant professionals (including social workers (SWs), nurses, medical officers, Chinese medicine practitioners, OTs, PTs or dispensers) registered under the laws of Hong Kong; and

  "Certificate in Training for Home Managers (Course B)" – for HMs working in RCHE or RCHD, or other staff nominated by RCH.

  For the above two courses, trainees who have obtained Statement of Attainment for the Recognition of Prior Learning (RPL) in "Customer Service Excellence" and "Accident Handling" may apply for exemption from the respective modules.

3.5.2 Training to alleviate the staff shortage in the welfare sector

To alleviate the shortage of nurses in the welfare sector, the SWD has commissioned the Hong Kong Metropolitan University (formerly the Open University of Hong Kong) to provide the "Enrolled Nurse (General) Training Programme for the Welfare Sector" from the academic year of 2017-18, providing fully subsidised training places for ENs (General) every year. Starting from the academic year of 2023-24, the SWD has commissioned two more institutions, the Saint Francis University (formerly the Caritas Institute of Higher Education) and the Tung Wah College, to provide more subsidised training places for five academic years. From the academic years of 2017-18 to 2027-28, the SWD is expected to subsidise a total of about 3 300 trainees to study this training programme. Tuition fees will be reimbursed to trainees in full on the condition that they have successfully completed the training programme and qualified to register as ENs within two years. Trainees are required to sign an undertaking to work as ENs (General) in NGOs or private organisations recognised by the SWD for providing elderly, rehabilitation, family and child care, or correctional services for a continuous period of no less than two or three years after completion of the

training[54].

To alleviate the shortage of allied health professionals in the welfare sector, the SWD has implemented a Training Sponsorship Scheme since 2012 to provide funding support for NGOs operating subsidised elderly or rehabilitation services to sponsor full tuition fees for trainees of designated programmes in occupational therapy or physiotherapy who are recruited by these NGOs. The sponsored trainees must undertake to work for the NGOs concerned for at least three years (graduates of a Master's Degree) and two years (graduates of a Bachelor's Degree) after graduation. As at 2022, 270 sponsored occupational therapy and physiotherapy graduates joined the welfare sector.

Starting from 2023-24, the Government continues to implement this Training Sponsorship Scheme over the next five years, fully sponsoring the tuition fees of an additional 750 trainees of the Master of Occupational Therapy and Master of Physiotherapy programmes of the Hong Kong Polytechnic University, as well as the Bachelor of Occupational Therapy and Bachelor of Physiotherapy programmes of the Tung Wah College.

3.6 Manpower challenges in the RCH sector

The RCH sector has been facing a challenge due to a shortage of care professionals. Following the gazetting of the Amendment Ordinance in June 2023, several new provisions will be implemented in phases. Starting from mid-2028, at least one nurse and one HW must be on duty simultaneously for a minimum of eight hours daily in high care level RCHs with more than 60 residents. Additionally, from a date to be specified by the Secretary for Labour and Welfare, high care level RCHs with 60 or fewer residents will also be required to comply with this statutory staffing requirement. According to current estimates, existing and new RCHs will need to recruit over 1 100 nurses over the next five years in response to the Amendment Ordinance. Along with the vacancies and attrition of existing ENs, the RCH sector will need to recruit more than 2 300 nurses, indicating a high demand for talent in professional nursing care.

As mentioned in paragraph 3.5.2, the SWD has commissioned tertiary institutions to provide the "Enrolled Nurse (General) Training Programme for the Welfare Sector". It anticipates that subsidising full tuition fees and requiring trainees to commit to working in the welfare sector for no less than two to three years after graduation will help nurture talent for the sector. However, some graduates, after spending some time in the welfare sector, have switched to the medical sector for reasons related to personal career development, job nature and salary

[54] Starting from the academic year of 2017-18, trainees enrolled in the "Enrolled Nurse (General) Training Programme for the Welfare Sector" are required to sign an undertaking to work as ENs (General) in institutions recognised by the SWD for providing elderly, rehabilitation, family and child care, or correctional services for a continuous period of no less than two years after completion of the training. Starting from the academic year of 2023-24, trainees are required to be employed in the welfare sector for three years after completion of the training.

considerations. Others pursue further education to become RNs and subsequently enter the medical sector. Consequently, the welfare sector has struggled to compete with the medical sector for care professionals and has found it difficult to establish its own pool of care professionals.

Moreover, the public at large have little understanding of the jobs and work in RCHs and generally perceive the care positions in RCHs as unprofessional, making the sector and the job posts unattractive to new entrants (particularly young people). And the absence of a clear career progression path for HWs in RCHs complicates the sector's ability to retain ambitious and capable talent.

Chapter 4 Methods for Collecting and Analysing Data and Opinions

4.1 Methods for collecting data and opinions

The Consultant collected data and opinions to conduct research through the following methods:

(a) Project initiation workshop (Annexes 2 & 3)

Objective	Introduced the content of the consultancy study to the participants and established common goals and expectations with the participants.
Target Group	All RCH staff and relevant stakeholders in Hong Kong.
Number of Participants	110
Implementation Time	15 November 2023 (Wednesday)

(b) Partnership team meetings

Objective	Followed up on the progress of the consultancy study and obtained support to liaise with relevant stakeholders and/or co-ordinate follow-up activities.
Target Group	Voluntary participants from the workshop.
Number of Participants	11
Implementation Time	28 November 2023 and 22 February 2024

(c) Desktop research

Objective	Collected relevant documents and information and conducted analysis.
Format	Apart from collecting study-related documents (e.g. annual reports, manpower planning, staff training and

development records) from a sample of 52 RCHs, reference was made to the practices of some overseas and Mainland RCHs.

Implementation Time	1 July 2023 to 26 April 2024

(d) Fieldwork (Annexes 4 to 12)

Objective	Gained in-depth understanding of the service processes and time allocation of key RCH staff.
Target Group	30 RCHEs and 22 RCHDs.
Format	Approximately 210 minutes were allocated for each sampled RCH. At least two consultants (including with nursing background) were arranged to participate in each fieldwork session to understand the care services provided by the RCH, the skills used, and the requirements of the residential care services. The consultants also intentionally scheduled the fieldwork for different days of the week (Monday to Sunday) and at various times of day (morning, afternoon, and evening) to gather comprehensive data across different time periods and observe staff performance at different intervals.
Implementation Time	27 November 2023 to 19 March 2024

(e) Individual interviews (Annex 13)

Objective	Gained a deeper understanding of stakeholders' concerns and explored issues from a strategic perspective.
Target Group	Various relevant stakeholders, including Legislative Council members, representatives from the nursing training sector, union members, RCH operators, etc.
Number of Participants	24
Implementation Time	From December 2023 onwards

(f) Focus groups (Annex 14)

Objective	Gained a deeper understanding of stakeholders' concerns and explored issues from a practical perspective.
Target Group	All RCH staff and relevant stakeholders in Hong Kong.
Number of Participants	106, plus 17 participants in the focus group on the training course for the promotion of in-service HWs.
Format	Eight online focus groups and three in-person focus groups were conducted, with approximately 90 minutes allocated for discussions with each group of participants. Among them, eight focus groups were organised by job posts within RCHs and included the following types of staff: • HMs (one group) • RNs/ENs (two groups) • HWs (two groups) • CWs (one group) • PTs/OTs/STs and TAs/RAs (one group) • SWs (one group) Additionally, there were two open groups for all interested RCH staff to join. Visiting Medical Officers were also invited to participate (one group).
Implementation Time	28 March to 18 April 2024
Remark	The Consultant conducted another online focus group on 12 November 2024 to discuss the training courses for the promotion of in-service HWs. 17 HWs participated.

(g) Stakeholder opinion survey (Annex 15)

Objective	Engaged with a broader range of relevant stakeholders to gather quantifiable data on motivations for entering the industry and industry enhancement.
Target Group	All RCH staff and relevant stakeholders in Hong Kong.
Number of	1 257 RCH staff and 99 non-RCH staff.

Participants	
Format	Voluntary anonymous questionnaires were made available in both paper and online formats.
Implementation Time	20 May to 23 June 2024

(h) Strategy forum (Annex 16)

Objective	Conducted more in-depth discussions and consultations on the issues and views gathered, particularly focusing on identifying potential short-, medium-, and long-term solutions.
Target Group	All RCH staff and relevant stakeholders in Hong Kong.
Number of Participants	85
Format	Half-day face-to-face workshop.
Implementation Time	5 September 2024

(i) Consultations with relevant professional bodies and advisory committees

Objective	Consulted the NCHK, Elderly Commission (EC) and Rehabilitation Advisory Committee (RAC) on the preliminary recommendations of the consultancy study and collected their views.
Format	Sent a letter to NCHK to introduce the preliminary recommendations; and attended EC and RAC meetings to introduce the main findings and recommendations of the consultancy study.
Implementation Time	Letter to NCHK on 11 September 2024; RAC meeting on 11 December 2024; and EC meeting on 12 December 2024.

4.2 Sample selection methods

To mitigate sampling bias, the Consultant used stratified and random sampling techniques to select the sampled RCHs. The Consultant also took the location of RCHs into consideration when selecting the samples.

The nature, type, and sample distribution of RCHEs are as follows:

Type of the Home	Home Nature	Number of RCHEs	Bed No.	Subtotal	Number of homes to be sampled for fieldwork
Nursing Home	Contract Home operated by NGO	23	60 and below	0	0
			61-120	10	1
			121 and above	13	1
	Contract Home operated by private operators	17	60 and below	0	0
			61-120	13	1
			121 and above	4	1
	Self-financing nursing homes (Not joining Nursing Home Purchase Scheme (NHPPS) operated by NGOs)	1	60 and below	0	0
			61-120	1	1
			121 and above	0	0
Care and Attention Home	Subvented Homes/subvented cum self-financing home	120	60 and below	12	1
			61-120	62	2
			121 and above	46	1
	Self-financing Homes joining RCSV	6	60 and below	3	0
			61-120	1	1
			121 and above	2	0
	Self-financing Homes not joining RCSV	18	60 and below	7	1
			61-120	9	1
			121 and above	2	1
	Self-financing Homes joining NHPPS (regardless joining RCSV or not)	4	60 and below	0	0
			61-120	1	0
			121 and above	3	1
	Private Homes joining Enhanced Bought Place Scheme (EBPS) and/or RCSV	215	60 and below	39	1
			61-120	99	2
			121 and above	77	2
	Private Homes not joining EBPS or RCSV	399	60 and below	218	5
			61-120	138	3
			121 and above	43	1
Aged Home	Private Homes	2	60 and below	2	0
			61-120	0	0
			121 and above	0	0
	Self-financing Homes	7	60 and below	4	1
			61-120	3	1
			121 and above	0	0
			Total	812	30

The nature, type and sample distribution of RCHDs are as follows:

SWD-subvented home		Total number of RCHDs in different care levels			Subtotal	Number of homes to be sampled for fieldwork
		High	Medium	Low		
(i)	Care and Attention Home for Severely Disabled Persons (C&A/SD)	24	0	0	24	1
(ii)	Care and Attention Home for the Aged Blind (C&A/AB)	11	0	0	11	1
(iii)	Long Stay Care Home (LSCH)	7	0	0	7	1
(iv)	Hostel for Severely Mentally Handicapped Persons (HSMH)	71	0	0	71	2
(v)	Hostel for Severely Physically Handicapped Persons (HSPH)	12	1	0	13	1
(vi)	Hostel for Severely Physically Handicapped Persons with Mental Handicap (HSPH/MH)	3	0	0	3	1
(vii)	Transitional Care and Support Centre for Tetraplegic Patients (TCSC)	1	0	0	1	1
(viii)	Halfway House (HWH)	0	36	0	36	1
(ix)	Hostel for Moderately Mentally Handicapped Persons (HMMH)	7	43	0	50	1
(x)	Supported Hostel (SHOS)	7	1	25	33	1
(xi)	Integrated Vocational Training Centre [IVTC] - Residential Service	0	0	2	2	1
(xii)	Small Group Home for Mildly Mentally Handicapped Children (SGH(MMHC))	0	0	6	6	1
LWB-subvented Home		0	1	0	1	1
Self-financing Home		3	9	6	18	3
Private Home joining Bought Place Scheme (BPS)		13	9	0	22	2
Private Home without joining BPS		0	40	1	41	3
	Total	159	140	40	339	22

Please refer to Annexes 5 and 6 for details of the sampled RCHs.

To gather a wide range of opinions, the Consultant employed the same sampling method and sample size to invite RCH staff to participate in focus group discussions and stakeholder opinion survey.

In summary, the Consultant conducted three sampling exercises. The first batch of RCHs was selected for fieldwork. The second and third batches were selected for focus groups and stakeholder opinion survey respectively. In the event of the overall number of a certain nature of RCHs was fewer than three (e.g. Self-financing Nursing Homes not joining NHPPS operated by NGOs, Transitional Care and Support Centre for Tetraplegic Patients), the quota was allocated to the nature of RCHs with a larger overall number. Overall, the Consultant contacted at least 90 RCHEs and 66 RCHDs to collect diverse data and information for the consultancy study.

4.3 Data analysis methods

The Consultant took a variety of approaches to data processing.

Data cleaning: Remove incorrect, missing, or inaccurate values in the dataset.
Data integration: Integrate statistics from multiple data sources.
Data analysis: Analyse and interpret data using statistical methods.
Data visualisation: Present data in charts and graphs for better comprehension.

Once data from various research tools was collected, the consultants responsible for fieldwork, individual interviews, and focus group discussions were required to input the data directly into the designated platform by the Consultant within a specified time frame (e.g. 24 hours). They also needed to submit the manuscript and any audio recordings (if any) to the reviewer. Additionally, the support staff were responsible for inputting data from the reply form related to the daily health and rehabilitation services received by the residents (Annexes 8 to 9), time logs (Annex 12), and survey questionnaires (Annex 15). The original questionnaires were required to be submitted to the reviewer within the specified time frame following data input.

The consultant team employed a rigorous data verification and processing protocol to ensure data quality and trustworthiness. First, the accuracy and completeness of the input data were reviewed. Next, data collation occurred, and both descriptive and numerical statistics were calculated. Qualitative analysis techniques were then applied to identify patterns and trends within the data. Meanwhile, the triangulation method was utilised to cross-compare data sources and examine the relationships between variables. Throughout the analysis process, the consultant team conducted repeated reviews and discussions to validate the results and enhance accuracy and reliability.

4.4 Data management methods

Data management is an essential component of any consultancy study. All along, the Consultant strictly adhered to the data retention and destruction policy to ensure the security and confidentiality of the data. During the research period, the consultant team encrypted the data, which could only be decrypted and accessed by team members, ensuring that all information remained secure. If it becomes necessary to present a specific case, prior consent from the relevant organisation and the person concerned must be obtained, along with appropriate measures to safeguard any information that could compromise the confidentiality and privacy of institutions and individuals.

Within one month after the completion of the consultancy study, the Consultant will destroy all data containing identifiable information of RCHs and individuals,

as well as the original personal reply forms submitted by stakeholders, to eliminate any risk of data leakage for both RCHs and individuals. However, in order to fulfil professional duties and maintain a comprehensive record of the research process, the Consultant will retain anonymised documents such as integrated research results, research methods and procedures, data analysis reports, etc., and all retained data will be encrypted and protected for internal use only by the consultant team. The Consultant will provide the SWD with aggregate statistical data upon request that has been anonymised and cannot be traced back to any RCHs or individuals.

Chapter 5 Results of Data Collection and Analysis on Residential Care Services

Health services in RCHs cover a wide range of areas. Except from arranging annual health examinations and regular visits from medical officers for medical consultations and follow-up treatments, RCH staff are responsible for providing various daily health and rehabilitation services to residents. As residents in different types of RCHs differ in health conditions and self-care abilities, their service needs may also vary. On the other hand, different types of RCHs employ a diverse range of staff to deliver corresponding services based on specific conditions.

By reviewing the core health services that key RCH staff deliver on a daily basis, the Consultant gained an understanding of the actual job functions of RCH staff and their practical needs for continuing education and professional development. This understanding helped to formulate more realistic and forward-looking human resource development strategies for enhancing overall service quality.

The following data analysis results were obtained from the Consultant's fieldwork conducted at 30 RCHEs and 22 RCHDs between late November 2023 and mid-March 2024.

5.1 Daily health services currently provided by staff in RCHEs

The sample of 30 RCHEs included 5 NHs, 23 C&A Homes, and 2 Aged Homes.

To ensure data confidentiality, any classifications with a sample size of fewer than three were reported alongside the most similar type. Consequently, the following reports were grouped into "NHs" and "C&A Homes and Aged Homes". At the time of the consultancy study, there were no self-care hostels in Hong Kong.

5.1.1 Average frequency and ratio of various healthcare services received by residents in RCHEs

In accordance with the Code of Practice for Residential Care Homes (Elderly Persons) June 2024 (Revised Edition), and based on the data from fieldwork, reply forms (Annex 8), and time logs (Annex 12) returned from RCHEs, the Consultant compiled the statistics on the content and hours of healthcare services provided by various staff of RCHEs as follows:

(a) Health surveillance services

Daily health surveillance services involve monitoring residents' health conditions as needed, including checking body temperature and blood pressure. These tasks are typically performed by HWs, followed by RNs/ENs and CWs, with an average duration of 2.93 minutes per resident. The average daily usage is 1.09 times per resident in C&A Homes and Aged Homes, and 2.40 times per resident in NHs.

(b) Personal care

Personal care is generally carried out by CWs on a daily basis. These tasks include:

- Bathing and hair washing as needed, is performed by at least two CWs at a time, with an average duration of 14.23 minutes. The average daily usage is 0.83 times per resident in C&A Homes and Aged Homes, while the average daily usage is 0.5 times per resident in NHs.
- Hair cutting, shaving, manicuring, dental and oral cleaning are provided to residents with an average duration of 3.65 minutes per session. Regardless of whether the residents are in C&A Homes, Aged Homes, or NHs, each resident uses these services an average of 1.00 time per day.
- Changing clothes, bed linens and pillows requires an average of 6.03 minutes per session. The average daily usage is 0.82 times per resident in C&A Homes and Aged Homes, and 0.5 times per resident in NHs.
- Changing diapers is performed by at least two CWs at a time, with an average duration of 4.72 minutes. Regardless of whether the residents are in C&A Homes, Aged Homes, or NHs, each resident uses this service an average of 4.5 times per day.
- Assisting bedridden residents in changing their positions regularly is performed by at least two CWs at a time, with an average duration of 4.25 minutes per position change. The average daily usage is 7.43 times per resident in C&A Homes and Aged Homes, while the average usage in NHs that required more frequent assistance is 8.40 times per resident.
- Preparing food/nutritional well-balanced diet or coagulant powder requires an average of 1.73 minutes per session. The average daily usage is 3.60 times per resident in C&A Homes and Aged Homes, while the average daily usage is 4.00 times per resident in NHs.

The average frequency of bathing and hair washing as well as changing clothes, bed linens and pillows as needed is higher for residents in C&A Homes and Aged Homes compared to NHs. This is primarily attributed to the daily bathing services offered to residents in some of these RCHEs.

(c) Drug management

The administration of medication on a daily basis is generally the responsibility of HWs or RNs/ENs. These tasks include:

- Preparing drugs for residents requires an average of 7.16 minutes per session. The average daily administration is 1.07 times per resident in C&A Homes and Aged Homes, while the average is 2.06 times per resident in NHs.
- Giving (oral) drug requires an average of 2.13 minutes per session, typically performed by at least two RCH staff (e.g. with one nurse supervising another nurse or HW giving drugs). The average daily administration is 3.75 times per resident in C&A Homes and Aged Homes, while it is 4.30 times per resident in NHs.
- Giving (topical) drug requires an average of 3.79 minutes per session. The average daily administration is 2.89 times per resident in C&A Homes and Aged Homes, while it is 4.10 times per resident in NHs.
- Giving (subcutaneous) injection requires an average of 5.81 minutes per session. The average daily administration is 1.38 times per resident in C&A Homes and Aged Homes, while the average is 1.80 times per resident in NHs.

Except from HWs or RNs/ENs, some RCHEs employ dispensers or use the services of the Medication Management Centre to prepare drugs for residents.

(d) Use of restraint(s)

When using physical restraint(s), it is required to release physical restraint(s) during the period of restraint on the resident. This type of task is generally performed by CWs, followed by HWs or RNs/ENs. The average time required for each session is 3.75 minutes. Each resident in need in C&A Homes and Aged Homes receive this service an average of 7.20 times per day, while each resident in need in NHs receive it 8.00 times per day.

(e) Special nursing care procedures

With the exception of CWs who assist residents with urinary catheters, other daily special nursing care procedures are typically provided by HWs or RNs/ENs. These tasks include:

- Assisting residents in the use of urinary catheters requires an average of 13.82 minutes per session. The average daily usage in C&A Homes and Aged Homes is 3.13 times per resident in need, while in NHs, it is 4.10 times.

- Performing peritoneal dialysis requires an average of 9.00 minutes per session. The average daily usage in C&A Homes and Aged Homes is 3.33 times per resident in need, while in NHs, it is 2.00 times.
- Assisting residents in the use of feeding tubes requires an average 6.79 minutes per session. The average daily usage in C&A Homes and Aged Homes is 4.14 times per resident in need, while in NHs, it is 4.60 times.
- Providing dressing for wounds requires an average of 11.38 minutes per session. The average daily usage in C&A Homes and Aged Homes is 1.21 times per resident in need, while in NHs, it is 1.40 times.
- Assisting residents in the use of ventilator/oxygen therapy requires an average of 2.00 minutes per session. The average daily usage in C&A Homes and Aged Homes is 1.00 time. None of the residents in samples of NHs required this service.

Except from RCH staff, the community nurses also visit RCHs to provide wound care for residents in need.

(f) Rehabilitation services

In RCHEs, rehabilitation services generally include physiotherapy, occupational therapy, and speech therapy. While a few RCHEs employ therapists (physio/occupational/speech) and TAs/RAs, most rehabilitation services are provided through individualised exercise training by CWs and group exercises led by ancillary workers (AWs). Additionally, some RCHEs use services from the Outreach Services Team.

Please refer to Tables L 9 and L 10 for details.

5.1.2 Staff-to-resident ratio in RCHEs

According to the "RCHE Staff List" submitted to SWD on 30 September 2023, the total number of staff with reported working hours in the sample of 5 NHs was 441, serving 649 residents, yielding a staff-to-resident ratio of 1 : 1.47. In the sample of 25 C&A Homes and Aged Homes, the total number of staff was 1 025, serving 2 047 residents, yielding a staff-to-resident ratio of 1 : 1.99.

Please refer to Table L 6 and Table L 7 for details.

5.1.3 Total number of hours worked per week by staff in RCHEs

In the sample of 5 NHs, 441 staff (including full-time, half-time, or part-time and relief; staff without reported working hours are not included) reported a total of 19 992.45 hours worked per week, averaging 45.33 hours per staff. Of these hours, 19.48% were contributed by RNs and ENs, 74.24% by HWs, CWs, and AWs, and the remaining 6.28% by HMs, SWs, and others (Table L 1).

In the sample of 25 C&A Homes and Aged Homes, 1 025 staff reported a total of 54 637.85 hours worked per week, averaging 53.31 hours per staff. Of these hours, 10.59% were contributed by RNs and ENs, 81.31% by HWs, CWs, and AWs, and the remaining 8.10% by HMs, SWs, and others (Table L 2).

5.1.4 Average hours per resident day (HPRD) in RCHEs

To facilitate international benchmarking, the Consultant categorised the staff in the sampled RCHs into (1) job posts that could be compared against an international benchmark and (2) other job posts. Since RCHs operate around the clock, the Consultant calculated the average daily working hours by dividing the weekly total working hours of each job post by seven days.

In the sample of 5 NHs, 326 staff (73.92%) reported their working hours, that could be compared against an international benchmark, totalling an average of 2 136.05 hours per day (Table L 3). The average daily working hours were 6.55 hours per staff.

In the sample of 25 C&A Homes and Aged Homes, 698 staff (68.10%) reported their working hours, that could be compared against an international benchmark, totalling an average of 5 400.43 hours per day (Table L 4). The average daily working hours were 7.73 hours per staff.

Since job titles vary across economies, the Consultant identified comparable key job posts in Hong Kong's RCHs to those in the international LTC studies, including RNs, ENs, HWs, and CWs (Table L 5). The average HPRD was then compared with those in other economies.

In contrast to other RCHEs in Hong Kong, NHs' baseline of manpower allocation on the number of beds. For the sample of 5 NHs, the Consultant divided the average number of hours worked per day by the total number of residents, the average HPRD from benchmark job posts were 3.29 hours, including 0.55 hours from RNs, 0.34 hours from ENs, and 2.39 hours from HWs and CWs. The average daily care hours provided by other job posts were 1.11 hours, resulting in a total of 4.40 hours when combining both categories of staff (Table L 6).

For the sample of 25 C&A Homes and Aged Homes, the average HPRD was were 2.64 hours, including 0.18 hours from RNs, 0.23 hours from ENs, and 2.22 hours from HWs and CWs. The average daily care hours provided by other job posts were 1.17 hours, resulting in a total of 3.81 hours when combining both categories of staff (Table L 7).

5.1.5 Baseline for manpower allocation in RCHEs

(a) Calculation of minimum staffing needs based on the workload and number of hours worked

The Consultant first calculated the average number of hours required for the provision of various services by the sample staff in RCHEs based on the fieldwork records (Table L 8). Then, the number of residents receiving various services and the average frequency of service use were counted according to the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by the sample of RCHEs (Tables L 9 and L 10).

As residents in NHs are more likely to require dedicated and highly specialised care (though do not require continuous medical supervision) due to their weakened physical functions, the Consultant estimated the care hours required for residents in need of comprehensive care. From fieldwork in 5 sampled NHs, the Consultant found that residents requiring comprehensive care usually need most of the first to fifth health services mentioned in Table L 8. Consequently, the Consultant selected the most frequently used service items among these residents for the estimate. The results indicate that the care hours required per resident in NHs range from 1.36 hours to 4.36 hours, depending on individual needs (Table L 9).

For C&A Homes and Aged Homes, the Consultant referenced the method used to estimate the number of care hours required by nursing home residents to assess the situation in C&A Homes and Aged Homes. The results indicate that the care hours required per resident range from 1.19 hours to 3.72 hours, depending on individual needs (Table L 10).

(b) Current staffing of C&A Homes and Aged Homes

Based on the number of care hours required by 1 595 residents in Table L 11 and the estimated distribution of working hours by key job posts (Table L 12), the estimated staffing needs include about 133 nurses, 110 HWs, and 451 CWs.

According to the staff lists from the sample of 25 C&A Homes and Aged Homes submitted on 30 September 2023, the numbers of key RCH staff providing health services were 137 nurses, 130 HWs, and 416 carers (Table L 4). The above results suggest that RCHEs currently meet the required number of care hours for their residents.

(c) Current staffing of NHs

According to the Residential Care Homes (Elderly Persons) Regulation, staffing requirement is currently determined by the total number of beds in NHs. Therefore, the estimated manpower requirements based on overall working hours are not applicable to NHs.

5.2 Daily health services currently provided by staff in RCHDs

The sample of 22 RCHDs included 11 high care level homes, 7 medium care level homes, and 4 low care level homes.

5.2.1 Average frequency and ratio of various healthcare services received by residents in RCHDs

In accordance with the Code of Practice for Residential Care Homes (Persons with Disabilities) June 2024 (Revised Edition), and data from fieldwork, reply forms (Annex 9), and time logs (Annex 12) returned from RCHDs, the Consultant compiled the statistics on the content and hours of healthcare services provided by various staff of RCHDs as follows:

(a) Physical training services

Daily physical training services involve providing physical activity exercise for residents. These tasks are typically carried out by PTs, OTs, STs, TAs/RAs, as well as CWs, followed by rehabilitation workers, programme workers, community rehabilitation workers, housekeeping assistants, or houseparents. The average duration of these services is 4.98 minutes per session. The average daily usage is 1.00 times per resident in high care level homes, 1.04 times per resident in medium care level homes, and 1.00 times per resident in low care level homes.

(b) Personal care

The daily provision of personal care is generally carried out by CWs, housekeeping assistants, or houseparents, followed by rehabilitation workers or programme workers. These tasks include:

- Bathing and hair washing as needed, is performed by at least two CWs at a time, with an average duration of 11.38 minutes per session. The average daily usage per resident is 0.90 times in high care level homes, and 1.00 time in both medium and low care level homes.
- Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning are provided to residents with an average duration of 2.14 minutes

per session. The average daily usage per resident is 1.80 times in high care level homes, and 1.00 time in both medium and low care level homes.

- Changing clothes, bed linens and pillows requires an average of 4.80 minutes per session. The average daily usage per resident is 0.90 time in high care level homes, 1.00 time in medium care level homes and 1.00 time in low care level homes.
- Changing diapers is performed by at least two CWs at a time, with an average duration of 5.08 minutes. The average daily usage per resident is 4.80 times in high care level homes and 3.17 times in medium care level homes. In the sample of low care level homes, none of the residents required this service.
- Assisting bedridden residents in changing their positions regularly is performed by at least two CWs at a time, with an average duration of 3.40 minutes per position change. The average daily usage per resident is 7.11 times in high care level homes, while 6.67 times in medium care level homes. In the sample of low care level homes, none of the residents required this service.
- Preparing food/nutritional well-balanced diet or coagulant powder requires an average of 3.00 minutes per session. The average daily usage per resident is 4.33 times in high care level homes. In the samples of medium and low care level homes, none of the residents required this service.

(c) Drug management

The administration of medication on a daily basis is generally the responsibility of HWs or RNs/ENs. In some RCHDs where nurses are not present, trained CWs or AWs would assist HWs. These tasks include:

- Preparing drugs for residents requires an average of 7.34 minutes per session. The average daily administration is 1.23 times per resident in high care level homes, 0.79 time in medium care level homes, and 0.78 time in low care level homes.
- Giving (oral) drug requires an average of 1.82 minutes per session, typically performed by at least two RCH staff (e.g. with one nurse supervising another nurse or HW giving drugs, one trained CW or AW assisting HW). The average daily administration is 2.25 times per resident in high care level homes, 2.65 times in medium care level homes, and 3.33 times in low care level homes.
- Giving (topical) drug requires an average of 2.74 minutes per session. The average daily administration is 2.27 times per resident in high care level homes, 2.25 times in medium care level homes, and 3.00 times in low care level homes.
- Giving (subcutaneous) injection requires an average of 5.00 minutes per session. The average daily administration in both high and medium care

level homes is 2.00 times per resident. In the sample of low care level homes, none of the residents needed to use this service.

Except from HWs or RNs/ENs, some RCHDs employ dispensers or use the services of the Medication Management Centre to prepare drugs for residents.

(d) Use of restraint(s)

When using physical restraint(s), it is required to release physical restraint(s) during the period of restraint on the resident. This type of task is generally performed by CWs, HWs or RNs/ENs, followed by rehabilitation workers, programme workers or SWs, with an average of 2.00 minutes per session. The average daily usage is 8.00 times per resident in both high and medium care level homes. In the sample of low care level homes, none of the residents needed to use this service.

(e) Special nursing care procedures

With the exception of CWs who assist residents with urinary catheters, other daily special nursing care procedures are typically provided by HWs or RNs/ENs. These tasks include:

- Assisting residents in the use of urinary catheters requires an average of 2.00 minutes per session. The average daily usage per resident in need is 4.13 times in high care level homes and 4.50 times in medium care level homes. In the sample of low care level homes, none of the residents needed to use this service.
- Performing peritoneal dialysis requires an average of 12.00 minutes per session. The average daily usage per resident in need is 4.00 times in high care level homes. In the samples of medium and low care level homes, none of the residents required this service.
- Assisting residents in the use of feeding tubes requires an average of 10.70 minutes per session. The average daily usage per resident in need is 4.13 times in high care level homes and 3.00 times in medium care level homes. In the sample of low care level homes, none of the residents required this service.
- Providing dressing for wounds requires an average of 12.50 minutes per session. An average daily usage per resident in need is 1.00 time in high, medium and low care level homes.
- Emptying stoma bags requires an average of 10.00 minutes per session. The average daily usage per resident in need is 6.00 times in medium care level homes. None of the residents in the samples of high and low care level homes required this service.

(f) Rehabilitation services

In RCHDs, rehabilitation services generally include physiotherapy, occupational therapy, and speech therapy. While a few RCHDs employ therapists (physio/occupational/speech) and TAs/RAs, most rehabilitation services are provided through individualised exercise training and group exercises by wardens, programme workers, or activity assistants. Additionally, some RCHDs use services from the Outreach Services Team.

Please refer to Tables D 11 to D 13 for details.

5.2.2 Staff-to-resident ratio in RCHDs

According to the "RCHD Staff List" submitted to SWD on 30 September 2023, the total number of staff with reported working hours in the sample of 11 high care level homes was 1 066, serving 1 588 residents, yielding a staff-to-resident ratio of 1 : 1.48. In the sample of 7 medium care level homes, the total number of staff with reported working hours was 154, serving 527 residents, yielding a staff-to-resident ratio of 1 : 3.42. In the sample of 4 low care level homes, the total number of staff with reported working hours was 32, serving 141 residents, yielding a staff-to-resident ratio of 1 : 4.40.

Please refer to Tables D 7 to D 9 for details.

5.2.3 Total number of hours worked per week by staff in RCHDs

In the sample of 11 high care level homes, 1 066 staff (including full-time, half-time or part-time and relief; staff without reported working hours are not included) reported a total of 49 128.50 hours worked per week, averaging 46.09 hours per staff. Of these hours, 7.95% were contributed by RNs and ENs, 83.51% by HWs, CWs, and AWs, and the remaining 8.54% by HMs, SWs, and others (Table D 1).

In the sample of 7 medium care level homes, 154 staff reported a total of 6 875.00 hours worked per week, averaging 44.64 hours per staff. Of these hours, 5.74% were contributed by RNs and ENs, 80.58% by HWs, CWs, and AWs, and the remaining 13.68% by HMs, SWs, and others (Table D 2).

In the sample of 4 low care level homes, 32 staff reported a total of 1 388.00 hours worked per week, averaging 43.38 hours per week per staff. Of these hours, 82.20% were contributed by HWs, CWs, and AWs, and the remaining 17.80% by HMs, SWs, and others (Table D 3).

5.2.4 Average hours per resident day (HPRD) in RCHDs

Similar to the method used to calculate the average HPRD in RCHEs, the Consultant categorised the staff in the sampled RCHDs into (1) job posts that could be compared against an international benchmark and (2) other job posts.

In the sample of 11 high care level homes, 568 staff (53.28%) reported their working hours, that could be compared against an international benchmark, totalling an average of 3 793.71 hours per day (Table D 4). The average daily working hours were 6.68 hours per staff.

In the sample of 7 medium care level homes, 80 staff (51.95%) reported their working hours, that could be compared against an international benchmark, totalling an average of 510.71 hours per day (Table D 5). The average daily working hours were 6.38 hours per staff.

In contrast to the statutory minimum staffing requirements for the aforementioned two types of RCHDs, low care level homes are not mandated to employ HWs or nurses. Consequently, only the reported working hours of 5 staff (15.63%) from the sample of 4 low care level homes were available for international benchmarking, averaging 35.43 hours per day (Table D 6). The average daily working hours were 7.09 hours per staff.

The above data indicate that the number of job posts that could be compared against an international benchmark is relatively limited, ranging from 15.63% to 53.28%. This represents a gap compared to 68.10% to 73.92% found in the broader sample of RCHEs. Although this data does not provide a complete picture of the staffing situation, it can still serve as a valuable reference. It is important to note that the average daily total of care hours per resident encompasses both job posts that could be compared against an international benchmark and other job posts. Therefore, the hours worked in benchmark job posts should be considered within a broader context, rather than as a complete representation of the total care hours a resident receives.

For the sample of 11 high care level homes, the average HPRD was 2.39 hours, including 0.10 hours from RNs, 0.25 hours from ENs, and 2.03 hours from HWs and CWs. The average daily care hours provided by other job posts were 2.03 hours, resulting in a total of 4.42 hours when combining both categories of staff (Table D 7).

Given that residents of medium care level homes typically engage in training or work outside the home during the day, the Consultant estimated the average daily hours spent in the sampled homes to reflect this reality. After making the necessary adjustments, the Consultant obtained the average daily hours actually spent in each RCHD. In the sample of 7 medium care level homes, the average daily length of stay for residents ranged from 0.57 to 0.79 days. Consequently, the

average HPRD for international benchmarking was 1.34 hours, including 0.02 hours from RNs, 0.13 hours from ENs, and 1.19 hours from HWs and CWs. The average daily care hours provided by other job posts were 1.24 hours, resulting in a total of 2.58 hours when combining both categories of staff (Table D 8).

According to the Residential Care Homes (Persons with Disabilities) Regulation, low care level homes are not required to employ HWs or nurses. In the sample of 4 low care level homes, 3 homes employed 2 HMs with HW qualifications and 1 HW. Given that residents of low care level homes typically attend school, training, or work outside the home during the day, the Consultant calculated the average daily hours spent in the sampled homes to accurately reflect this situation. After making the necessary adjustments, the Consultant obtained the average daily hours actually spent in each RCHD. In the sample of 4 low care level homes, the average daily length of stay for residents ranged from 0.50 to 0.76 day. Consequently, the average HPRD for international benchmarking was 0.39 hours, which was provided by 3 HWs and 2 CWs. The average number of care hours provided by other job posts were 1.81 hours, resulting in a total of 2.20 hours when combining both categories of staff (Table D 9).

5.2.5 Baseline for manpower allocation in RCHDs

(a) Calculation of minimum staffing needs based on the workload and number of hours worked

The Consultant first calculated the average number of hours required for the provision of various services by the sample staff in RCHDs based on the fieldwork records (Table D 10). Then, the number of residents receiving various services and the average frequency of service use were counted according to the “Reply Form for Daily Health and Rehabilitation Services Received by the Residents” voluntarily submitted by the sample of RCHDs (Tables D 11 to D 13).

Based on the observation and data collected from fieldwork, the Consultant estimated the care hours required for residents in need of comprehensive care. From fieldwork in the sample of 11 high care level homes, the Consultant found that residents requiring comprehensive care usually need most of the first to fifth health services mentioned in Table D 10. Consequently, the Consultant selected the most frequently used service items among these residents for the estimate. The results indicate that the care hours required per resident in high care level homes range from 1.12 hours to 3.04 hours, depending on individual needs (Table D 11).

Residents of medium care level homes are capable of basic self-care but have a degree of difficulty in daily living activities. Fieldwork revealed that residents in these homes needing comprehensive care usually required most of the first to third health services mentioned in Table D 10. The Consultant

therefore selected the most frequently used service items among these residents for the estimate. The results indicate that the care hours required per resident in medium care level homes range from 0.67 to 1.32 hours, depending on individual needs (Table D 12).

Residents of low care level homes are capable of basic self-care and require only minimal assistance in daily living activities. Fieldwork indicated that the health services required by residents in these homes primarily focused on the third health service listed in Table D 10. Notably, there was little difference in the number of care hours required between residents needing normal care and those needing comprehensive care. The results indicate that the care hours required per resident is 0.20 hour for normal care and 0.28 hour for comprehensive care, respectively (Table D 13).

(b) Current staffing of high care level homes

Based on the number of care hours required by 1 093 residents in Table D 14 and the estimated distribution of working hours by key job posts (Table D 17), the estimated staffing needs include about 89 nurses, 48 HWs, and 187 CWs.

According to the staff lists from the sample of 11 high care level homes submitted on 30 September 2023, the numbers of key RCH staff providing health services were 90 nurses, 64 HWs, and 412 CWs (Table D 4). This indicates that high care level homes meet the required number of care hours for their residents.

(c) Current staffing of medium care level homes

Based on the number of care hours required by 420 residents (Table D 15) and the estimated distribution of working hours by key job posts (Table D 17), the estimated staffing needs include 42 nurses or 35 HWs and 22 CWs or AWs. The difference in the number of nurses or HWs required was attributed to the varying estimated distribution of working hours for direct care services versus management and other services provided by these two types of staff in RCHDs: 42.36% : 57.64% for nurses; and 51.08% : 48.92% for HWs (Table D 17).

According to the staff lists from the sample of 7 medium care level homes submitted on 30 September 2023, the numbers of key RCH staff providing health services were 12 nurses, 36 HWs, and 31 CWs (Table D 5). This indicates that medium care level homes meet the required number of care hours for their residents.

(d) Current staffing of low care level homes

Based on the number of care hours required by 58 residents (Table D 16), 3 CWs are required. According to the staff lists from the sample of 4 low care

level homes submitted on 30 September 2023, the numbers of key RCH staff providing health services were 1 HW and 2 CWs (Table D 6). This indicates that low care level homes meet the required number of care hours for their residents.

5.3 International benchmark of daily health services provided by RCH staff

The Consultant analysed the number of hours worked in the job posts that could serve as international benchmarks (i.e. RNs, ENs, HWs, and CWs). According to estimates, the average HPRD in NHs is 3.29 hours (Table L 6), with 2.64 hours in C&A Homes and Aged Homes (Table L 7); and 2.39 hours in high care level homes for persons with disabilities (Table D 7). The results indicate that the average HPRDs in Hong Kong are comparable to those in other economies (i.e. Australia, the US, and New Zealand, please refer to paragraph 2.2 for details).

As mentioned in paragraph 5.2.5(a), the scope of services provided in medium and low care level homes for persons with disabilities differs from the internationally accepted definition of LTC, as the residents of these RCHDs retain basic self-care abilities. Different from the data of high care level homes, it is challenging to directly compare the data of medium and low care level homes in Hong Kong with the data of other countries.

However, for reference, the average HPRD is 1.34 hours for medium care level homes (Table D 8) and 0.39 hours for low care level homes (Table D 9). Although an international benchmark is not possible between these two types of RCHDs, the data can reflect the staffing level, which is useful for the existing staffing situation examined in paragraphs 5.2.5(c) and (d).

Chapter 6 Stakeholders' Opinions

In addition to fieldwork, the Consultant also collected data and information through various research activities. Targeting both RCH staff and non-RCH staff, the Consultant designed respective questionnaires (Annex 15) to solicit stakeholders' opinions on the research topics.

To facilitate the completion of the questionnaires by various stakeholders, the Consultant adopted a hybrid approach to distribute the questionnaires. Most of the questionnaires were distributed via hyperlinks, whereas paper questionnaires were also provided to individual RCHs in need. All questionnaires are completed in an anonymous way. From 20 May to 23 June 2024, the Consultant successfully collected valid questionnaires from 1 257 RCH staff and 99 non-RCH staff.

A comprehensive analysis of the opinions from these two relevant stakeholder groups is presented below.

6.1 Opinions from RCH staff respondents

6.1.1 Stakeholder groups of the respondents

Satisfactory responses were received regarding the stakeholder opinion survey, with the RCH staff respondents covering a wide range of ranks. Among them, responses from HWs were the most enthusiastic, accounting for about a quarter of the total number of replies (297, 23.63%). It was followed by HMs/wardens (290, 23.07%) and CWs (159, 12.65%). The responses from these three ranks covered more than half of the total sample size of the respondents (59.35% in total) (Figure 1).

The data showed that more than 90% of the respondents from HMs/wardens possess relevant professional qualifications. More than half (156, 53.79%) of them are registered SWs, indicating that SWs play a central leadership role in the management team. Among them, 2 registered SW HMs/wardens also have professional qualifications as ENs or registered HWs, reflecting their characteristics of inter-professional talents. Apart from registered SWs, 60 (20.69%) HMs/wardens are registered HWs and 31 (10.69%) are RNs. The remaining HMs/wardens are ENs and rehabilitation professionals such as registered PTs/OTs (Figure 2).

Figure 1 Distribution of the stakeholder groups of RCH staff respondents

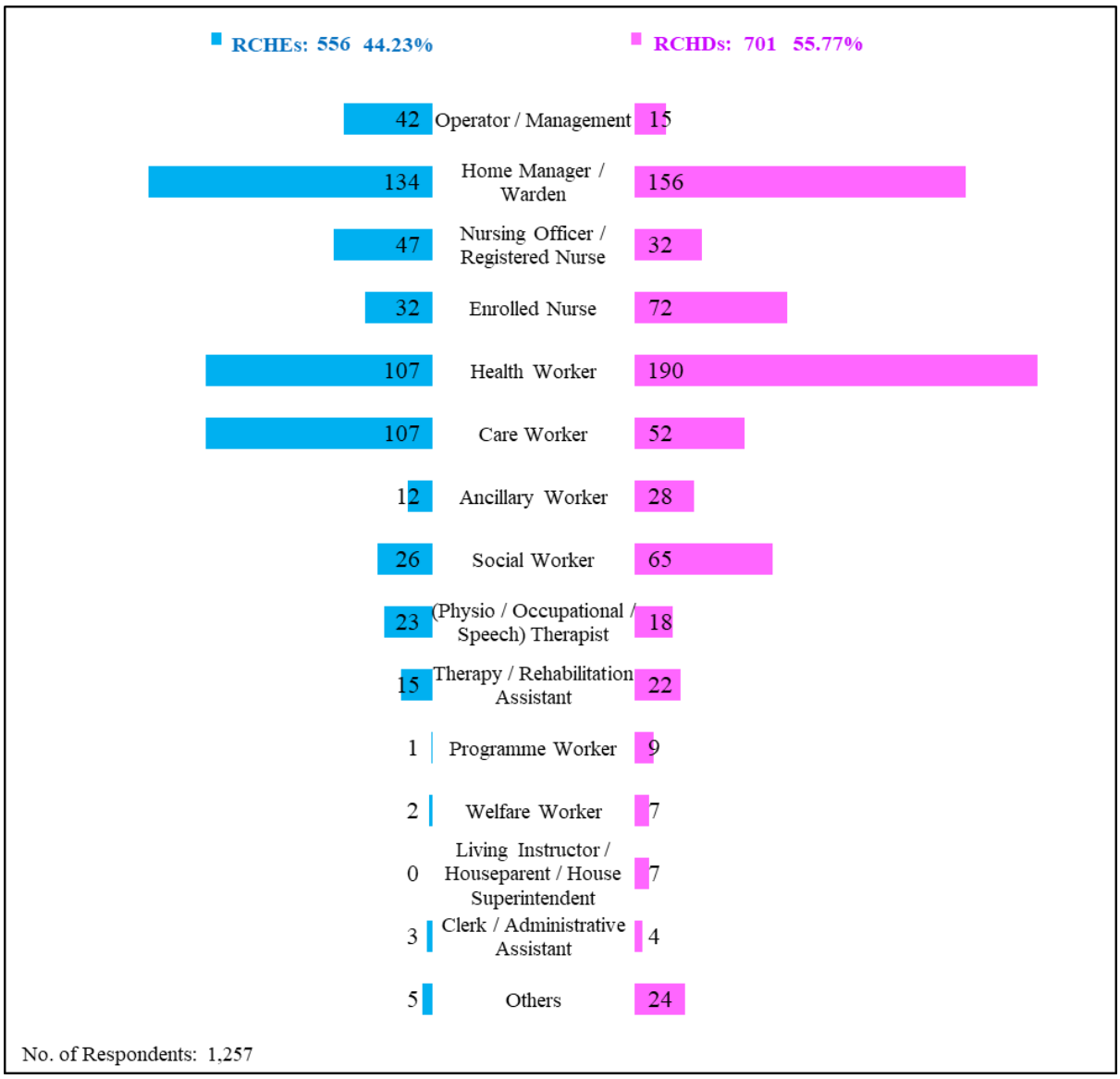
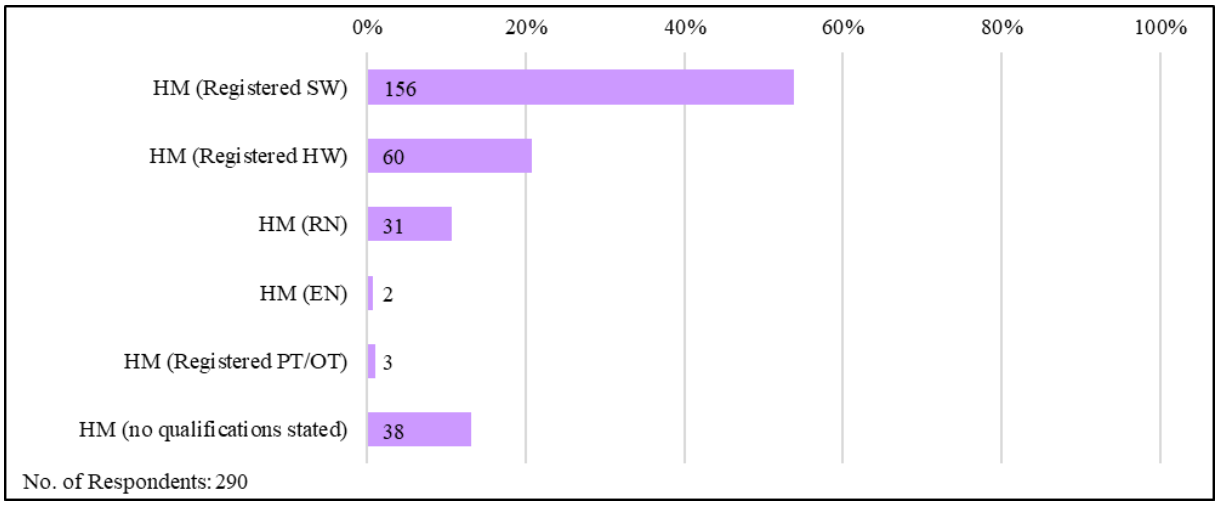


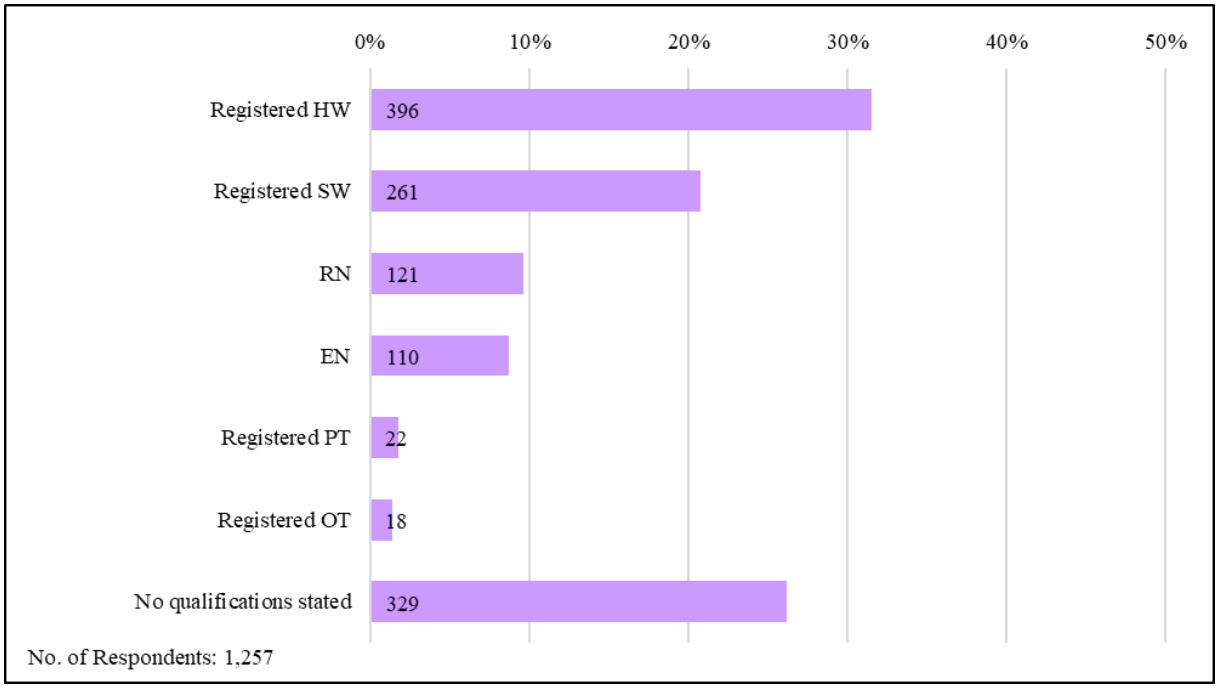
Figure 2 Distribution of the qualifications of HM/warden respondents



6.1.2 Qualifications and experience

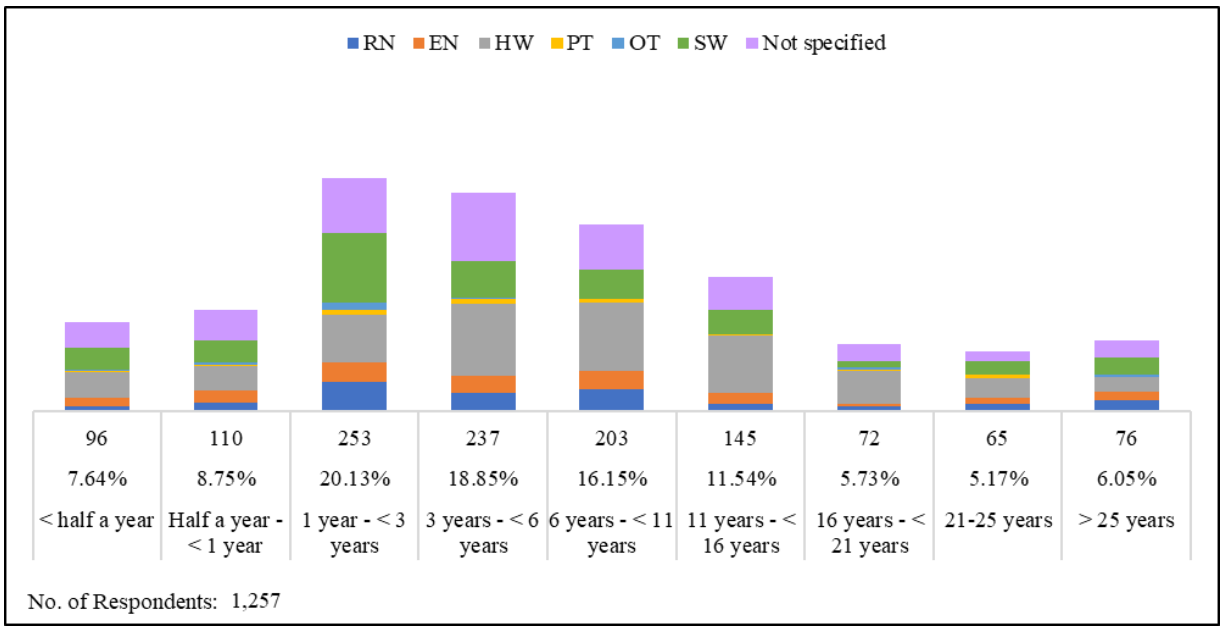
Consolidating the professional qualifications of all respondents, more than one-third of them (396, 31.50%) are registered HWs, followed by registered SWs (261, 20.76%), RNs/ENs (231, 18.38%), registered PTs (22, 1.75%), and registered OTs (18, 1.43%). The remaining 329 (26.17%) respondents did not indicate their qualifications (Figure 3).

Figure 3 Distribution of the qualifications of RCH staff respondents



Overall, respondents' current seniority level was broad, ranging from experienced staff with more than 25 years of experience to novices who just joined the industry for less than half a year, reflecting involvement of different talent at different stages. It is worth noting that the most enthusiastic responses came from staff with 1 to 16 years of experience. This indicated that a group of key staff has a keen attitude towards residential care services. They have not only accumulated considerable qualifications, but also maintained enthusiasm at their work, which is conducive in contributing to the development of the RCHs and passing on the professionalism. In addition, 206 (16.39%) respondents who were new to the industry with experience of less than one year were keen to respond, reflecting RCHs' continual introduction of new blood and injection of new impetus is conductive to the development of the industry (Figure 4).

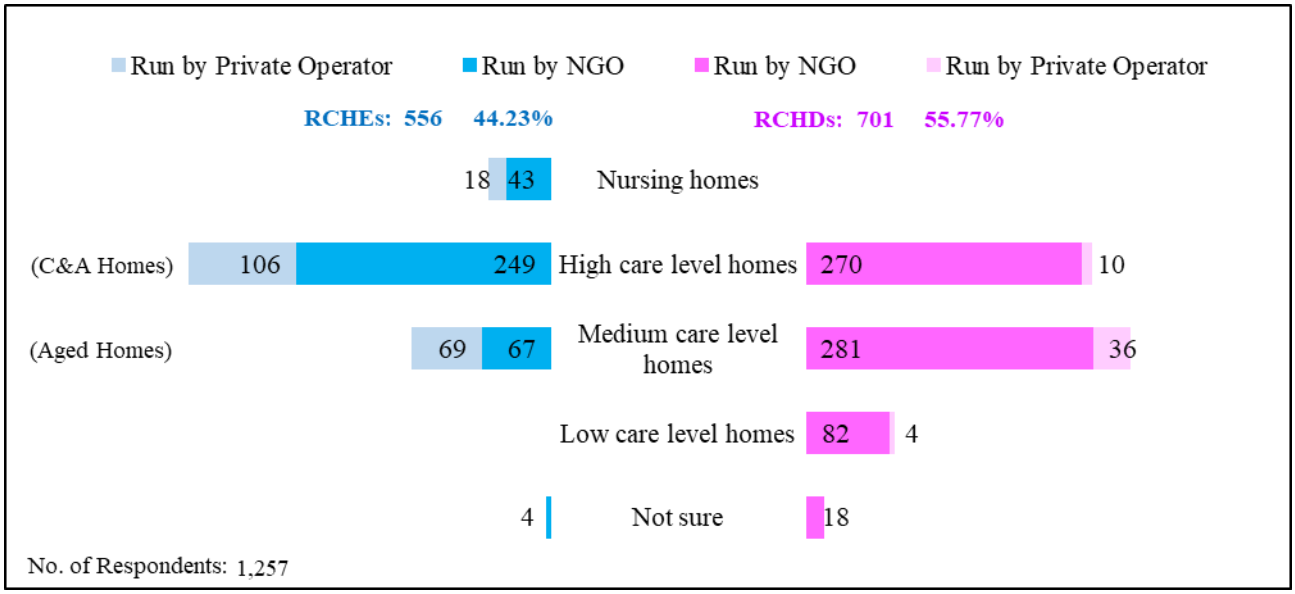
Figure 4 Distribution of the qualifications and experience of RCH staff respondents



6.1.3 Types of homes RCH staff respondents come from

Among the RCH staff respondents, 701 (55.77%) were from RCHDs and 556 (44.23%) were from RCHEs (Figure 5).

Figure 5 Distribution of the types of homes RCH staff respondents come from



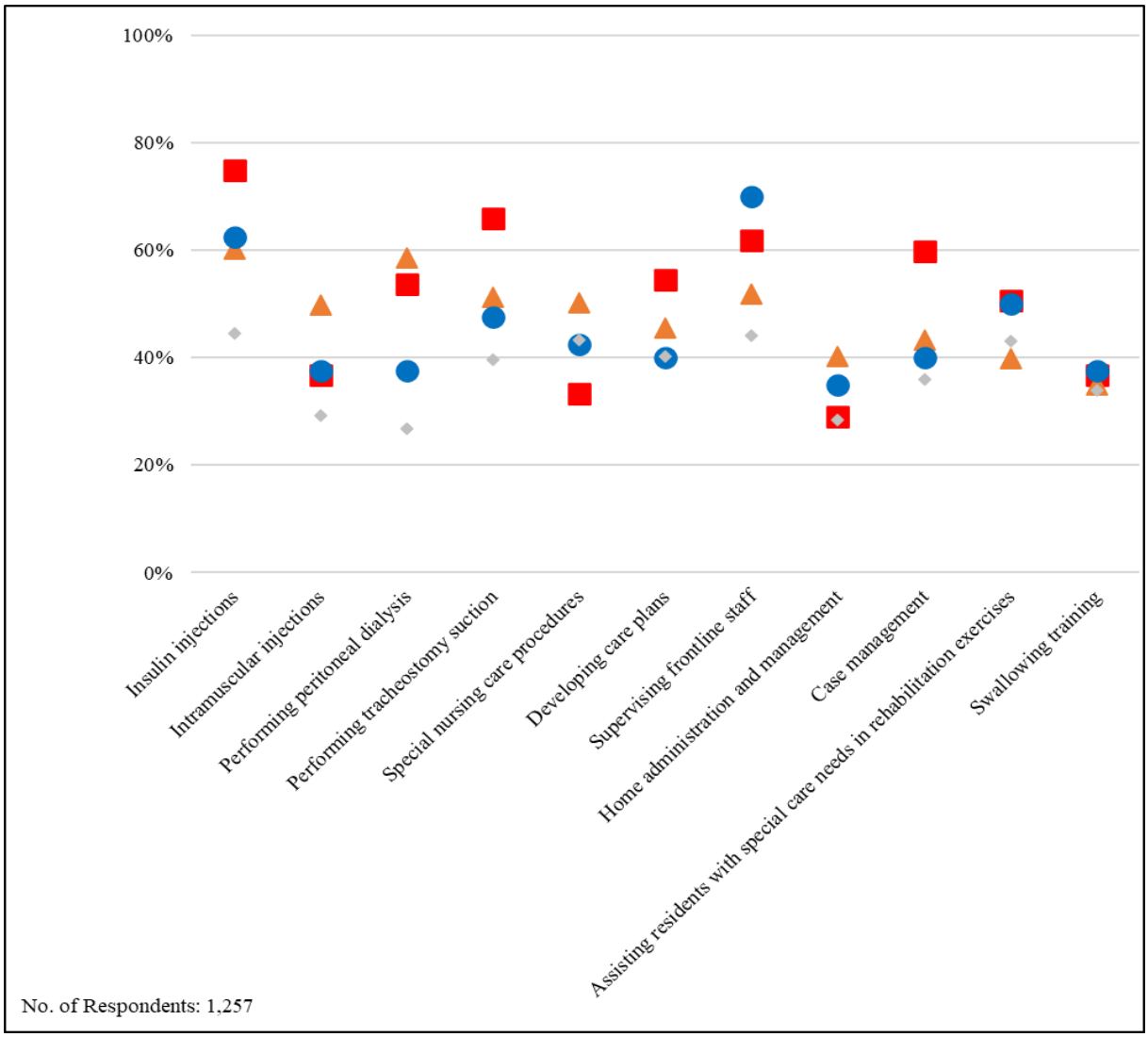
Given a considerable number of differences were identified among the above response rates, the Consultant had re-analysed the data in groups to verify the tendency of replies from different types of homes.

6.1.4 New responsibilities that "SHWs" can assume by incorporating proper training into the curriculum

Since the professional nursing tasks listed in the questionnaire are mainly performed by RNs/ENs at present, nurses' views are particularly crucial. In addition, most of the rehabilitation exercises for residents with special care needs are currently undertaken by registered PTs/OTs, whose opinions also carry a certain weight. As for the provision of swallowing training, STs are mainly responsible for it at current stage.

More than half of the nurse respondents believed that when proper training was incorporated in the curriculum, the "SHW" would be able to extend its functions and be able to perform a range of professional nursing duties, including insulin injections (74.89%), performing tracheostomy suction (65.80%), supervising frontline staff (61.90%), case management (59.74%), developing care plans (54.55%), performing peritoneal dialysis (53.68%), and assisting residents with special care needs in rehabilitation exercises (50.65%) (Figure 6).

Figure 6 RCH staff respondents indicated that "SHWs" can assume new responsibilities by incorporating proper training into the curriculum

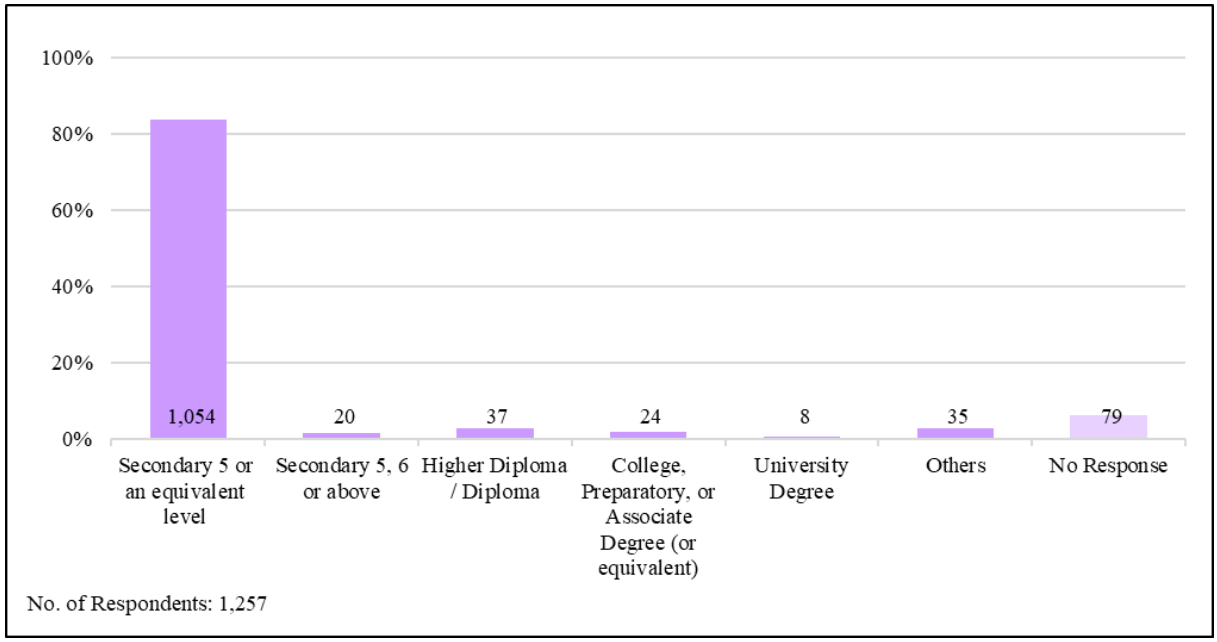


6.1.5 Qualifications required for "SHWs"

6.1.5.1 Academic requirement

Regarding the academic requirements, the majority (1 054, 83.85%) of the respondents considered that a minimum Secondary 5 or equivalent level should be set for officers serving as "SHWs". [Note: Since 2016, according to the arrangement of the new academic structure in Hong Kong, Secondary 1 to 5 levels are regarded as equivalent to Secondary 1 to 5 levels under the old academic structure[55].] Yet, 35 (2.78%) of the respondents expressed different views, including recommending to set the academic requirements below Secondary 5, Diploma Yi Jin Programme, tertiary education in the Mainland, completion of relevant training with relevant tests passed or possession of a valid first aid certificate (Figure 7).

Figure 7 Distribution of opinions from RCH staff respondents on the academic requirements for "SHWs"



6.1.5.2 Content of the "Training Course for SHWs" in addition to the "HWTC"

Apart from the above academic requirements, respondents from different professional fields also made suggestions on the content of the "Training Course for SHWs". Most of the respondents expected that the curriculum should cover "clinical care nursing" training (80.99%) and "psychological, social, and spiritual services" training (55.53%) to equip "SHWs" to cope with various job requirements. Besides, more than half

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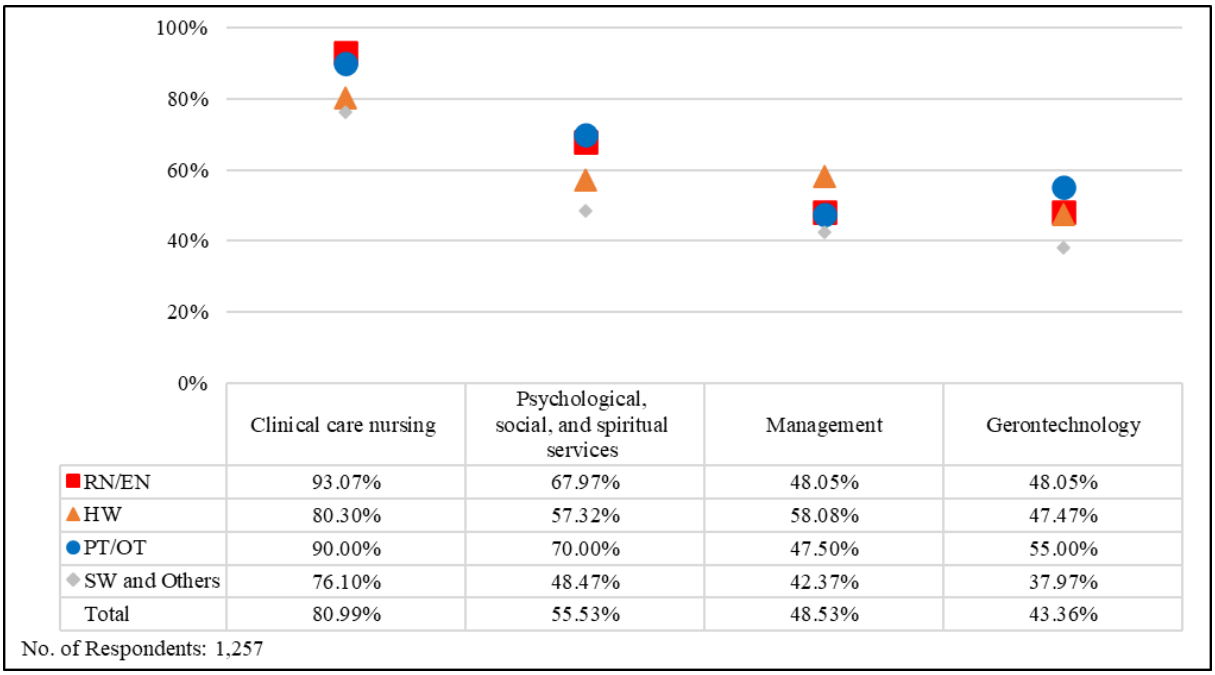
(58.08%) of the registered HWs suggested including "Management" training to enhance the supervisory and leadership skills of "SHWs". More than half (55.00%) of the registered PTs/OTs suggested "gerontechnology" training to tie in with the development trend of smart RCHs (Figure 8).

Figure 8 Distribution of comments from RCH staff respondents on the content to be covered in the "Training Course for SHWs"



	Clinical care nursing	Psychological, social, and spiritual services	Management	Gerontechnology
RN/EN	93.07%	67.97%	48.05%	48.05%
HW	80.30%	57.32%	58.08%	47.47%
PT/OT	90.00%	70.00%	47.50%	55.00%
SW and Others	76.10%	48.47%	42.37%	37.97%
Total	80.99%	55.53%	48.53%	43.36%

No. of Respondents: 1,257

6.1.5.3 Working experience requirements

In addition to the academic and training requirements, the majority (1,102, 87.67%) of the respondents considered that "SHWs" must have some working experience in RCHs to ensure the officers possess sufficient knowledge and practical skills in the actual working environment.

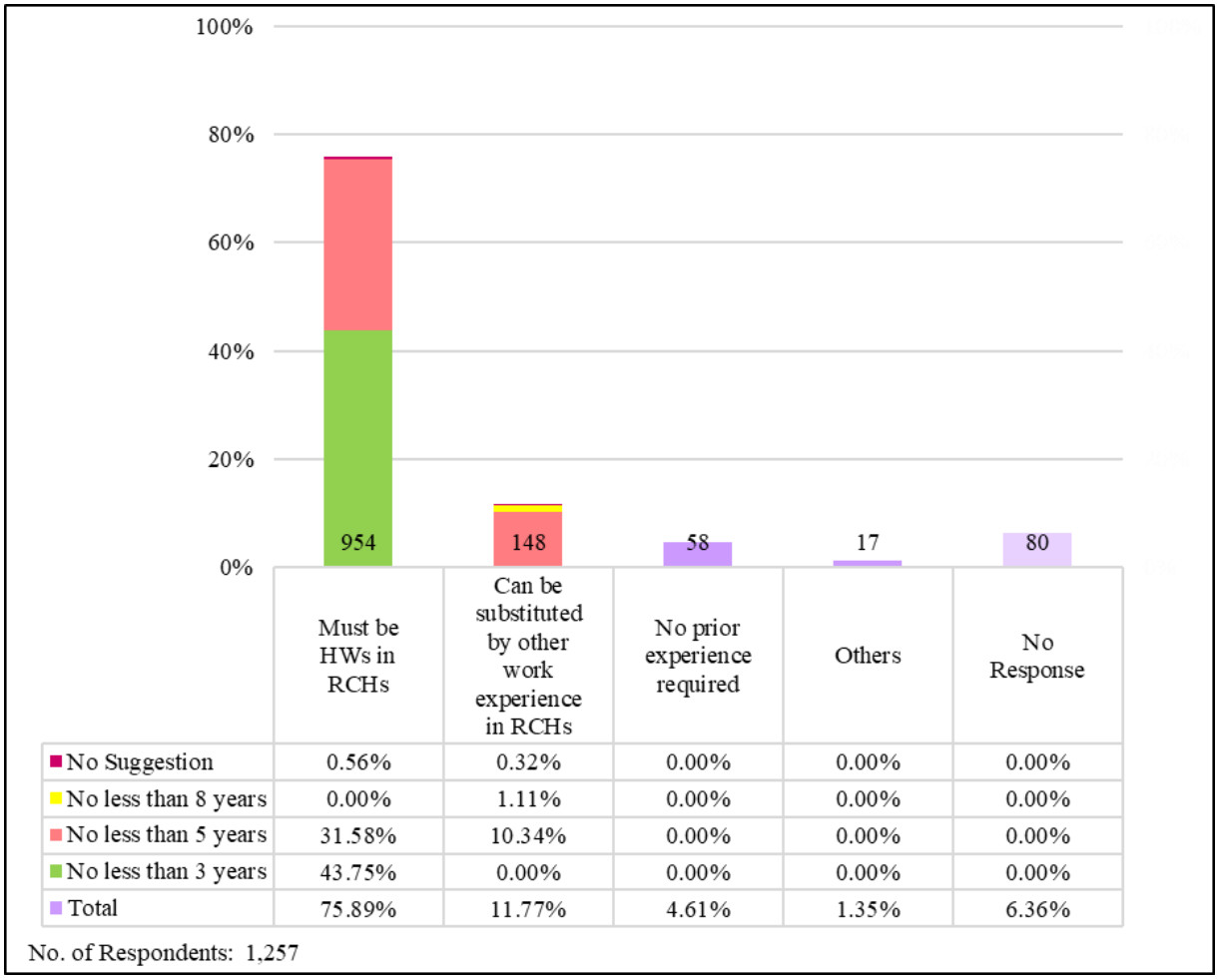
In terms of specific seniority requirements, two-thirds (954, 75.89%) of the opinions were received with focus on the need for the officer to serve as a HW for no less than three years (550, 43.75%) or no less than five years (397, 31.58%). Only a few of the respondents (7, 0.56%) did not indicate their comment on the recommended seniority. Given the above, it is noted that most of the respondents tended to request "SHWs" to have at least three to five years of working experience as HWs so as to accumulate sufficient clinical experience and professional knowledge.

Moreover, 148 (11.77%) respondents considered that working experience of CWs, TAs or RAs in RCHs could also be regarded as equivalent working experience as HWs. Among them, 130 (10.34%) recommended that they should serve in the industry for no less than five years, while the remaining 14 (1.11%) recommended the required services being no less

than eight years, which was significantly longer than the length of service for HWs in RCHs.

Overall, the results reflected that majority of the stakeholders expect "SHWs" to have extensive experience in RCHs (Figure 9).

Figure 9 Distribution of comments from RCH staff respondents on the working experience requirements of "SHWs"



	Must be HWs in RCHs	Can be substituted by other work experience in RCHs	No prior experience required	Others	No Response
No Suggestion	0.56%	0.32%	0.00%	0.00%	0.00%
No less than 8 years	0.00%	1.11%	0.00%	0.00%	0.00%
No less than 5 years	31.58%	10.34%	0.00%	0.00%	0.00%
No less than 3 years	43.75%	0.00%	0.00%	0.00%	0.00%
Total	75.89%	11.77%	4.61%	1.35%	6.36%

No. of Respondents: 1,257

In view of the requirements of academic qualifications, training and working experience, the expectation from the industry for a "SHW" is a talent with knowledge, professional training, practical experience, together with solid all-round and competent abilities for future work.

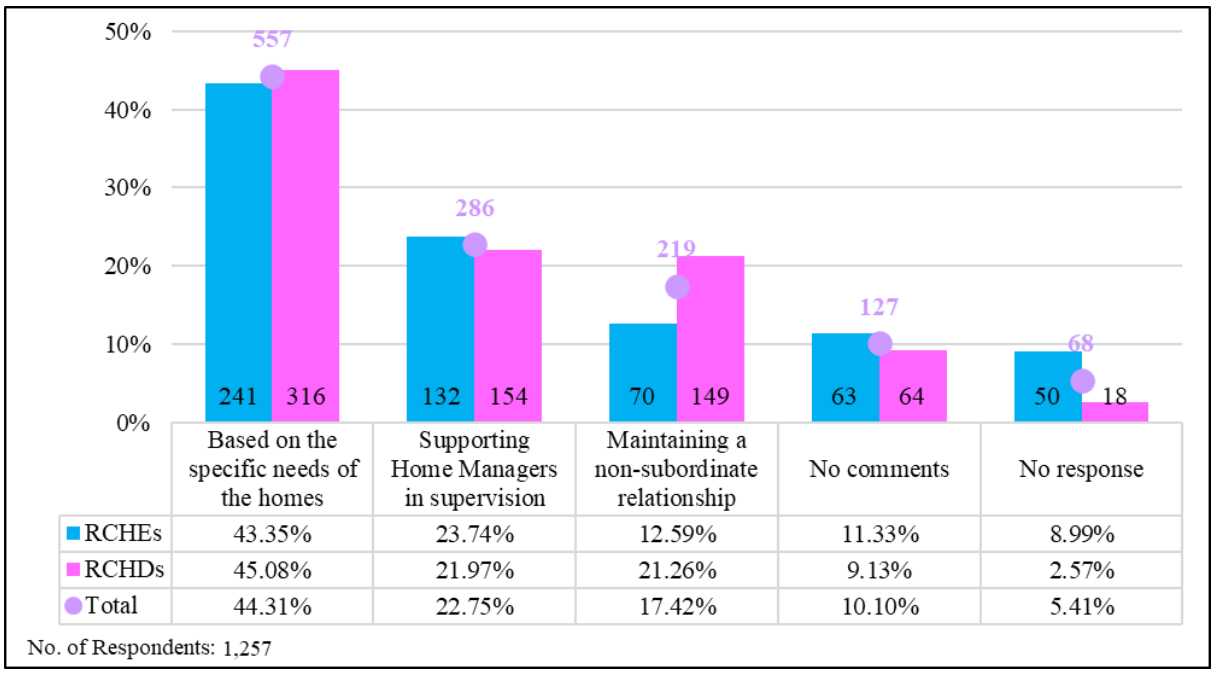
6.1.6 Subordinate relationship between "SHWs" and existing HWs

There were divergent views on the working relationship between the new rank of "SHW" and the existing HWs. For RCHEs and RCHDs, more than 40% of the respondents considered that to avoid being rigid, the existence of subordinate relationship between the two ranks should be flexibly considered by individual RCHs according to their actual situation. This reflected the sector preferred a higher degree of autonomy and flexibility so that they could rationally plan the manpower structure according to actual needs.

In addition, more than one-fifth of the respondents in RCHEs and RCHDs suggested that "SHWs" should take up a supervisory role to assist the existing HMs in supervising and guiding HWs and other frontline staff. This view envisaged that "SHWs" would perform the middle management function, play an important supervisory role, and share part of the managerial work.

On the other hand, some divergent views between the staff of RCHEs and RCHDs on whether there should be a subordinate relationship between "SHWs" and existing HWs were noted. In RCHDs, more than one-fifth (21.26%) of the respondents held the view of non-subordinate relationship towards this opinion while only more than one-tenth (12.59%) of the respondents in RCHEs shared the same (Figure 10).

Figure 10 RCH staff respondents' opinions on the relationship between "SHWs" and existing HWs



	Based on the specific needs of the homes	Supporting Home Managers in supervision	Maintaining a non-subordinate relationship	No comments	No response
RCHEs	43.35%	23.74%	12.59%	11.33%	8.99%
RCHDs	45.08%	21.97%	21.26%	9.13%	2.57%
Total	44.31%	22.75%	17.42%	10.10%	5.41%

No. of Respondents: 1,257

6.1.7 Suggestions for the job title of "SHW"

There were also different views on the proposed title of "SHW".

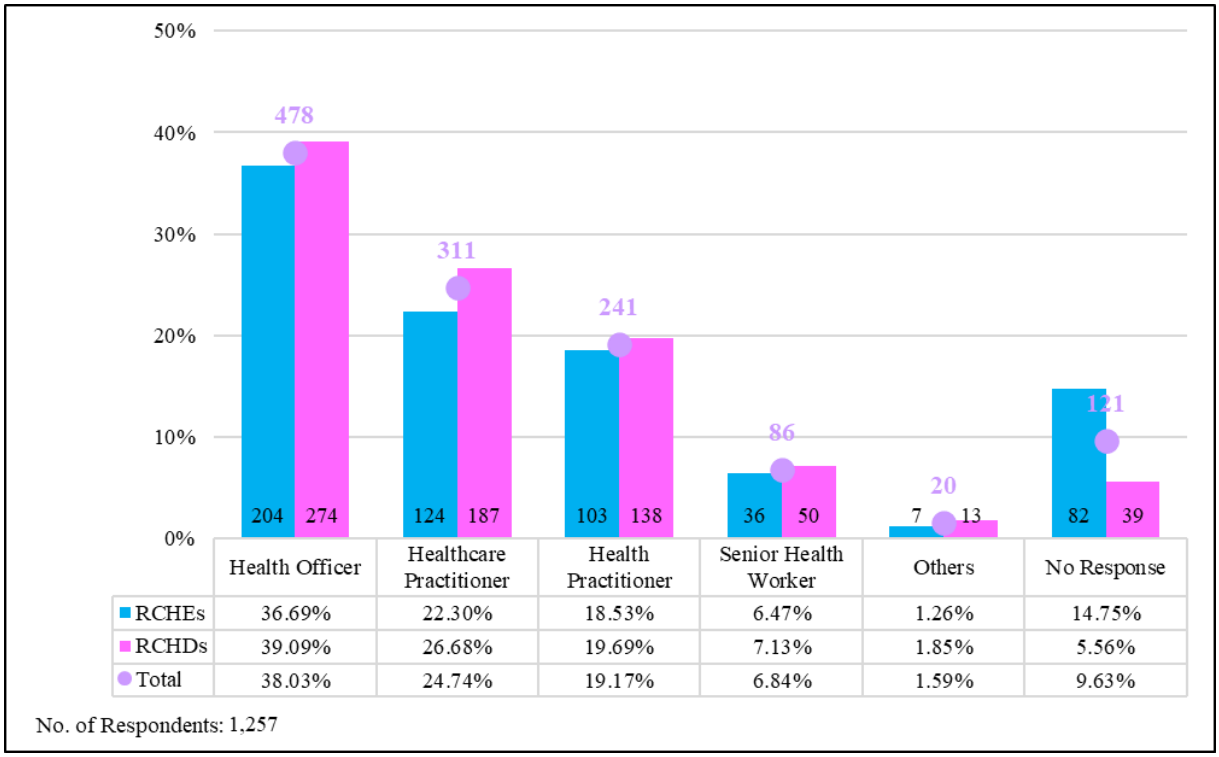
The largest number of respondents (478, 38.03%) preferred using the title "Health Officer", expecting to highlight their leading role in the field of health services through this title.

Apart from this, a considerable number of respondents (311, 24.74%) supported using the title "Healthcare Practitioner", as they may expect to emphasise their nursing professional background and the nature of their practical work by using this title.

Also, 241 (19.17%) of the respondents suggested adopting the simple and direct title of "Health Practitioner".

By making reference to these three of the most popular options, it is noted that the industry had various preferences and consideration in choosing the title. Some of them wished to highlight the leadership and expertise of the new role while others to emphasise their professional background and the nature of their work. (Figure 11).

Figure 11 Distribution of RCH staff respondents' suggestions for the title of "SHW"



	Health Officer	Healthcare Practitioner	Health Practitioner	Senior Health Worker	Others	No Response
RCHEs	36.69%	22.30%	18.53%	6.47%	1.26%	14.75%
RCHDs	39.09%	26.68%	19.69%	7.13%	1.85%	5.56%
Total	38.03%	24.74%	19.17%	6.84%	1.59%	9.63%

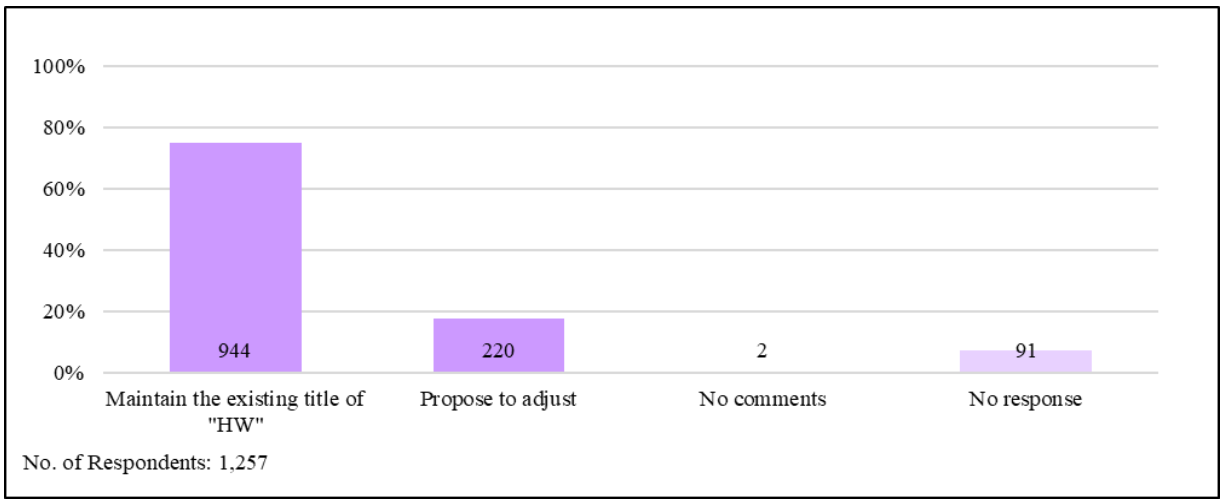
No. of Respondents: 1,257

Another 20 (1.59%) respondents suggested other titles for "SHW" including Advanced Health Worker, Health Worker I, Health Practitioner I or II, Nursing Care Officer, Home Manager Assistant, etc.

6.1.8 The need for corresponding adjustment to the existing job title of HWs

Three-quarters (944, 75.10%) of the respondents expressed that the existing job title of "Health Worker" should be maintained (Figure 12).

Figure 12 Distribution of opinions from RCH staff respondents on the existing job title of HW



Another 220 (17.50%) RCH staff respondents suggested that the current job title of "Health Worker" be adjusted to Assistant Health Officer, Assistant Healthcare Practitioner, Assistant Health Practitioner, or Health Assistant.

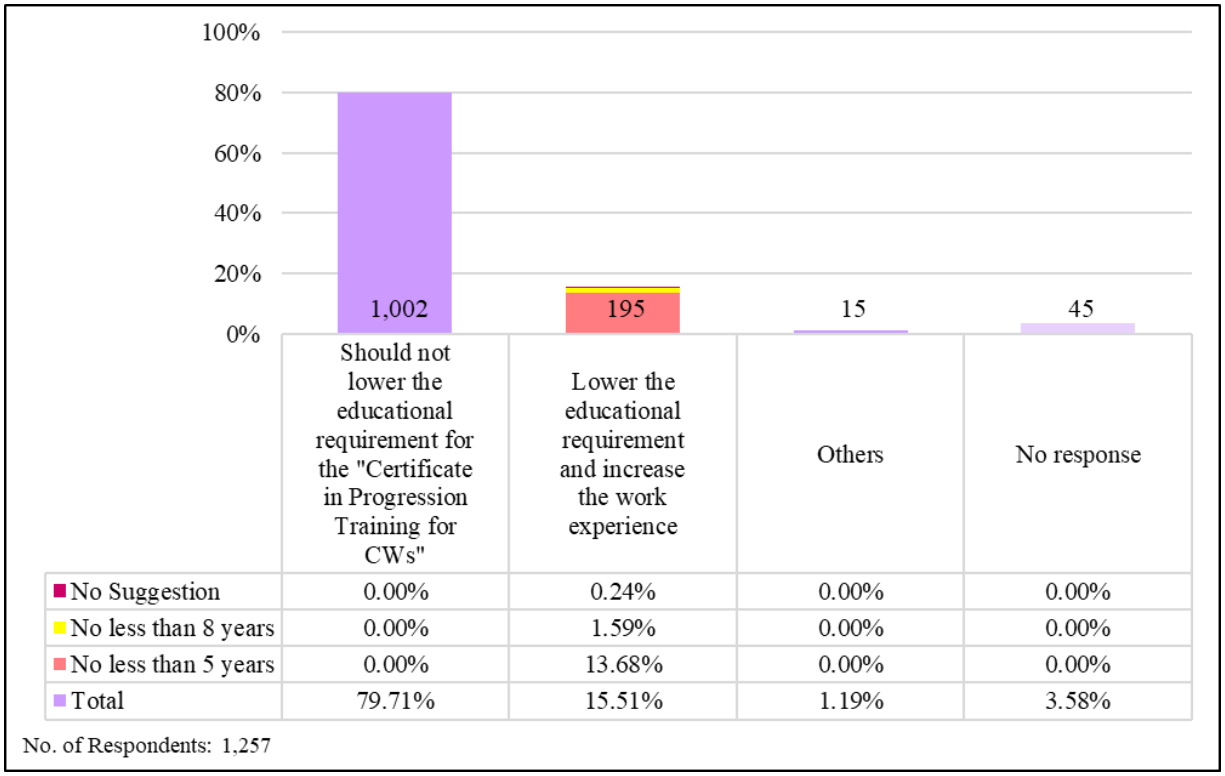
6.1.9 Academic requirements for CWs enrolling in the "Certificate in Progression Training for Care Workers"

Currently, the academic requirement for HWs is set at the Secondary 5 level. CWs who have attained Secondary 3 or above, with working experience as CW in RCHEs or RCHDs for at least three years, and have successfully completed the "Certificate in Progression Training for CWs", may apply for the "HWTC".

Regarding the question of whether the academic requirement of Secondary 3 or above can be lowered, nearly 80% (1 002, 79.71%) of RCH staff opposed relaxing the academic qualifications, including over half of the CW respondents (85, 53.46%). Another 39 (24.53%) CW respondents expressed that the academic requirements could be lowered to primary graduates with an accordingly lengthened working experience requirement. The remaining 35 (22.01%) CW respondents did not reply.

Overall, 195 (15.51%) of the RCH staff respondents expressed that the academic requirements for CWs to apply for the "HWTC" could be lowered, with working experience requirement to be increased accordingly. Among them, 172 (13.68%) indicated that the CWs should have served "for no less than five years", 20 (1.59%) "for no less than eight years", and the remaining 3 (0.24%) did not specify the proposed length of service (Figure 13).

Figure 13 Distribution of opinions from RCH staff respondents on the academic requirements for CWs to enrol in "Certificate in Progression Training for Care Workers"



	Should not lower the educational requirement for the "Certificate in Progression Training for CWs"	Lower the educational requirement and increase the work experience	Others	No response
No Suggestion	0.00%	0.24%	0.00%	0.00%
No less than 8 years	0.00%	1.59%	0.00%	0.00%
No less than 5 years	0.00%	13.68%	0.00%	0.00%
Total	79.71%	15.51%	1.19%	3.58%

No. of Respondents: 1,257

6.1.10 Effective methods for attracting and retaining talent

While there was an overall agreement among healthcare staff in different professional fields on how to attract and retain talent, some differences on the importance of individual measures were observed. These divergences reflected that different recruitment targets and retention strategies would be required for different groups.

Overall, "providing career development and promotion opportunities" was regarded as the most important measure, with more than 70% of respondents across all professional fields agreeing that it was the most effective way. This reflected that RCH staff were eager to look for career development and promotion prospects regardless of ranks.

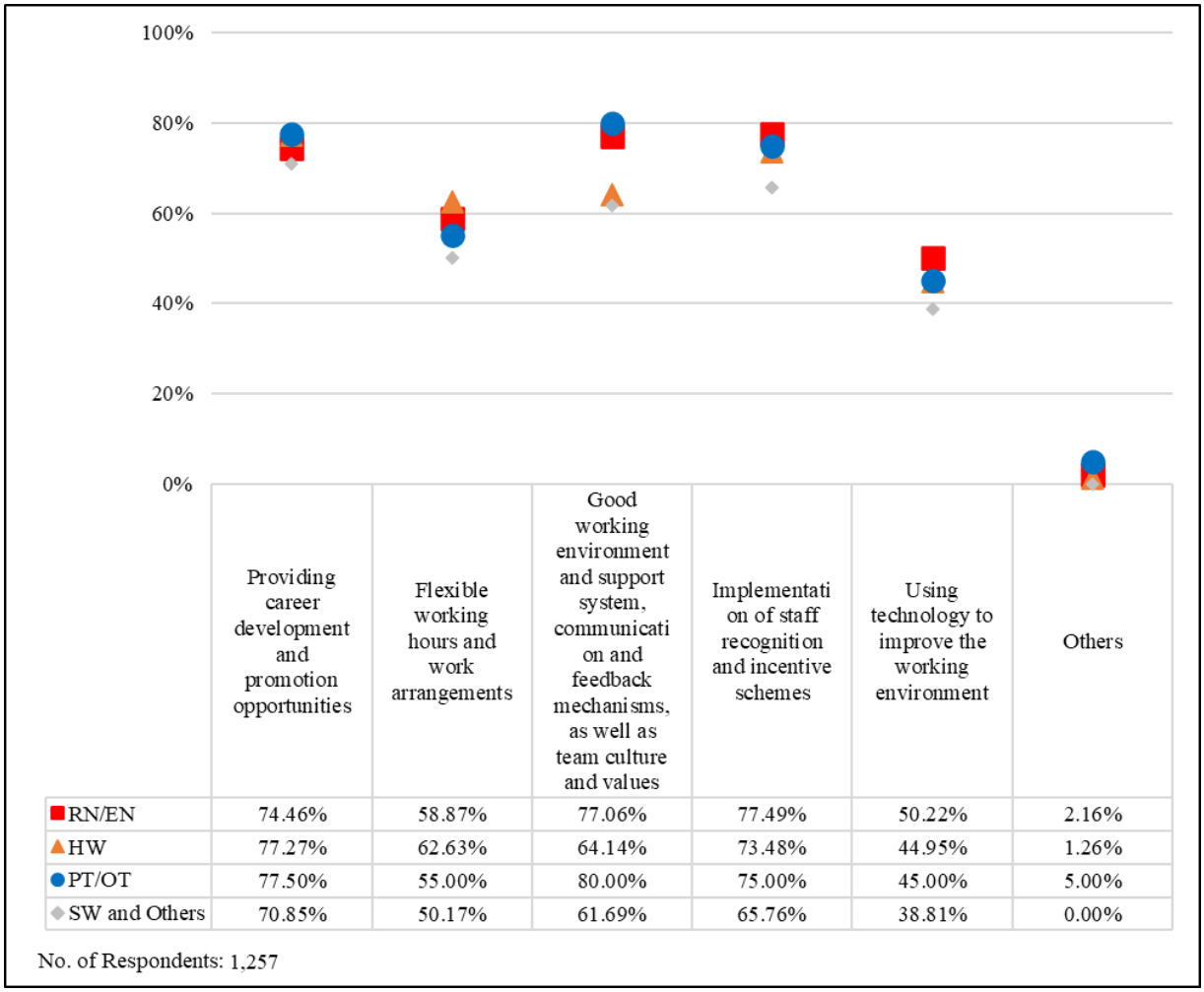
The second measure is "implementation of staff recognition and incentive schemes", which was attractive to most of the staff as it could help promote job satisfaction and create a positive environment. It is worth noting that registered SWs and other staff who did not specify their qualifications attach less importance to this measure. The fifth-ranked option "using technology to improve the working environment" also indicated a similar trend.

In addition, "establishing good working environment with support system, communication and feedback mechanisms, as well as team culture and values" has been highly valued by registered PTs/OTs and RNs/ENs, reflecting their high

expectations on the working environment and atmosphere.

"Flexible working hours and work arrangements" was also preferred by more than 60% of registered HWs. This may be related to the nature of their work and daily routines (Figure 14).

Figure 14 RCH staff respondents consider effective ways to attract and retain talent



	Providing career development and promotion opportunities	Flexible working hours and work arrangements	Good working environment and support system, communication and feedback mechanisms, as well as team culture and values	Implementation of staff recognition and incentive schemes	Using technology to improve the working environment	Others
RN/EN	74.46%	58.87%	77.06%	77.49%	50.22%	2.16%
HW	77.27%	62.63%	64.14%	73.48%	44.95%	1.26%
PT/OT	77.50%	55.00%	80.00%	75.00%	45.00%	5.00%
SW and Others	70.85%	50.17%	61.69%	65.76%	38.81%	0.00%

No. of Respondents: 1,257

On top of the above five methods, other opinions raised by 12 RCH staff respondents included: salary and fringe benefits be in line with civil servants (e.g. eligibility for non-means-tested public rental housing); five-day work week, with extra holidays; the option to "sell holidays" selectively, work more and reward more; a maximum of eight working hours per day for all RCH staff; and employment subsidies provided by the Government.

Concluding the above analysis, while the methods for attracting and retaining talent were widely recognised by various types of staff, there were still unique consideration factors and expectations for different ranks and professions. To address the specific needs of various ranks, RCHs must offer flexible solutions to meet diverse needs and expectations, thereby maximising their ability to attract and retain talent across different positions.

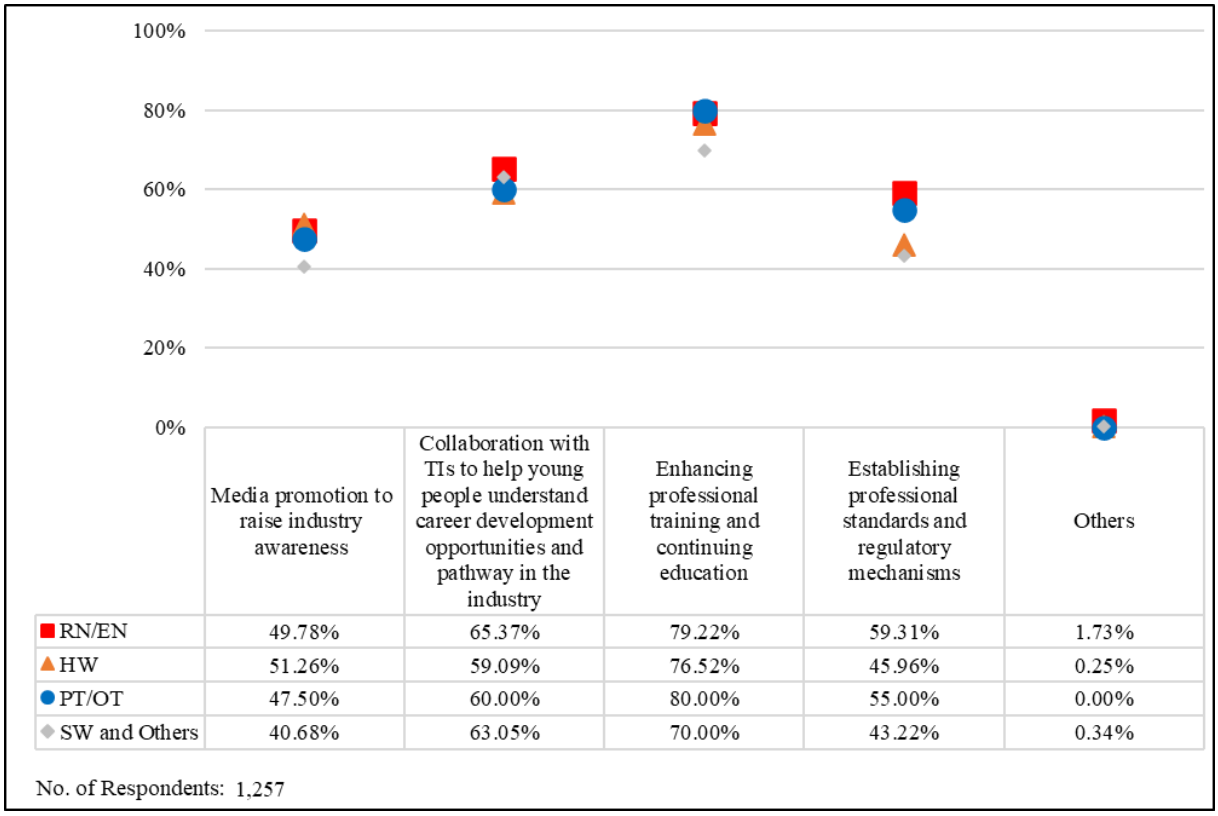
6.1.11 Promoting professionalism in the residential care service industry

On the approach to enhance the promotion of professionalism in the residential care service industry, the views of healthcare staff across all professional fields are broadly the same; they all regarded "enhancing professional training and continuing education" as the most effective approach. RCH staff clearly understood that the continuous development of knowledge and skills is essential to the practice of professional services.

Secondly, more than half of the respondents considered that "collaboration with TIs to help young people understand career development opportunities and pathway in the residential care service industry" would help strengthen the long-term talent pool and sustainability of the industry. This reflected the respondents' long-term expectations for the future development of the industry and the succession of human resource.

In addition, "establishing professional standards and regulatory mechanisms" has been highly recognised by RNs, ENs, registered PTs and registered OTs. These professions expected an introduction of a well-defined and established standard and regulatory mechanisms to ensure service quality are promising, aligning with the current trend of the industry development towards refinement and professionalism (Figure 15).

Figure 15 RCH staff respondents considered the effective way to promote professionalism within the residential care service industry



	Media promotion to raise industry awareness	Collaboration with TIs to help young people understand career development opportunities and pathway in the industry	Enhancing professional training and continuing education	Establishing professional standards and regulatory mechanisms	Others
RN/EN	49.78%	65.37%	79.22%	59.31%	1.73%
HW	51.26%	59.09%	76.52%	45.96%	0.25%
PT/OT	47.50%	60.00%	80.00%	55.00%	0.00%
SW and Others	40.68%	63.05%	70.00%	43.22%	0.34%

No. of Respondents: 1,257

In addition to the four approaches mentioned above, other suggestions put forward

by 7 RCH staff respondents included the establishment of professional colleges and continuing education schools to enhance the sense of professionalism. They also suggested using both practice and theory in courses to improve their effectiveness, as well as compensation and fringe benefits are key factors.

Based on the above analysis, the industry has reached a considerable consensus on its professional development direction, with the primary focuses for the sector to enhance the professional strength and image of the industry through continuous investment in training enhancement, talent cultivation, and regulatory standards.

6.1.12 Additional opinions on career progression path, recruitment and retention, qualifications, and training requirements for RCH Staff

The Consultant gathered additional opinions from 207 (16.47%) RCH staff respondents, which could be categorised into the following main categories:

(a) Rank system and career progression path: establishing a clearer career progression path, rank system, and creating a rank for "SHW". Some responses noted a shortage of healthcare professions in low care level homes, where staff must manage a high volume of medications and self-care training in their duties. They proposed adding HWs to these homes to enhance service quality.

(b) Manpower allocation: increasing manpower, hiring foreign workers, and implementing flexible work arrangements, and a 5-day work week.

(c) Training and qualifications: providing more training opportunities for staff, subsidies for further education, degree courses, etc.

(d) Government support and policies: expecting the Government to provide additional subsidies and to review existing policies and regulations, including raising the retirement age to 65. Some pointed out that as the manpower ratio requirement has been increased after the implementation of the Amendment Ordinance, adequate subsidies should also be provided. Without such support, RCHs could only meet minimum manpower requirements under the Ordinance, which might hence hinder the implementation of other measures (such as training, incentive schemes, promotions, and salary increases) that ultimately affect residents' quality of life.

(e) Salary and fringe benefits: raising the salary level, provide year-end bonuses, allowances, additional holidays (such as enhanced allowances or extra holidays for staff on duty during weekends, public holidays, and on overnight shifts with reference to overseas experience).

(f) Staff relations and incentives: strengthening communication with staff, provide incentive programmes, improve the working environment, etc.

(g) Recruitment and retention of talent: Organising more training courses for middle-aged and unemployed individuals transitioning to work, enhance recruitment procedures, provide development opportunities, improve the industry's image, etc.

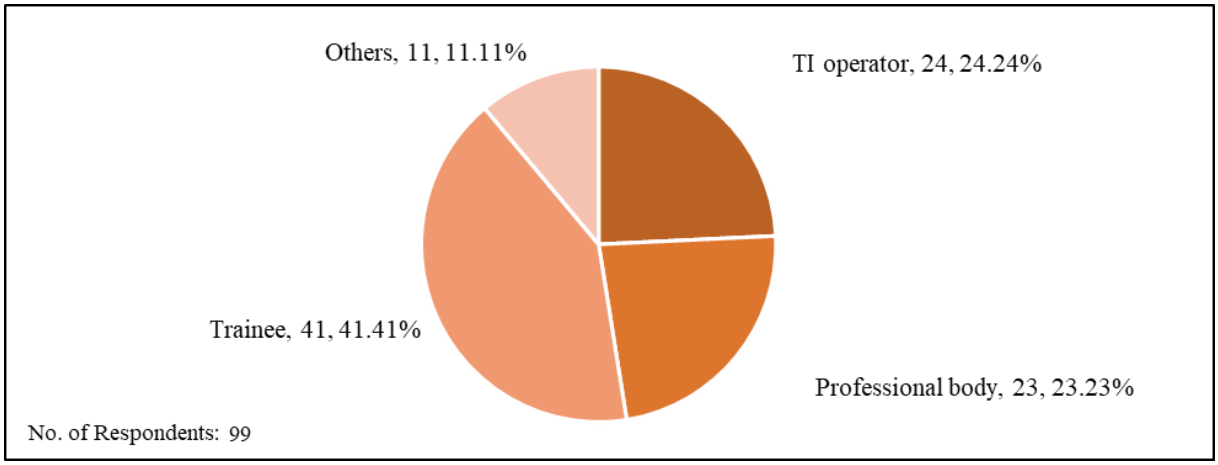
These categories covered a broad range of proposals which aimed at enhancing staff compensation and benefits, improving staffing establishment and working conditions, refining the ranking system and qualification accreditation, strengthening government support, etc., all with the goal of helping RCH recruit and retain high-quality staff.

6.2 Opinions from non-RCH staff respondents

6.2.1 Stakeholder groups of the respondents

In addition to the satisfactory responses from RCH staff, the survey also received valuable feedback from 99 non-RCH staff. Among them, the number of responses from trainees was the largest, accounting for 41.41% of the total. There were also 24 TI operators, 23 representatives of healthcare professional bodies, and 11 other respondents (Figure 16).

Figure 16 Distribution of the stakeholder groups of non-RCH staff respondents



Others included representatives of private RCH associations, medical professionals in-charge of visiting medical practitioner service for RCHs, executive directors of NGOs, instructors and trainees of the "Enrolled Nurses (General) Training Programme for the Welfare Sector", representatives from nursing TIs, and nurses who are not working in RCHs, etc.

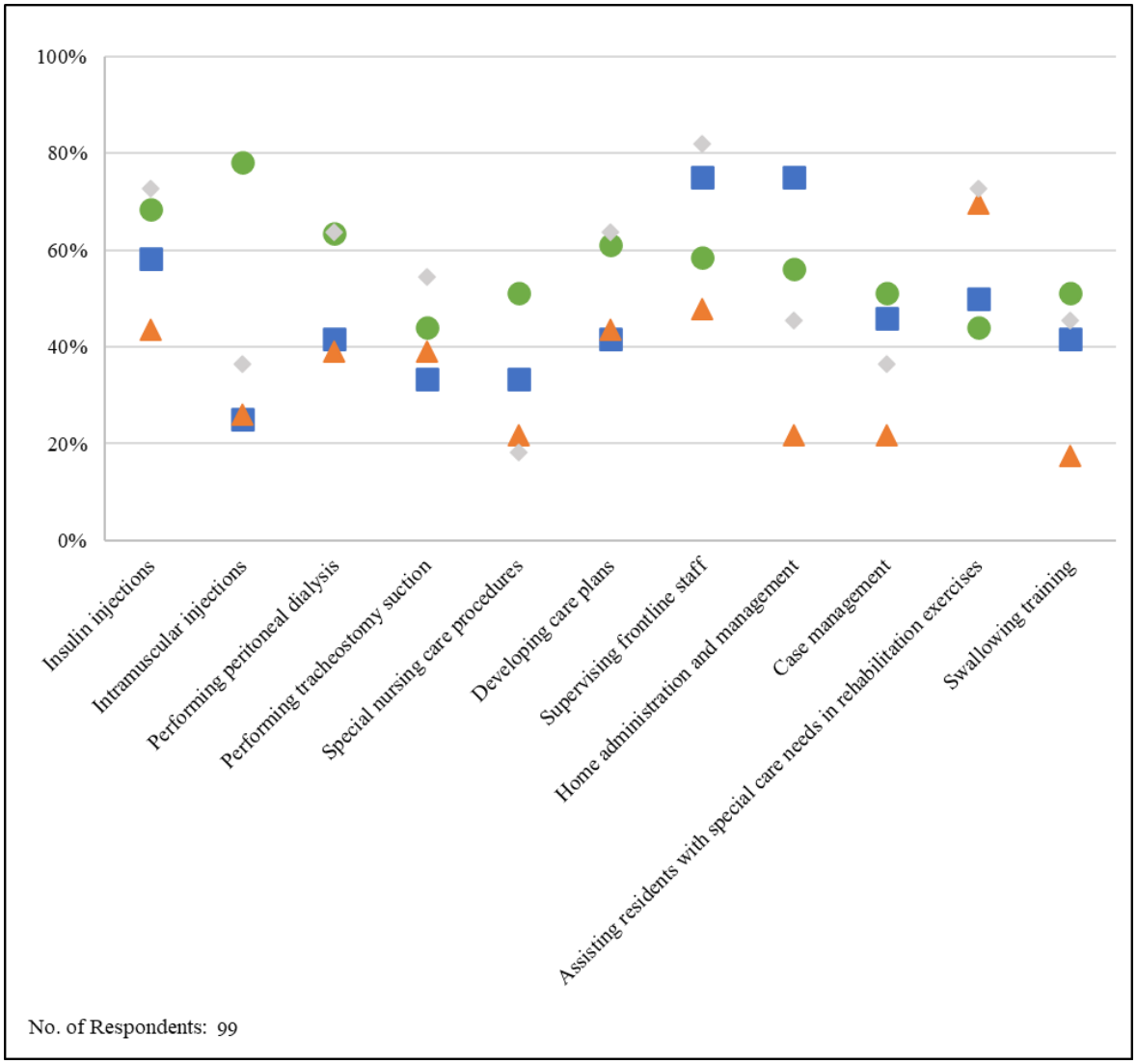
6.2.2 New responsibilities that "SHWs" can assume by incorporating proper training into the curriculum

More than half of the respondents from healthcare professional bodies believed that with proper training, "SHWs" could assist residents with special care needs in rehabilitation exercises. In addition, more than half of the TI operators believed that with proper training, "SHWs" could perform a wider range of job functions, including insulin injections, supervising frontline staff, RCH administration and management, and assisting residents with special care needs in rehabilitation exercises. Respondents did not choose some of the duties listed in the questionnaire, but this did not mean that they believe "SHWs" would not be competent enough even if they were trained, or they might have reservations about this part of the duties.

Others with some experience in RCHs or professional nursing backgrounds believed that "SHWs" with proper training would be able to supervise frontline staff, conduct insulin injections, assist residents with special care needs in rehabilitation exercises, perform peritoneal dialysis, develop care plans, and perform tracheostomy suction. Their confidence in the capability for "SHWs" to carry out the above six tasks after training surpassed that of the other three non-RCH staff stakeholder groups. These six tasks are in fact part of the seven professional nursing duties that the RCH staff respondents considered the "SHW" to be competent in, except for case management.

On the other hand, trainees had ambitious expectations over "SHWs". Except for performing tracheostomy suction and assisting residents with special care needs in rehabilitation exercises, more than half of the trainee respondents considered that, with proper training, "SHWs" would be able to perform most of the professional nursing duties listed (Figure 17).

Figure 17 Non-RCH staff respondents indicated that "SHWs" can assume new responsibilities by incorporating proper training into the curriculum

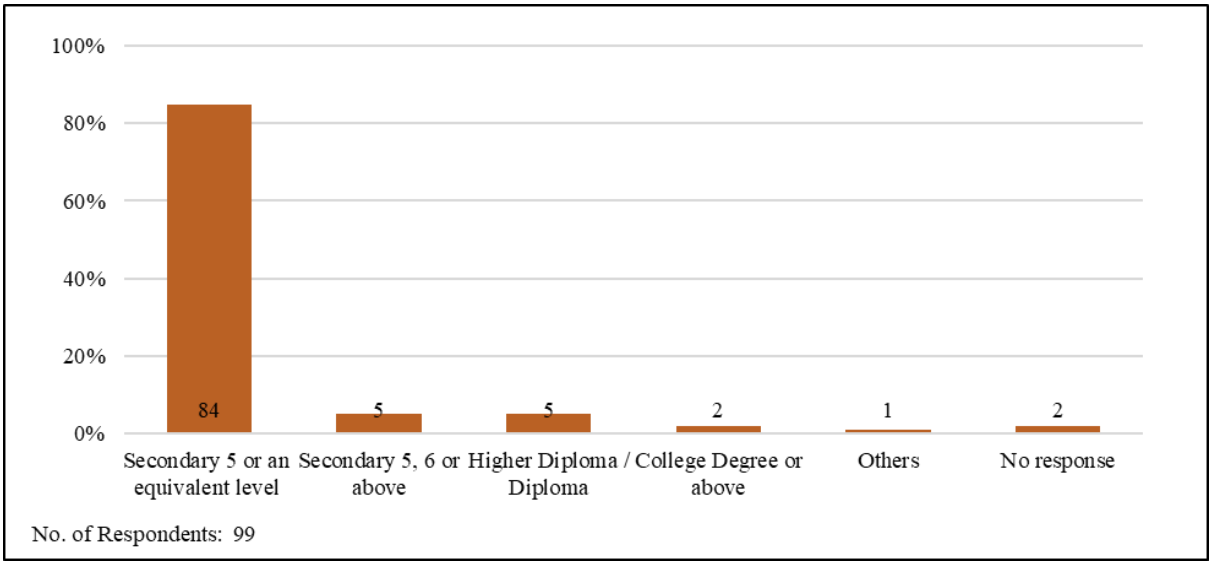


6.2.3 Qualifications required for "SHWs"

6.2.3.1 Academic requirements

In terms of academic requirements, the majority (84, 84.85%) of non-RCH staff respondents were of the view that a minimum of Secondary 5 or equivalent level should be set for the post of "SHW". Only one respondent suggested that the academic requirements should be at Secondary 3 or above (Figure 18).

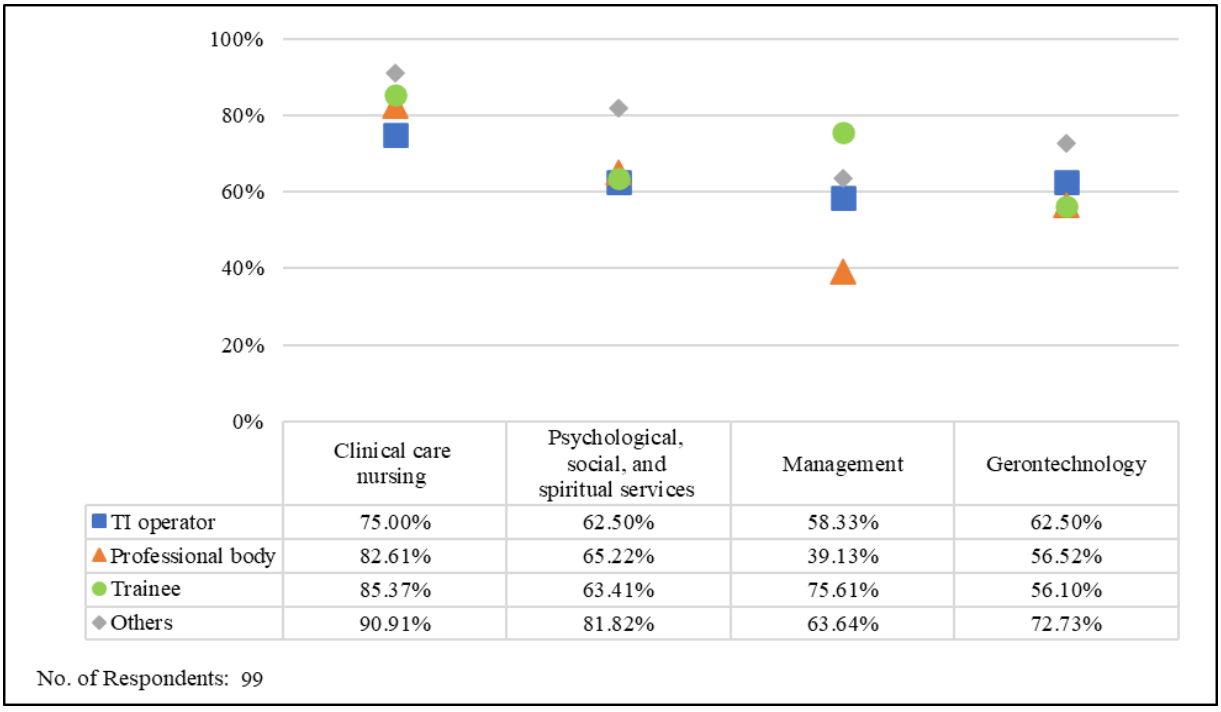
Figure 18 Distribution of opinions from non-RCH staff respondents on the academic requirements for "SHWs"



6.2.3.2 Content of the "Training Course for SHWs" in addition to the "HWTC"

The majority of non-RCH staff respondents had high expectations of the areas covered in the "Training Course for SHWs", not only clinical care and nursing training but also psychological, social, and spiritual services training, gerontechnology training, and management training. Overall, they hoped that the course would enhance the professional competence of "SHWs" to enable them to perform a wide range of job functions (Figure 19).

Figure 19 Distribution of comments from non-RCH staff respondents on the content to be covered in the "Training Course for SHWs"



	Clinical care nursing	Psychological, social, and spiritual services	Management	Gerontechnology
TI operator	75.00%	62.50%	58.33%	62.50%
Professional body	82.61%	65.22%	39.13%	56.52%
Trainee	85.37%	63.41%	75.61%	56.10%
Others	90.91%	81.82%	63.64%	72.73%

6.2.3.3 Working experience requirements

On top of the academic and training requirements, more than half (54, 54.55%) of the respondents considered that "SHWs" must possess certain working experience in RCHs.

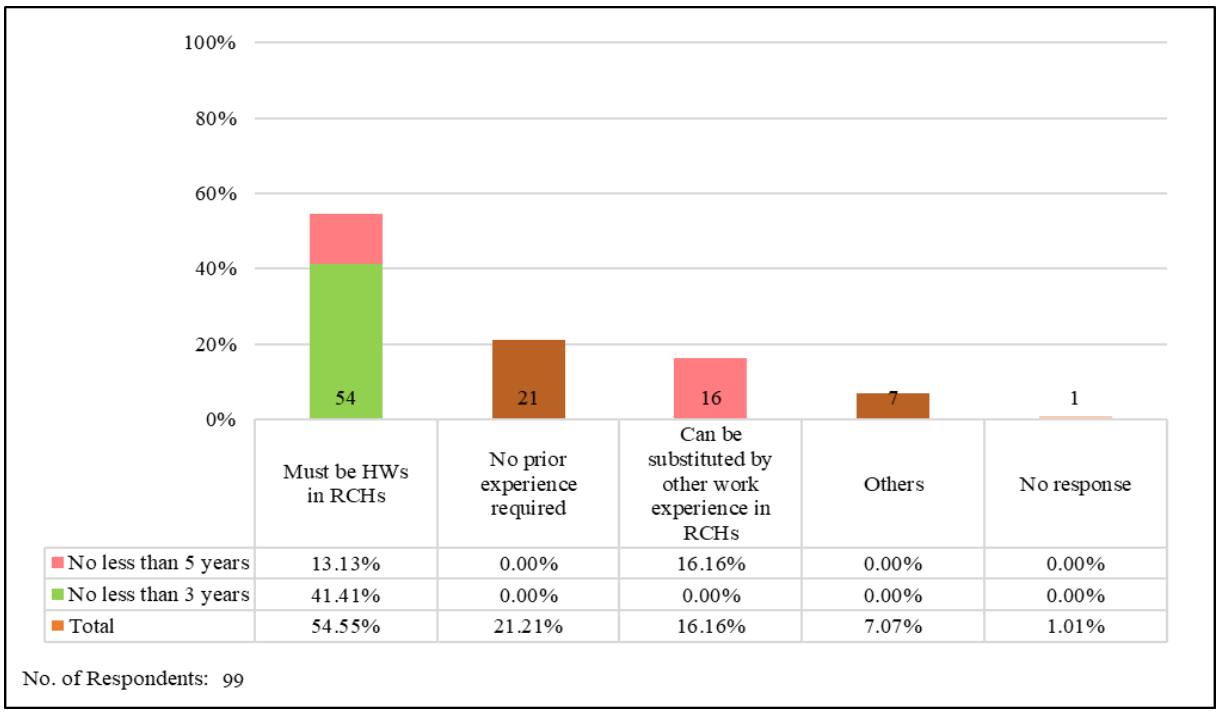
In terms of specific seniority requirements, more than 40% (41 respondents, 41.41%) of the opinions focused on the requirement for a HW for no less than three years, while 13 (13.13%) of the respondents suggested that they should work as a HW for no less than five years. This showed that most of the respondents tended to require "SHWs" to have at least three to five years of working experience as HWs to accumulate sufficient clinical experience and professional knowledge.

In addition, 16 (16.16%) respondents considered that having worked as a CW, TA or RA in RCHs for no less than five years could be regarded as equivalent working experience.

On the other hand, more than one-fifth (21 respondents, 21.21%) of the respondents considered that "SHWs" did not need to have working experience in RCHs (Figure 20).

Although the proportions were different, the prevailing views of non-RCH staff were in line with those of the sector on the working experience requirement.

Figure 20 Distribution of comments from non-RCH staff respondents on the working experience requirements of "SHWs"



	Must be HWs in RCHs	No prior experience required	Can be substituted by other work experience in RCHs	Others	No response
No less than 5 years	13.13%	0.00%	16.16%	0.00%	0.00%
No less than 3 years	41.41%	0.00%	0.00%	0.00%	0.00%
Total	54.55%	21.21%	16.16%	7.07%	1.01%

No. of Respondents: 99

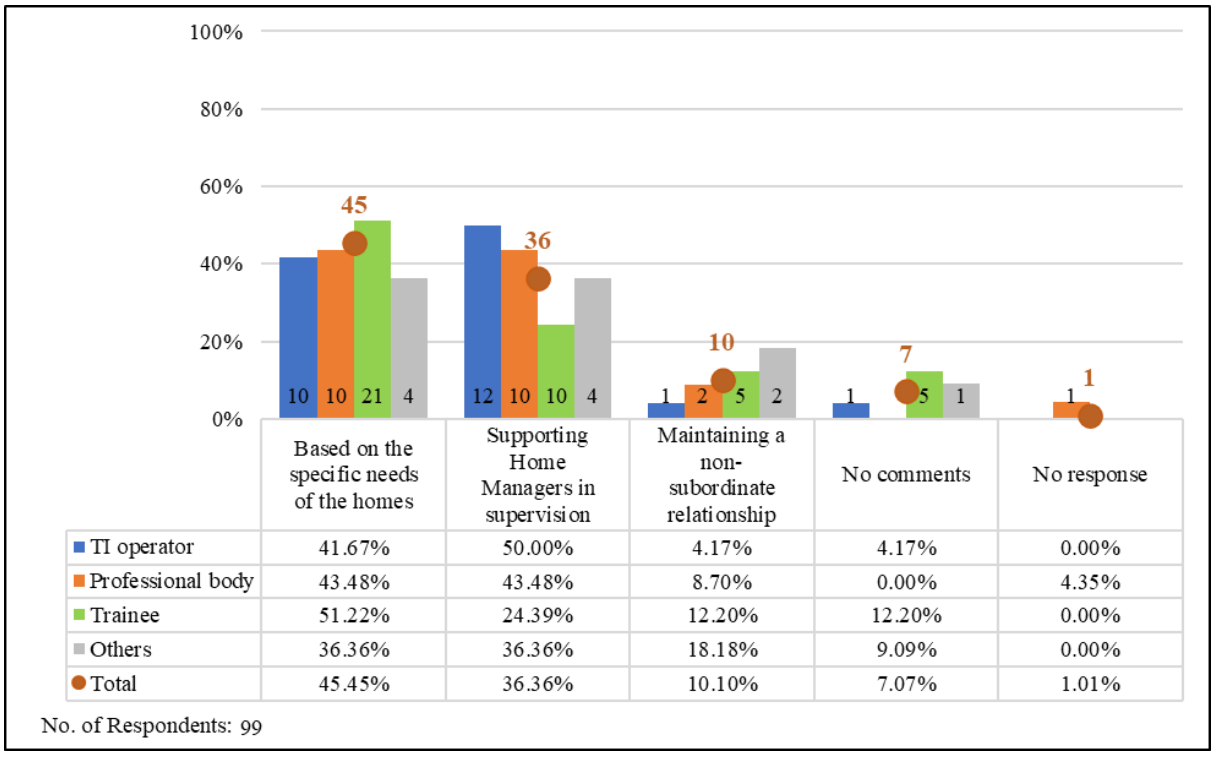
In sum, the 3 aspects of academic requirement, training and working experience show that the expectations of non-RCH staff respondents were in line with those of the sector.

6.2.4 Subordinate relationship between "SHWs" and existing HWs

Respondents were divided on the working relationship between the new rank of "SHWs" and the existing HWs. In terms of trends, the distribution of opinions was similar to that of RCH staff respondents.

Again, more than 40% of the respondents considered that whether there was a subordinate relationship between the two should be flexibly arranged according to the actual situation of individual RCHs. However, non-RCH staff respondents were more likely to expect "SHWs" should assist their existing HMs and supervise the HWs and/or other frontline staff compared to RCH staff respondents (Figure 21).

Figure 21 Non-RCH staff respondents' opinions on the relationship between "SHWs" and existing HWs



	Based on the specific needs of the homes	Supporting Home Managers in supervision	Maintaining a non-subordinate relationship	No comments	No response
TI operator	41.67%	50.00%	4.17%	4.17%	0.00%
Professional body	43.48%	43.48%	8.70%	0.00%	4.35%
Trainee	51.22%	24.39%	12.20%	12.20%	0.00%
Others	36.36%	36.36%	18.18%	9.09%	0.00%
Total	45.45%	36.36%	10.10%	7.07%	1.01%

No. of Respondents: 99

6.2.5 Suggestions for the job title of "SHW"

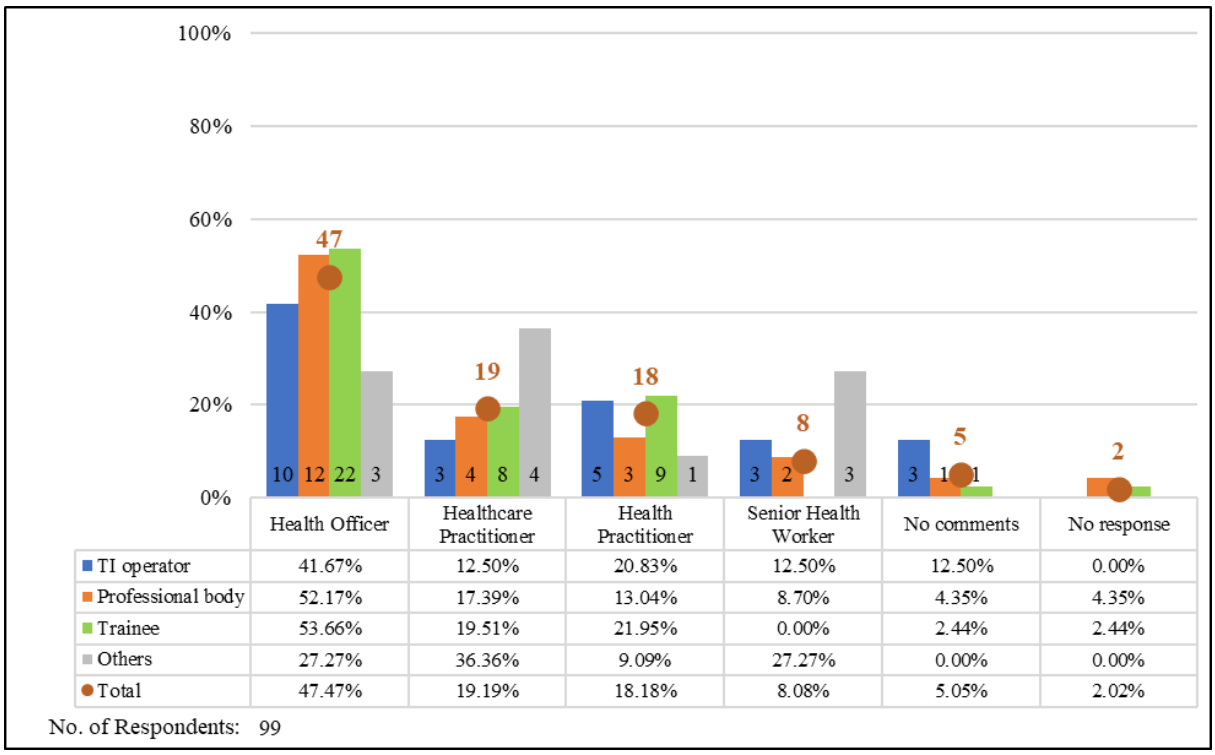
In terms of the proposed job title of "SHW", the distribution of opinions among non-RCH staff respondents was similar to that of RCH staff respondents.

The largest number of respondents (47, 47.47%) preferred using the title "Health Officer". When analysed in groups, it was found that more than half of the

respondents from healthcare professional bodies and trainees preferred to adopt this title.

In addition, nearly 20% (19, 19.19%) supported the job title of "Healthcare Practitioner", while 18 (18.18%) respondents suggested using the job title "Health Practitioner" (Figure 22).

Figure 22 Distribution of non-RCH staff respondents' suggestions for the title of "SHW"



	Health Officer	Healthcare Practitioner	Health Practitioner	Senior Health Worker	No comments	No response
TI operator	41.67%	12.50%	20.83%	12.50%	12.50%	0.00%
Professional body	52.17%	17.39%	13.04%	8.70%	4.35%	4.35%
Trainee	53.66%	19.51%	21.95%	0.00%	2.44%	2.44%
Others	27.27%	36.36%	9.09%	27.27%	0.00%	0.00%
Total	47.47%	19.19%	18.18%	8.08%	5.05%	2.02%

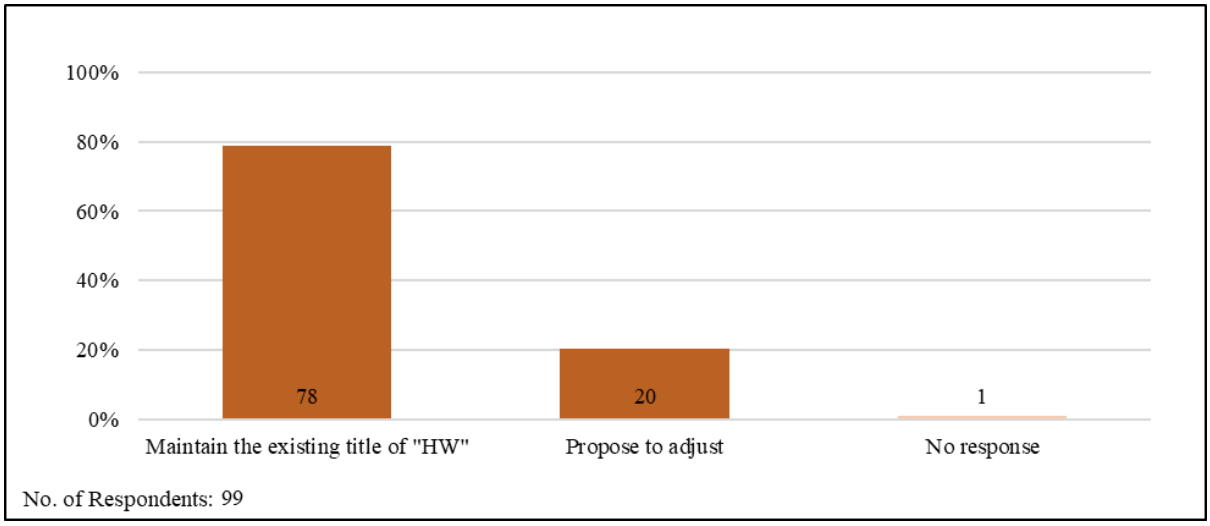
No. of Respondents: 99

For the job title of "SHW", another 5 (5.05%) non-RCH staff respondents suggested Advanced Health Workers, Nurse Assistant, Pro Healthcare Assistant, Healthcare Assistance I. It was also suggested not to use the word "health" because it seems outdated, and some people have thought that the HW refers to a massage therapist. Therefore, it was suggested to use the term "healthcare" instead.

6.2.6 The need for corresponding adjustment to the existing job title of HWs

Nearly 80% (78 respondents, 78.79%) of non-RCH staff respondents expressed that the existing title of "Health Worker" should be maintained (Figure 23). The prevailing views of non-RCH staff were in line with those of RCH staff respondents.

Figure 23 Distribution of opinions from non-RCH staff respondents on the existing job title of HW



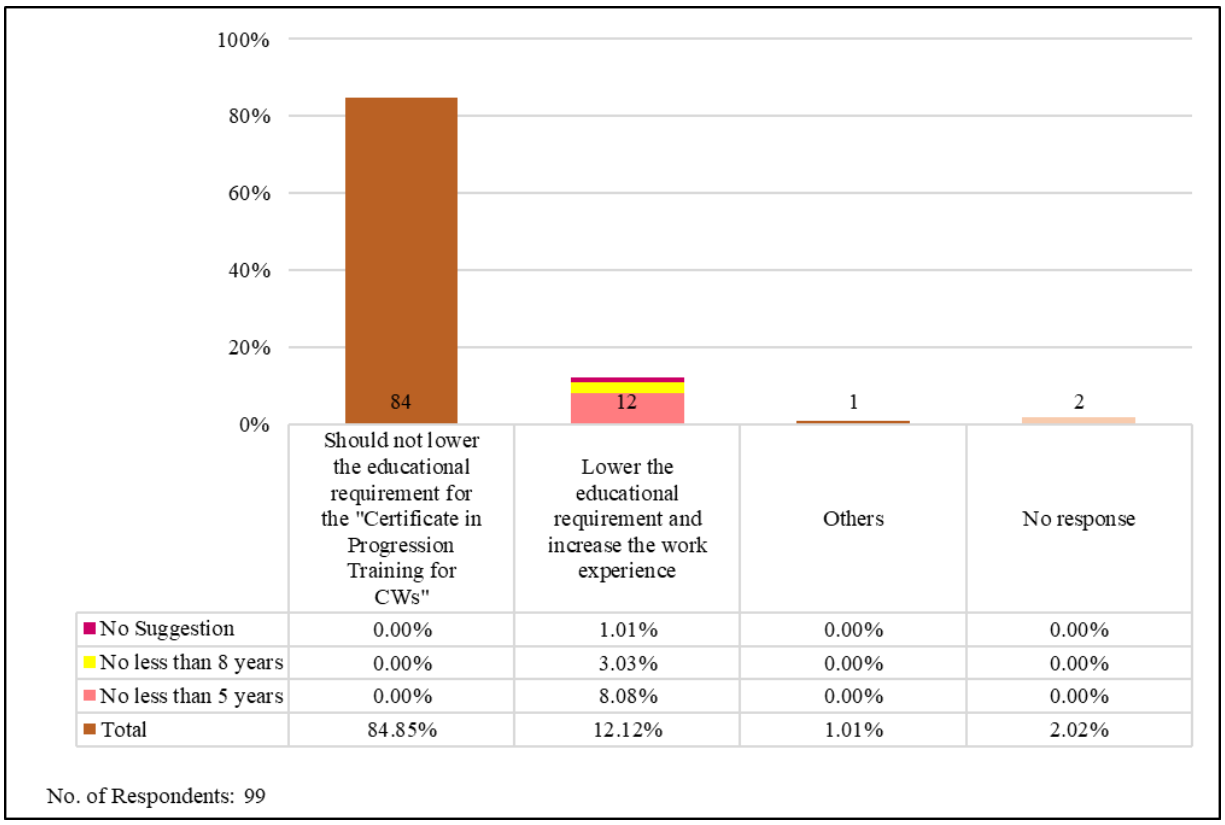
Another 20 (20.20%) non-RCH staff respondents suggested changing the current job title of "Health Worker" to: Assistant Health Officer, Health Assistant, or Assistant Health Practitioner.

6.2.7 Academic requirements for CWs enrolling in the "Certificate in Progression Training for Care Workers"

More than 80% (84 respondents, 84.85%) of non-RCH staff respondents opposed relaxing the academic requirements. They expressed that the academic requirements for the "Certificate in Progression Training for CWs" should not be lowered. Additionally, 1 respondent suggested that basic English proficiency should be assessed alongside the current academic requirements to qualify for the HW position.

On the other hand, 12 (12.12%) non-RCH staff respondents considered that the academic requirements could be lowered and the working experience requirement should be increased accordingly. Among them, 8 (8.08%) considered that they had served for no less than five years, 3 (3.03%) considered that they had served for no less than eight years, and the remaining 1 (1.01%) did not indicate the proposed length of service (Figure 24).

Figure 24 Distribution of opinions from non-RCH staff respondents on the academic requirements for CWs to enrol in "Certificate in Progression Training for Care Workers"



	Should not lower the educational requirement for the "Certificate in Progression Training for CWs"	Lower the educational requirement and increase the work experience	Others	No response
No Suggestion	0.00%	1.01%	0.00%	0.00%
No less than 8 years	0.00%	3.03%	0.00%	0.00%
No less than 5 years	0.00%	8.08%	0.00%	0.00%
Total	84.85%	12.12%	1.01%	2.02%

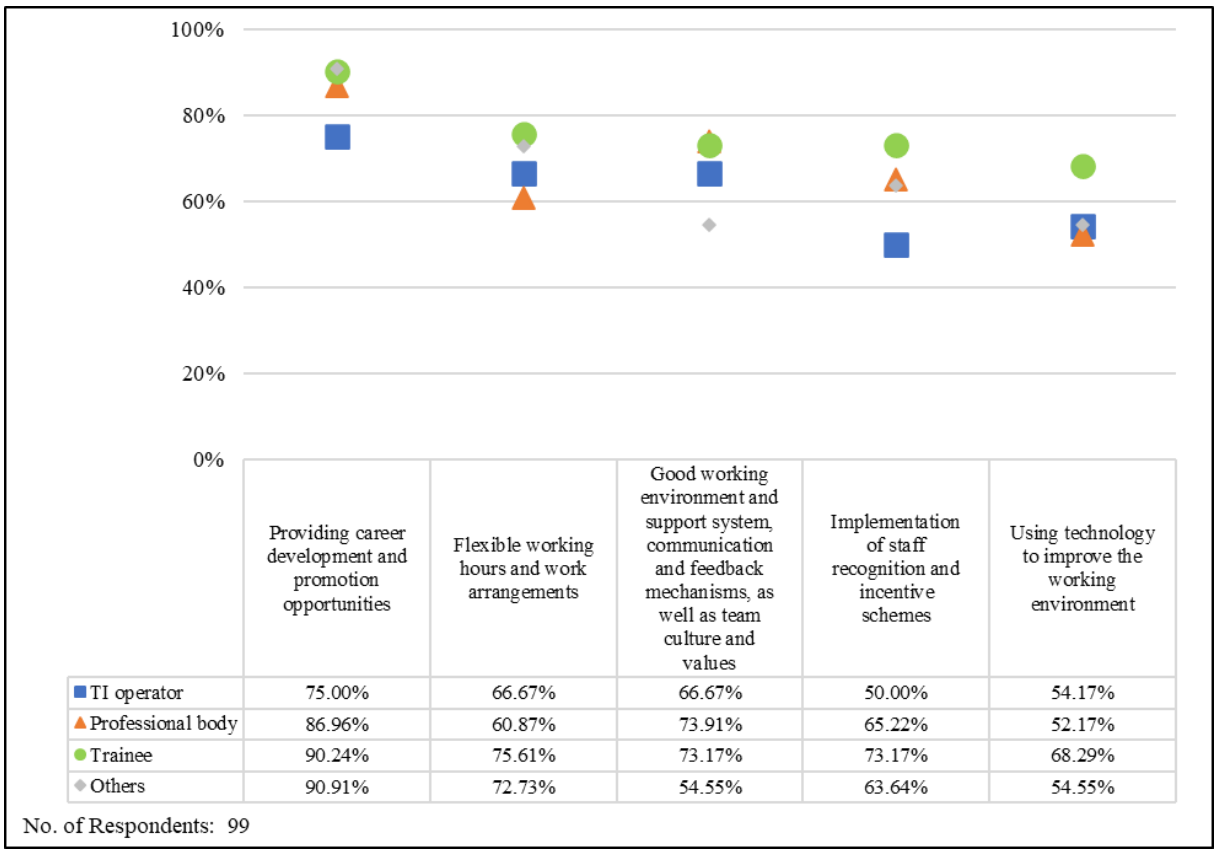
No. of Respondents: 99

6.2.8 Effective methods for attracting and retaining talent

Regarding the approach to attract and retain talent, four non-RCH staff groups share the same overall view, but they expressed varying degrees of effectiveness. Among them, the most effective method identified by respondents is "providing career development and promotion opportunities" (75.00% to 90.91%), which aligns with the views of the RCH staff respondents.

It is worth noting that, as trainees who would likely join the RCH sector in the future, the following factors were considered attractive: "flexible working hours and work arrangements" (75.61%); "good working environment and support system, enhancing communication and feedback mechanisms, as well as team culture and values" (73.17%); "implementation of staff recognition and incentive schemes" (73.17%); and "using technology to improve the working environment" (68.29%). At the same time, they attached more importance to "implementation of staff recognition and incentive schemes" and "using technology to improve the working environment" than the other three non-RCH staff groups (Figure 25).

Figure 25 Non-RCH staff respondents consider effective ways to attract and retain talent



	Providing career development and promotion opportunities	Flexible working hours and work arrangements	Good working environment and support system, communication and feedback mechanisms, as well as team culture and values	Implementation of staff recognition and incentive schemes	Using technology to improve the working environment
TI operator	75.00%	66.67%	66.67%	50.00%	54.17%
Professional body	86.96%	60.87%	73.91%	65.22%	52.17%
Trainee	90.24%	75.61%	73.17%	73.17%	68.29%
Others	90.91%	72.73%	54.55%	63.64%	54.55%

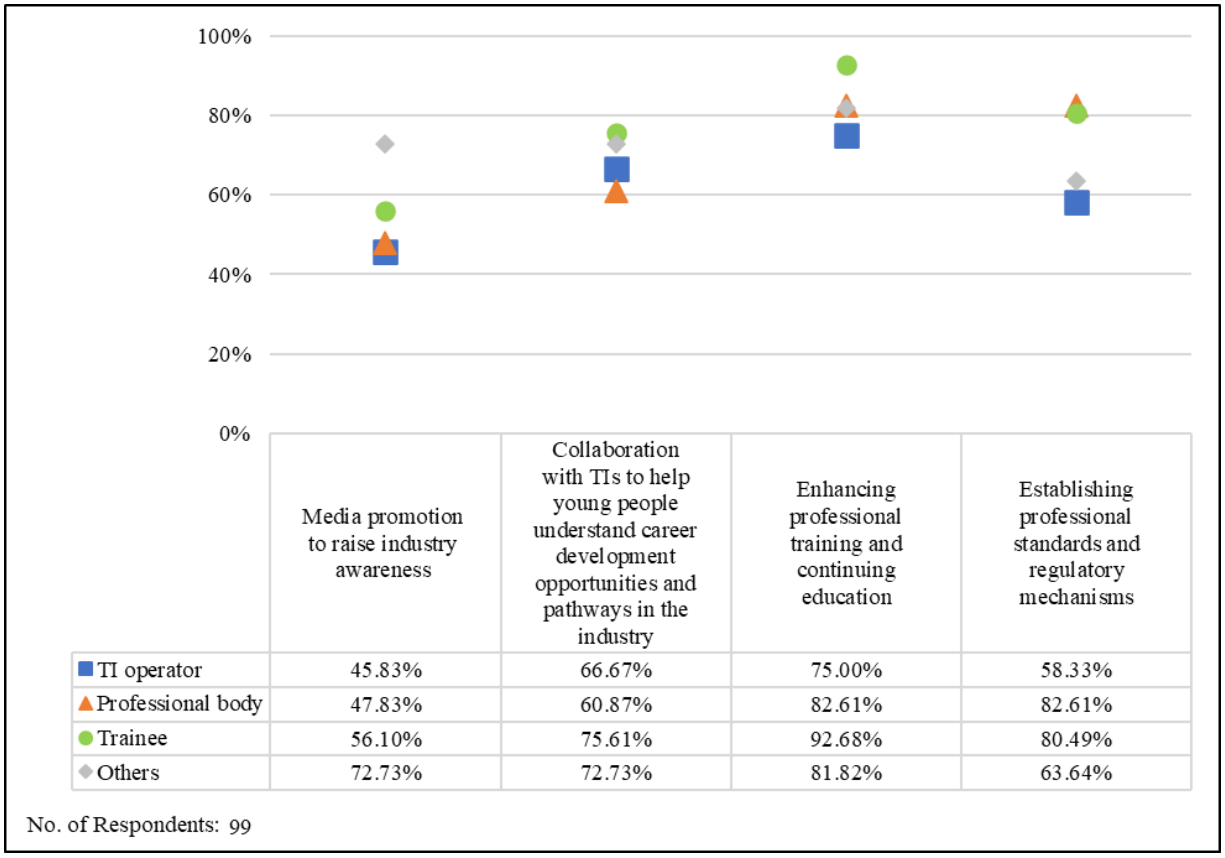
No. of Respondents: 99

6.2.9 Promoting professionalism in the residential care service industry

All four non-RCH staff groups considered "enhancing professional training and continuing education" to be the most effective way to promote greater professionalism of the residential care service industry. The second most effective methods identified were "establishing professional standards and regulatory mechanisms" and "collaboration with TIs to help young people understand career development opportunities and pathway in the residential care service industry" (Figure 26). The three methods mentioned above were also regarded as effective by the RCH staff respondents, indicating a consensus in views between the two groups.

Regarding effective ways to promote professionalism of the industry, one notable difference between the RCH staff respondents and non-RCH staff respondents was their perspective on "media promotion to raise industry awareness". Specifically, 72.73% of non-RCH staff respondents with some experience in RCHs or professional healthcare background, and 56.10% of the trainee respondents considered this practice effective. In contrast, fewer staff found this approach to be effective.

Figure 26 Non-RCH staff respondents considered the effective way to promote professionalism within the residential care service industry



	Media promotion to raise industry awareness	Collaboration with TIs to help young people understand career development opportunities and pathways in the industry	Enhancing professional training and continuing education	Establishing professional standards and regulatory mechanisms
TI operator	45.83%	66.67%	75.00%	58.33%
Professional body	47.83%	60.87%	82.61%	82.61%
Trainee	56.10%	75.61%	92.68%	80.49%
Others	72.73%	72.73%	81.82%	63.64%

No. of Respondents: 99

6.2.10 Additional opinions on career progression path, recruitment and retention, qualifications, and training requirements for RCH Staff

The Consultant collected additional opinions from 22 (22.22%) non-RCH staff respondents, which could be categorised into the following three main categories:

(a) Improving the working environment and atmosphere

- Review staff working hours and systems, implementing a more flexible schedule (e.g. a three-shift system) to prevent excessive working hours.
- Establish a reward system to enhance staff perception, foster a sense of belonging, recognising that residential care service is “a meaningful and impactful profession”.
- Strengthen relationships among staff, providing psychological counselling or emotional management training, and mental health.

(b) Improving the continuous learning mechanism

- Offer comprehensive onboarding training for new staff.
- Develop an accredited e-learning platform to provide flexible learning opportunities for current staff.
- Require staff to complete a specific number of professional training hours

annually to stay updated with the latest knowledge.

- Create professional qualification assessment channels for staff with a certain level of seniority and experience (e.g., hold a first aid certificate or intramuscular injection certificate for a certain number of years) to facilitate promotion opportunities.

(c) Government support and policies

- Establish an industry award scheme, with nominations and assessments conducted by stakeholders, where winning RCHs receive additional resources.
- Review policies on labour importation and the employment priority of local workers.
- Standardise the scope of duties and promotion mechanisms for senior healthcare ranks.
- Consider extending the retirement age to 65 to retain more experienced staff, in light of the ageing population.
- Provide "SHWs" with opportunities for promotion to higher levels (e.g. promote to RNs upon assessment).

Chapter 7 Stakeholders' Opinions Obtained from Other Research Activities

In addition to fieldwork and stakeholder opinion survey, the Consultant also collected views from various stakeholders through a project initiation workshop, individual interviews, focus group discussions, and a strategy forum. The Consultant directly engaged over 340 stakeholders. They included Legislative Council members, nursing academic representatives, medical officers who provide outreach services to RCHs, RCH operators, RCH staff in different job posts, etc. The following part is a comprehensive analysis of the views of various relevant stakeholders.

7.1 Current career development of key RCH staff

Over 100 focus group participants agreed that there is a great potential in the residential care service industry (particularly in elderly care), driven by the growing demand for professionals. However, participants also noted the career progression path issues faced by RCH staff. Owing to the limited job posts, RCH staff usually need to wait for promotion until vacant senior level positions are available. Promotion opportunities for HWs are further limited. In this regard, the sector is obliged to conduct a holistic review of the existing staffing and promotion mechanisms in establishing a clearer career progression path for staff seeking advancement and ensuring sufficient capacity for staff to be engaged within the organisational structure.

In addition, most continuing education courses in the community are offered on a full-time basis. This is challenging to RCH staff who often experience difficulty in pursuing further education due to the manpower shortages in RCHs. As a result, their career development is adversely affected.

7.2 Knowledge and skills to be enhanced by RCH staff

Feedback collected from the project initiation workshop, individual interviews and focus groups unanimously emphasised the importance of upholding professional standards and providing adequate training for RCH staff. Continuing education and appropriate guidance were highly valued. The focus group for Visiting Medical Officers (VMOs) noted that an RCHE achieved positive results in quality assessments due to the collaboration of well-trained staff, including RNs and ENs. This highlighted the critical role of staff training in maintaining service quality. Based on different job posts, the following knowledge and skills were identified to be enhanced among staff:

7.2.1 Home Managers

- Strengthen skills in recruitment, training, motivation, and performance appraisal to establish a stable and high-quality manpower.
- As nursing and care officers from various professional fields are involved in RCH operations, HMs should possess a basic understanding of respective professional fields and ensure smooth collaboration among all parties and effectiveness in completing the tasks through effective communication and coordination skills. Additionally, maintaining open lines of communication with residents' family members and addressing their concerns promptly is crucial.
- Given that emergencies frequently occur in RCHs, it is vital to develop comprehensive emergency plans. This requires enhancement of crisis awareness and response capabilities to ensure the safety of both residents and staff.
- Improve keen observational skills and maintain an open mind. HMs should be willing to question conventional practices and challenge preconceived notions, and to abandon way of habitual thinking.
- Acquire knowledge in financial management to allocate resources effectively, control costs and expenditures and maximise the benefits of limited resources.
- As the industry continues to evolve, HMs must embrace the new environment with innovation, introduce new ideas and technologies, and continuously optimise service models to enhance quality and efficiency in response to diverse needs.

7.2.2 Registered/Enrolled Nurses

- Enhance end-of-life care services to ensure that elderly residents and their family members receive comprehensive support before and after death.
- Foster stronger collaboration between nurses and family members, facilitating communication with hospitals and managing hospital-related arrangements.
- Enhance training in communication skills as nurses are required to frequently interact with different individuals.
- Regarding the differences of work settings between RCHs and hospitals, provide additional training for nurses to handle various tasks (e.g. meal arrangements).
- Strengthen training on institutional culture to help nurses in understanding the core values of the RCH, which hence contribute to build team spirit and cohesion.

7.2.3 Health Workers

- Current training for HWs primarily focuses on personal care. Future training should include professional knowledge, for example, in areas like dementia care to better support residents.

- Strengthen training on the use of urinary catheters, nasogastric tubes, and insulin needles, as well as enhancing understanding of various medical conditions.
- Refine training content related to caring for persons with disabilities by providing more specialised training modules.
- As HWs play a crucial intermediary role between upper management and frontline staff, enhancement of communication on training and streamlining teamwork processes are essential for improving collaboration and efficiency.

7.2.4 Care Workers and other frontline staff

- Basic first aid knowledge.
- The need for training to foster understanding of the concept of "respect" and develop a positive attitude towards their work.
- To understand new technologies and to learn operating new instruments.
- The need to strengthen training on occupational safety and health to minimise the risk of workplace injuries.
- Enhance training focused on a people-centred approach, emphasising empathy and compassion for those in their care.
- Foster a deeper understanding of the significance of their work and the societal needs addressed.
- Noting that CWs and other frontline staff (e.g. wardens, welfare workers, AWs) often face significant work pressure, training should be arranged to strengthen their sense of belonging and alleviate stress.

Apart from the above training aspects, it was proposed to incorporate topics such as emergency care, disease control and prevention, and customer service skills into the training programmes for CWs and other frontline staff riding on the existing basis. This comprehensive approach will significantly enhance the professional competence of RCH staff.

7.3 Potential needs for current health services

The following health services are vital for enhancing the health and quality of life of residents:

- Individualised care: It requires a thorough understanding of residents' needs, values, family dynamics, as well as lifestyles of residents and their family members. It is essential to collaborate with them in developing a tailor-made care plan addressing all aspects of each resident's needs. During the implementation of the individual care plan, there is a need to monitor resident's conditions and regularly assess the effectiveness of the plan. Adjustment on individual care plans to residents. Further adjustment and evaluation is required as necessary.

- Mental healthcare: Residents with conditions such as dementia, terminal illnesses, attention deficit/hyperactivity disorder, autism, hearing impairments, intellectual disabilities, mental health issues, physical disabilities, specific learning difficulties, speech impairments, organ disabilities and visual impairments require appropriate psychological counselling and training. These services aim to soothe the conditions and prevent or manage behavioural challenges.
- Palliative and hospice/end-of-life care services: Provide comprehensive palliative and hospice/end-of-life care that alleviates physical and emotional distress, addresses end-of-life needs, fulfils residents' unmet wishes, and ensures dedicated follow-up on post-mortem arrangements based on residents' preferences. Such services are crucial for maintaining the quality of life and dignity of residents in their final stages of life.
- Specialised and daily rehabilitation services: In addition to the regular specialised rehabilitation services provided by PTs/OTs, daily rehabilitation training is essential for helping residents to recover and regain their independence in self-care.

7.4 Roles, responsibilities, and tasks of the new rank

To provide for HWs and other frontline healthcare staff a better career progression path, participants in both individual interviews and focus groups suggested the establishment of a "SHW" rank. Most of the participants supported this idea and believed that the establishment of the post would provide a meaningful career progression path for HWs, thus facilitating talent retention.

In fact, there is currently a certain degree of overlap on the work of staff of different positions in RCHs. For instance, in certain RCHs, HWs have undertaken certain duties such as drug management, peritoneal dialysis, insulin injection, tracheostomy suction, wound care, chronic disease management, nursing co-ordination, etc. With proper training and assessment, HWs could become proficient in handling some of the tasks being performed by ENs at the moment, such as intramuscular injection, replacement of indwelling urethral catheters and nasogastric tubes. Nonetheless, invasive care procedures involving higher risks, such as insertion or replacement of suprapubic catheters and percutaneous endoscopic gastrostomy feeding tubes, should remain to be the responsibility of nurses who are more highly trained. These suggestions also received support from survey respondents (see Chapter 6 for details).

Most of these professional healthcare tasks were previously performed by RNs/ENs. By appropriately delegating certain responsibilities to "SHWs", nurses can allocate more time to specialise on clinical duties. With proper training as well as qualification and certifications, "SHWs" will be able to clarify their professional roles, thereby enhancing their job satisfaction.

7.5 Tasks for existing staff through role enhancement, expansion, substitution, and delegation

Fieldwork observations revealed that staff from different job posts collaborate closely to provide direct care services to residents. As a result, the same tasks may be performed by staff in different roles at different time. An analysis of the "time logs" submitted by 5 RNs, 11 ENs, and 21 HWs from the sample of RCHEs, and 8 RNs, 17 ENs and 25 HWs from the sample of RCHDs as at 19 March 2024, revealed that the ratio of nurses to HWs in providing direct care services versus management and other services was 44.22% to 55.78% in RCHEs. In RCHDs, the ratio was 42.36% to 57.64%. For HWs in RCHEs, the ratio was 62.29% to 37.71%, while in RCHDs, it was 51.08% to 48.92%.

Notably, among the 21 items of care and health services being examined, 16 (76.19%) showed overlapping responsibilities between nurses and HWs in RCHEs, with a significant emphasis on personal care provided by HWs. In terms of "drug management" and "special nursing care procedures", the involvement levels of nurses and HWs were similar, although the allocation of total daily hours worked differed. Tasks that do not overlap include the use of restraints and leading group activities by HWs and assisting residents in the use of urinary catheters, performing tracheostomy suction, and change of stoma bags by ENs (Table L 12). For RCHDs, except for peritoneal dialysis and leading group activities which are led by HWs, 18 (90.00%) of the 20 items of care and health services being examined were overlapping (Table D 17).

Based on these findings, the Consultant recommends the following four job optimisation strategies to enhance and expand the functions of staff across various RCHs:

- Enhancement: This involves developing the skills and responsibilities of RCH staff through ongoing education and training that align with clinical needs.
- Expansion: This refers to training staff to acquire a broader range of generic skills, such as resident education and teamwork.
- Substitution: This pertains to roles commonly shared across different occupations/functions.
- Delegation: This involves reallocating less skilled nursing tasks to frontline staff.

The following are optimisation strategies for different job posts based on the project initiation workshop, individual interviews, and focus group discussions:

	Enhancement	Expansion	Substitution	Delegation
Nurses	• Coordinate training and engage in management activities • Take responsibility for internal and external liaison and communication	• Mange complaints and crisis situations • Provide training for CWs in basic skills	• Organise interest classes or various activities for the elderly • Conduct training for frontline staff	• Delegate routine health services, such as checking body temperature and blood pressure, to experienced CWs
HWs	• Audit the work of frontline staff, including testing water temperatures for resident bathing • Mentor new HWs • Arrange schedules of work shifts	• Experienced HWs can act as case managers • Participate in clerical work and assist in daily management and risk management activities	• Communicate with residents' family members and respond to their inquiries • Act as an assistant to the VMOs • Assist with administrative tasks • Participate in nursing duties, such as learning about the effects and properties of drugs	• Experienced HWs can supervise frontline staff, including CWs, new HWs, and cleaning staff
CWs and other frontline staff	• Involve in planning and providing suggestions on frontline policies • Explore opportunities for further education or internal promotion • Experienced CWs can assist in identifying residents' signs of bodily deterioration	• Expand responsibilities in spiritual care, rehabilitation, and end-of-life services for residents • Leverage strengths, such as proficiency in specific languages • Manage room assignments and act as room leaders	• Experienced CWs can assist HWs or nurses in performing routine health services, such as checking body temperature and blood pressure	• Join working groups in the RCH • Assist in simple clerical and administrative tasks, such as archiving data for future reference

These suggestions aim to enhance staff roles, develop their strengths, and accumulate experience in continuous growth.

7.6 Factors influencing staff recruitment and retention in RCHs

The residential care service industry has been experiencing a long-term manpower shortage, evident in high staff turnover and a lack of new recruits. Based on

individual interviews and focus group discussions, the main reasons for this situation are as follows.

Firstly, focus group participants noted a significant lack of social recognition for the industry. The negative perception of nursing care as "low-end" and "obnoxious", coupled with uncompetitive pay level, has led to high turnover rates. As a result, potential recruits often opt for less physically demanding industries, such as security.

Secondly, there is a lack of clear career progression path in the industry. The absence of opportunities for career growth makes it difficult to attract ambitious individuals, particularly younger talent.

In addition, focus group participants highlighted the insufficient overall planning of the training system within the industry. They noted that RCH staff have a lower success rate in applying for nursing courses as compared to hospital staff. This has driven some RCH staff to change to work in the hospitals for better chances of pursuing the relevant courses thus climbing the career ladder. They considered that this situation has led to a brain drain, making it challenging for RCHs to retain experienced healthcare staff.

7.7 Approaches to enhance staff attraction and retention in RCHs

Focus group participants agreed that a multi-faceted approach is essential for effectively attracting and retaining talent in the residential care service industry:

- Strengthen the positive aspects of the residential care service industry to improve its professional image and appeal to potential recruits;
- Provide bridging courses and support for individuals seeking to enter the industry, facilitating their transition into these roles;
- Clearly define the responsibilities associated with different ranks to ensure that the scope of work for each job post is well understood; and
- Offer better career development opportunities and growth potential in addition to renumeration.

7.8 Main concerns of implementing the Consultant's preliminary recommendations

After in-depth discussions among the participants of the strategy forum, the following main concerns were raised in relation to the implementation of the Consultant's preliminary recommendations:

- The roles of "SHWs" and ENs must be clarified to ensure clear formulation of

specific arrangements with respect to the training courses, such as its design and implementation.

- Given that the training hours for HWs and ENs differ notably, some participants expressed concern about the appropriateness of classifying "SHWs" and ENs under the same QF Level 4. Some participants also expressed that if the salary and benefits of "SHWs" were to be similar to those of ENs in the future, this could lead to dissatisfaction among ENs, resulting in division within the sector.
- The academic requirements, the training course content, and assessment standards for SHWs must be properly defined to ensure the quality of SHWs. In particular, attention should be given to their language skills, clinical judgment, and drug management abilities, etc.
- The regulatory body and registration system for SHWs must be specified, and insurance arrangements should be explicitly stated to avoid RCHs from being held liable for errors in care procedures performed by SHWs.
- Some RCHs reflected that they have established the job post of "SHW" and that their HWs, along with those from other RCHs, have already undertaken certain responsibilities of "SHWs" as outlined in the consultancy study. HWs in some private RCHs have already assumed nursing responsibilities for most residents as well. Consequently, existing HWs lack motivation to pursue related courses. The Government needs to provide financial incentives to encourage these staff to pursue the "Training Course for SHWs".
- Some participants reflected that although they had completed training courses for HWs, some RCHs did not recognise their qualifications or skills, continuing to rely on nurses for relevant procedures, such as giving drugs and insulin injections. As a result, they were not permitted to perform necessary tasks in the RCHs, diminishing their motivation to continue their education. Therefore, the Government should ensure that "SHWs" can apply their nursing knowledge and skills in RCHs upon completion of the relevant courses.
- The Government should clearly communicate with the sector regarding the roles and implementation details of "SHWs", including job grade and remuneration, to secure support from the sector.

In general, participants were relatively more concerned about the differences in the job grade, responsibilities, and remuneration between "SHWs" and ENs, the quality of training and the necessary supervision arrangement so as to ensure the smooth establishment of this new rank with the expected outcomes.

In addition, the Consultant also consulted the relevant professional body, the RAC, and the EC on the preliminary recommendations. The RAC was mainly concerned about the quality assurance of the new rank in providing care procedures currently carried out by ENs, the relationship between the new rank and ENs, the training and supervision of the new rank, and the professional regulation of the new rank. The EC welcomed the establishment of the new rank, while emphasising the need to pay attention to the quality of training, supervision arrangement, risk management, and monitoring mechanism for implementing special nursing care

procedures for the new rank.

The opinions obtained from the above consultations can be summarised into three aspects:

(1) Recommend establishing a rigorous professional qualification training and assessment mechanism for the new professional rank to ensure individuals of the rank can provide necessary care and health services;
(2) Recommend establishing a regulatory mechanism to handle work irregularities and complaints, ensuring the professionalism and service quality of the new professional rank; and
(3) Recommend enhancing the communication with the sector and the public, emphasising that the new rank is a brand new care professional position dedicated to the welfare sector, responsible for performing the care procedures required. The establishment of this job post will help the welfare sector cope with the challenges of ageing population and the lack of care professionals in the future.

Chapter 8 Recommendations of the Consultancy Study

8.1 Establishment of the "Health&Care Practitioner" rank

With the increasing demand for professional care services in the RCH sector, there is a need to nurture specialised care professionals to sustain the healthy development of the welfare sector. Currently, essential services in RCHs encompass a wide range of care procedures. Nonetheless, the welfare sector lacks a sufficient pool of dedicated care professionals. Given the operational realities of different RCHs, these care procedures are often performed by both ENs and HWs, resulting in an overlap in their responsibilities. To address this issue, the Consultant recommends establishing a new professional rank of "Health&Care Practitioner (HCP)". This post will specialise in providing care services in RCHEs, RCHDs, and other elderly/rehabilitation welfare service units, with a view to developing a dedicated pool of care professionals for the welfare sector.

The Consultant recommends strengthening the understanding of the welfare sector and the public that the new rank is a brand new care professional position dedicated to the welfare sector. This new rank provides a career progression pathway in RCHs, which not only helps attract new entrants to the sector but also offers better career development opportunities for existing HWs, aiding in talent retention. From an operational perspective, the new rank provides RCH operators with an additional option for hiring care professionals, providing greater flexibility in utilising their manpower resource. To the welfare sector as a whole, the new rank will help build up a dedicated pool of care professionals, reduce competition for talent with the medical sector, and alleviate the tight manpower situation in RCHs.

8.1.1 Rationale and the role of HCP

(a) The role of ENs in RCHs differs from those in the hospitals. They are unable to fully utilise their professional skills in RCHs. Additionally, the salaries offered by RCHs are not competitive, leading some ENs to eventually transit to the medical sector after a period of service in the welfare sector.

(b) Fieldwork in the consultancy study revealed that there has been an overlap in more than three-quarters (16 out of 21) of ENs' and HWs' tasks in RCHEs, with HWs handling more "personal care tasks". In areas such as "drug management" and "special nursing care procedures", the involvement levels of nurses and HWs are comparable, although the time allocation in their total working hours per day was different. The non-overlapping tasks include HWs being responsible for use of restraint(s) and leading group activities, while nurses assist residents in

the use of urinary catheters, performing tracheostomy suction, and change of stoma bags (Table L 12). In RCHDs, among the 20 items of care and health services, 90% (i.e. 18 tasks) of the work content of nurses and HWs overlapped (Table D 17), with the exception that only HWs are responsible for performing peritoneal dialysis and leading group activities.

(c) The establishment of the new "HCP" rank will enable the sector to nurture and retain dedicated talent by assigning them nursing duties in RCHEs, RCHDs, and other elderly/rehabilitation welfare service units. The stakeholder opinion survey also indicated broad support for the "HCP" role, with most stakeholders agreeing that, after proper training and assessment, "HCPs" can be responsible for providing boarder/higher level of professional care procedures (such as intramuscular injections, insertion or replacement of indwelling urethral catheters and nasogastric tubes, etc.), and they can also supervise frontline staff in RCHs. The establishment of the new rank of "HCP" can solve the issue of professional staff shortage in RCHs and provide a better career progression path for staff who are interested in long-term development in the sector.

(d) At the initial stage of the establishment of "HCP", serving registered HWs or those with relevant experience should be invited to undergo training, thus providing them with promotion opportunities. In addition to performing more specialised and extensive functions in RCHs, "HCPs" may also perform the care procedures required in elderly/rehabilitation welfare service units (such as day care centres for the elderly). This will help enhance the professionalism and service quality of the welfare sector.

(e) The Residential Care Homes (Elderly Persons) Regulation and the Residential Care Homes (Persons with Disabilities) Regulation respectively specify the statutory staffing requirements for various types of RCHEs and RCHDs. The provisions of the Amendment Ordinance concerning respective registration systems for HMs of RCHs have come into effect, setting out the application qualifications for becoming a registered HM or registered HM (provisional) to enhance their professionalism and strengthen the RCH management. RCH operators decide the roles and pay levels of different job posts in their RCHs based on several factors, including the operational needs, market supply and demand, as well as staff experience and performance. In this regard, after the establishment of the new rank of "HCP", the relationship between the "HCP" and other job posts in RCHs, as well as their pay levels, are internal management matters. The Consultant recommends that RCH operators make their judgments and decisions based on their specific circumstances.

8.1.2 Job titles of "HCP" and existing HWs

(a) With reference to the feedback from various stakeholders, in taking the career development preferences of the younger generation, the training course content, and drawing the primary responsibilities of the role into consideration, the Consultant suggests designating the new rank as "HCP". The title reflects the fact that the post covers both care and health duties, with due emphasis on practice.

(b) It is recommended to retain the current title of "Health Worker".

8.1.3 Registration and regulation of "HCP"

It is recommended that the existing regulatory mechanism for HWs be referenced, with the SWD responsible for the registration and renewal of "HCP" and for handling complaints related to care procedures, etc.

8.1.3.1 Registration and renewal requirements

(a) **Registration requirement:** Any person who wishes to obtain the qualification of a registered "HCP" must have attended a designated training course approved in writing by the DSW. The course is designed to equip "HCPs" with both theoretical knowledge and practical skills, enabling trainees to master the essential competencies required for higher-level professional care services. Applicants must pass standardised assessments or evaluations, including written and practical tests, achieving scores that meet the passing standard. Upon successful completion, they will be awarded a certificate.

(b) **Renewal requirement:** It is recommended that the validity period of "HCP" registration should not exceed five years. If the applicants fail to renew on time, their registrations will become invalid.

Please refer to Annex 17 for detailed recommendations regarding the registration and renewal of "HCP".

8.1.3.2 Regulatory mechanism

The SWD has professional inspectorate teams to regulate residential care services, conduct surprise inspections, and handle care-related complaints, etc. These teams consist of senior nursing officers, nursing officers, and RNs with extensive professional nursing experience and background. The Consultant recommends that the regulation of "HCP" continue to adhere to this existing mechanism to ensure that "HCPs"

uphold their professional ethics and deliver high-quality care services to residents in RCHs. In addition, concerning the quality assurance and professional regulation of "HCPs", the Consultant advises the SWD to develop a registration, assessment, registration renewal, and professional supervision mechanism. This system should be referenced to the regulatory frameworks, complaint handling procedures, and disciplinary protocols of other medical and allied health professions, along with mechanisms for registration renewal. These measures will help ensure the professional competence of "HCPs" and facilitate effective regulation. Furthermore, the SWD should review the relevant regulatory mechanism, including the quality of the Training Course for "HCPs" as well as the continuing education and assessment of registered "HCPs". This will help maintain the professional standards and ensure that residents receive safe and reliable care.

If the DSW is satisfied that a "HCP" is no longer competent to perform the duties of the post or is no longer a fit and proper person to be registered as a "HCP", he or she may cancel the registration of the "HCP" concerned.

8.1.3.3 Continuing education

The continuing education should encompass the latest nursing knowledge relevant to the care of the elderly and persons with disabilities, advancements in healthcare and rehabilitation equipment technology, skills enhancement, applicable laws and regulations, as well as training in professional ethics, etc. To accommodate diverse learning needs and schedules, a variety of learning modes can be utilised, e.g., including face-to-face and online formats.

In the long run, the SWD may consider integrating the requirement of continuing education into the condition for renewal of the registration as a "HCP".

8.1.4 Training Course for "Health&Care Practitioners"

8.1.4.1 Entry requirement

The basic academic qualifications for the designated Training Course for "HCPs" align with those for the "Enrolled Nurse (General) Training Programme", i.e.[56]:

(a) Applicable to applicants with Hong Kong Certificate of Education

[56] The entry requirement is extracted from the "Enrolled Nurse (General) Training Programme" on the Hospital Authority's website.

Examination results: having completed Secondary 5 or equivalent; or

(b) Applicable to applicants with Hong Kong Diploma of Secondary Education Examination results: having obtained Level 2 or above in 5 subjects, including Chinese Language, English Language, Mathematics and any two other subjects in Category A (Core/Elective Subjects) and Category B (Applied Learning Subjects)[57], or equivalent.

Most stakeholders considered that "HCPs" should possess certain level of experience working in RCHs. At the initial stage of the establishment of the "HCP", the Consultant recommends inviting serving registered HWs who have served in the position for no less than three years to undergo the training.

In the future, the SWD may consider allowing persons who meet the academic qualifications outlined in paragraph 8.1.4.1 (a) and (b) above but without prior experience as HWs to obtain the registration qualification of "HCP" by completing a designated training course. The content and duration of the relevant training course should be expanded compared to those mentioned in paragraph 8.1.4.2 below to ensure it covers the curriculum of the existing "Combined Health Worker Training Course" and includes sufficient practical hours in RCHs.

8.1.4.2 Course content

"HCP" is a newly established care professional position. The Consultant referenced the syllabus for the similar "Enrolled Nurse (General) Training Programme" (Annex 18) and incorporated the units of competency (UoCs) from the "Specification of Competency Standards (SCS) for the Elderly Care Service Industry" as well as its Community Care and Support under the HKQF. The Training Course for "HCPs" focuses on equipping trainees with the professional knowledge and skills required for care procedures in residential care services. The course is classified at QF Level 4.

The Consultant recommends the Training Course for "HCPs" targeted to serving registered HWs, is with a total 760 learning hours, equivalent to 76 QF credits. The course comprises 2 UoCs at QF Level 3, 33 UoCs at QF Level 4, and 9 UoCs at QF Level 5; a total of 44 UoCs. It consists of 480 hours of in-person instruction, which includes lectures, demonstrations, skill practice, and assessments. Additionally, trainees will complete 15 days of practicum in a NH or a high care level RCHE,

[57] For Category B (Applied Learning Subjects), trainees awarded "Attained" results will be considered as having acquired Level 2.

15 days in a high care level RCHD, and 5 days in an elderly care/rehabilitation welfare service unit, totalling 280 hours. Considering that registration as a HW requires a minimum of 248 hours of training (including 200 hours of in-person instruction and 48 hours of visit and practicum), the above course has eliminated duplicate learning content. To ensure that trainees are adequately prepared for future care work, the Consultant recommends that the application of relevant nursing skills (e.g. intramuscular injections, insertion or replacement of indwelling urethral catheters and nasogastric tubes) be included as core competency topics. Only those trainees who pass all assessments will be awarded a graduation certificate. Specific course content and relevant requirements are detailed in Annex 19.

8.1.4.3 Award title

According to the Hong Kong Qualifications Framework (QF), the "level" (i.e. Level 1 to Level 7) of a recognised qualification reflects the depth and complexity of the learning content; the "title" reflects the nature, subject area, and level of the relevant qualification; while the "credit" indicates the learning hours required for the relevant qualification. Qualifications at QF Levels 3 to 6 with the amount of learning of 60 QF credits or above may use "diploma" as an award title.

The Award Titles Scheme stipulates that qualifications at Levels 4 to 6 of the QF may use "advanced", "higher", "professional" and "postgraduate" as qualifier.

Based on the amount of learning and content of the Training Course for "HCPs", the Consultant recommends using "Professional Diploma" as the award title to clearly reflect the nature of the course.

8.1.4.4 Implementation plan

(a) Potential TIs for the Training Course for "HCPs"

To ensure the quality of the Training Course for "HCPs", educational and/or training institutions must undergo strict accreditation and review. Specifically, potential TIs that can provide the above training course must have been approved by the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (HKCAAVQ) in accordance with the Accreditation of Academic and Vocational Qualifications Ordinance (Cap. 592) and the HKCAAVQ Ordinance (Cap.1150), and have been confirmed to have the capacity to offer courses that meet the standards of the QF at the relevant level. For this QF Level 4 training course, both self-accredited institutions and recognised

professional nursing TIs meet this qualification.

TIs must arrange qualified professional instructors (including SWs, nurses (general/psychiatric), medical officers, pharmacists, PTs/OTs, etc.). To further enhance the training quality, the following additional requirements may be considered:

- The instructors must have relevant professional qualifications and more than five years of working experience, including at least three years of supervision or training experience
- TIs must be equipped with adequate facilities (e.g. classrooms, simulation practice rooms)
- Introduce third-party curriculum review and on-site evaluation mechanisms (such as the HKCAAVQ)
- Open channels for trainees to provide feedback on courses and instructors

(b) Training cost

The "Enrolled Nurse (General) Training Programme for the Welfare Sector" has a theoretical and practical teaching time of 780 to 860 hours, plus a minimum of 1 600 hours of clinical practice. The tuition fee is approximately HK$205,000.

The total learning time of the full-time "Training Course for Health Workers in RCHEs" must be no less than 248 hours, including 8 hours of visiting RCHEs and 40 hours of practicum. The tuition fee is approximately HK$12,000.

With reference to the tuition fees of the above courses, for the Training Course for "HCPs" with a total learning time (including clinical practice) of no less than 760 hours, the course fee for each trainee will be ranged from HK$60,000 to HK$100,000.

(c) Implementation time

Assuming that the total learning time for the Training Course for "HCPs" is no less than 760 hours, it will take TIs about nine months to one year to complete the course design.

Under the Accreditation of Academic and Vocational Qualifications Ordinance (Cap. 592), qualifications from self-accredited institutions (i.e. the institutions listed in Annex 2 to the Ordinance) only require QR verification and can be registered without HKCAAVQ assessment. In other words, TIs with self-accreditation

qualifications can launch the relevant course in about a year at the earliest.

As for other TIs that do not have the qualifications to conduct self-accreditation, they must submit their course to the HKCAAVQ for accreditation in accordance with established procedures. Due to the complexity of this course, it is expected to take an additional nine months to one year after the submission of the accreditation documents for course design review and issuance of the accreditation report.

Therefore, the earliest the Training Course for "HCPs" can be launched is around the second half of 2026 (refer to paragraph 8.5 for details).

8.1.5 Demand forecast for "Health&Care Practitioners" in the RCH sector

By March 2024, there are approximately 3 200 ENs working in RCHs. "HCPs" can undertake duties currently performed by ENs in RCHs. The supply and demand forecasts for "HCPs"/ENs in the RCH sector in the next five years are as follows:

Demand:	
(a) To fill existing EN vacancies[1]	Approx. 440
(b) To replace ENs lost to attrition (e.g. retirement, career change)[1]	Approx. 800
(c) To recruit additional nurses for compliance with the statutory staffing requirements under the Amendment Ordinance	Approx. 200
(d) Manpower required for new subvented/contract RCHs[2] and Enhanced A1 places under the EBPS	Approx. 650
(e) Manpower required for new private RCHs[3]	Approx. 90
(f) Manpower required to address the ageing population of users in RCHDs[4]	Approx. 140
(A)	**Approx. total 2 320**
Supply of ENs:	
Graduates of the Enrolled Nurse (General) Training Programme for the Welfare Sector[5] (B)	**Approx. 2 100**
Potential demand for "HCPs":	
(A) – (B)	**Approx. 220**

1 Calculated with reference to the data collected by the Labour and Welfare Bureau in 2023 on the vacancy rate (approximately 12%) and staff turnover rate (approximately 5%) in RCHs for the new round of manpower projections.

2 Approximately 60 new subvented/contract RCH projects are expected to commence service in the next five years. Staffing requirements are estimated based on the size of these institutions and the staffing ratios specified in their service contracts/agreements.

3 The number of ENs required by the private sector in the next three years is estimated based on the net growth of private RCH places in the past three years and in proportion to the size of the institutions and the statutory requirements.

4 According to the 2023 Policy Address, the Government increases the healthcare staffing in RCHs in 2024 to address the ageing population of users in RCHDs.

5 Starting from the academic year of 2023-24, trainees are required to sign an undertaking to work as ENs (General) in NGOs or private organisations recognised by the SWD for providing elderly, rehabilitation, family and child care, or correctional services for a continuous period of no less than three years after completion of the training.

For medium- to long-term demand in and after 2030, it will depend on the growth of the RCHs and the development of the sector after the establishment of the new rank.

8.2 Adjustment to the training content of the "Certificate in Progression Training for Care Workers"

(a) At present, CWs who have completed the local Secondary 5 curriculum or an equivalent/higher qualification can enrol in the "HWTC" at QF Level 3 to become registered HWs. CWs who have completed the Secondary 3 curriculum and possess at least three years of working experience in RCHEs or RCHDs may also enrol in this course, provided that they have successfully graduated from the "Certificate in Progression Training for Care Workers" at QF Level 2, which serves as a bridging course to the "HWTC".

(b) According to the fieldwork and consultations with various stakeholders in the consultancy study, CWs primarily provide personal care to residents (e.g. bathing, dressing and changing, etc.). Most experienced CWs are middle-aged women who, despite having limited formal education, possess significant practical experience and caring capabilities.

(c) The stakeholder opinion survey revealed that the majority of respondents opposed relaxing the academic qualification requirements for the "Certificate in Progression Training for Care Workers". In this regard, the Consultant recommends maintaining the current entry requirements while adjusting the training content to place greater emphasis on practical learning and operational competences on caring. This approach aims to attract and retain suitable talent and enhance the quality of residential care services.

(d) The current course of "Certificate in Progression Training for Care Workers" includes 150 contact hours: 35 hours each for Chinese and English, and 28 hours each for numeracy and information technology. The remaining 24 hours are allocated to "Knowing Basic Knowledge of Medications", "Master Communication Skills with Elderlies" and "Master Communication Skills with the Families of the Elderlies". As language proficiency can be further developed through other means while the duties of HWs are mostly practical, it is recommended to reallocate the contact hours for various subjects by reducing those for Chinese and English, while correspondingly increasing training in vocational-related knowledge, such as the prevention of elder abuse, assisting elderly persons in using assistive devices, etc.

(e) The proposal for reallocating contact hours and adjusting the course content

(Annex 21) has been submitted to the QF Secretariat and the HKCAAVQ, with subsequent confirmation that the course will remain at QF Level 2. The decision on whether the revised course can continue to serve as a bridging course for HWs rests with the SWD. Since the proposed changes to the course content exceed 10% of the total QF credits of the existing course, the TIs currently offering the courses must update their course accreditation with the HKCAAVQ. The Consultant recommends that the SWD engage with the relevant TIs as soon as possible so that they would have sufficient time to revise the course content and complete the updating of course accreditation.

8.3 Amendments to the statutory staffing requirements

The consultancy study indicated that the staffing provision of RCHs can meet residents' care needs under the existing statutory staffing requirements outlined in the Residential Care Homes (Elderly Persons) Regulation and the Residential Care Homes (Persons with Disabilities) Regulation. Furthermore, the average daily care hours for residents in Hong Kong are broadly similar to those in other advanced economies (e.g. Australia, the U.S., and New Zealand).

The Consultant thus recommends introducing the "HCP" rank into the aforementioned regulations without altering the existing statutory staffing requirements. Other staffing requirements will remain unaffected. The proposed amendments to the relevant regulations are as follows (***bold italics*** indicate proposed amendments; the rest are existing requirements):

8.3.1 Medium care level RCHEs or RCHDs

- For 6 hours within "the specified period" each day, 1 nurse ***or "HCP"***; or 1 HW (on duty) for every 60 residents is required.
- For 11 hours within "the specified period", 1 CW or AW (on duty) for every 30 residents is required.

8.3.2 High care level RCHEs or RCHDs

- For 13 hours within "the specified period" each day, 1 HW (on duty) for every 30 residents is required. During 8 of these hours, there must be at least 1 nurse ***or "HCP"*** and 1 HW (on duty) simultaneously. For the purposes of this provision, 1 nurse ***or "HCP"*** (on duty) is considered equivalent to 2 HWs (on duty).
  (i) For 10 hours within "the specified period", 1 CW for every 20 residents is required
  (ii) At any time outside the 10 hours mentioned in (i), 1 CW for every 40 residents is required

- For 11 hours within "the specified period", 1 AW for every 40 residents is required.

8.3.3 Nursing Homes

The Consultant notes that current NH statutory staffing requirements are based on the number of beds and do not clearly define the roles of CWs and HWs. To align with international practice and the statutory staffing requirements of other levels of care in Hong Kong, the Consultant recommends that the basis of calculating statutory staffing requirement for NHs be changed to the total number of residents and the staffing requirement for HWs should also be clearly set out to reflect their important role in the NHs. Specific recommendations are as follows:

RCH operators must employ ——

(a) 1 person as the HM (who may also serve as the Nurse-in-Charge);
(b) 1 RN as the Nurse-in-Charge; and
(c) A specified number of healthcare staff, as outlined below
    (i) At all times, at least 1 RN must be on duty in the nursing home;
    (ii) For nursing homes with 90 or fewer residents: 10 nurses or "HCPs" in total, and 20 CWs or HWs in total; and
    (iii) For nursing homes with more than 90 residents: in addition to the requirements in (ii), for every 9 (or fewer) additional residents, employ 1 additional nurse or "HCP" or 2 HWs, and 2 CWs or HWs in total.

8.4 Staff recruitment and retention

The Consultant recommends that operators of RCHEs and RCHDs adopt the following strategies to attract and retain staff:

(a) Enhancing career development and promotion opportunities

- The establishment of the "HCP" rank and the adjustment to the training content of the "Certificate in Progression Training for Care Workers" are key measures for RCHs to retain talent. RCH operators should leverage these initiatives to establish a clear career progression path, in order to attract more potential staff to the sector.
- RCH operators should create internal promotion opportunities for long-term career growth to staff. For example, experienced CWs can mentor and support new CWs through regular interactions, knowledge sharing, and skill development; CWs can assist HWs, "HCPs", or nurses in performing specific basic care tasks and simple administrative duties (e.g. measuring body temperature and blood pressure, filing records). This

broadens their skill sets and prepares them for promotion to HWs.

(b) Applying information technology and gerontechnology

- RCH operators should adopt information technology in administrative and financial processes (e.g. using cloud technology and mobile applications to digitise administrative records, etc.). This reduces the burden of paperwork on frontline staff and enhances their efficiency.
- RCH operators should integrate gerontechnology into daily care services (e.g. introducing service robots to assist residents with mobility, installing smart monitoring systems to track residents' vital signs, etc.). This reduces the workload of healthcare staff, minimises the risk of injuries from physically demanding tasks (e.g. transferring residents), ease the job aversion and improves the overall image of the sector, making it more appealing to younger job seekers.

(c) Encouraging RCH staff to undergo training

- RCH operators should actively render training to their HMs on leadership, accountability, and professional competence; besides, to encourage HMs to implement topics such as management enhancement, delegation, effective communication, to create a shared vision in their daily work with staff.
- RCH operators should encourage RCH staff to pursue continuous education and professional training opportunities. This ensures that staff could equip the latest knowledge and skills while providing them with opportunities for career advancement at different levels within the sector.

(d) Improving the work environment and culture

- RCH operators should improve the work environment by ensuring safe, comfortable, and modern facilities.
- RCH operators should foster an inclusive work culture that encourages collaboration and mutual support among staff from diverse backgrounds.
- RCH operators should involve staff participation in decision making process so as to create an open and trusting communication environment, making them feel valued and respected

(e) Establishing staff engagement and incentive mechanisms

- RCH operators should establish feedback mechanism to collect and respond to staff suggestions and feedbacks regularly.
- RCH operators should implement performance-based rewards and recognition mechanism to enhance staff work motivation and enthusiasm.

8.5 Implementation timeline for the Consultant's recommendations

The preliminary timetable for implementing the Consultant's recommendations is as follows:

Timeline	Key Tasks (***bold italics*** indicate regulatory amendments; others relate to organising training course)
First half of 2025	Notify the Elderly Care Service Industry Training Advisory Committee of the proposed Training Course for "HCPs" Engage with potential TIs regarding the Training Course for "HCPs" Engage with relevant TIs on adjustments to the "Certificate in Progression Training for CWs" to allow sufficient time for course revisions and accreditation updates ***Preparatory work for amending the Residential Care Homes (Elderly Persons) Regulation (Cap. 459 Subsidiary Legislation A) and the Residential Care Homes (Persons with Disabilities) (Cap. 613 Subsidiary Legislation A)***
Second half of 2025	Potential TIs begin course design and other preparatory work (expected to take 9-12 months) ***Begin drafting the Amendment Regulations***
Approx. 2026	***Consult the Legislative Council Panel on Welfare Services on the Amendment Regulations, followed by submission to the Legislative Council for approval under the "negative vetting" procedure (expected in the first half of 2026)*** Self-accrediting TIs upload the Training Course for "HCPs" to the QR, promote the course, and begin enrolment and classes (expected in the second half of 2026) Non-self-accrediting TIs submit the course to the HKCAAVQ for accreditation
Approx. 2027	Non-self-accrediting TIs complete the HKCAAVQ accreditation process, upload the Training Course for "HCPs" to the QR, and begin promotion, enrolment, and classes The first cohort of "HCP" trainees completes the course (offered by self-accrediting TIs) ***Implement the "HCP" registration***

List of the Tables about Detailed Data Analysis Results

Residential Care Homes for the Elderly

Residential Care Homes for Persons with Disabilities (PWDs)

List of Annexes

Table L 1 Total hours worked per week by staff in Nursing Homes (based on job posts)

Job post	Number of sampled homes	Total number of staff	Total number of staff who reported working hours	Total hours worked per week by staff based on reported working hours	Average	Median	Mode	Maximum	Minimum	Range
Nursing Homes (Overall)	**5**	**487**	**441**	**19,992.45**	**45.33**	**45.00**	**48.00**	**60.00**	**2.30**	**57.70**
		100.00%	**100.00%**	**100.00%**						
Home Manager		5	5	222.00	44.40	44.00	44.00	45.00	44.00	1.00
		1.03%	1.13%	1.11%						
Registered Nurse		71	55	2,335.85	42.47	44.00	44.00	53.30	2.30	51.00
		14.58%	12.47%	11.68%						
Enrolled Nurse		46	35	1,559.40	44.55	44.00	44.00	49.80	27.00	22.80
		9.45%	7.94%	7.80%						
Health Worker		32	32	1,248.00	39.00	44.00	44.00	49.80	8.30	41.50
		6.57%	7.26%	6.24%						
Care Worker		216	200	9,631.10	48.16	48.00	48.00	60.00	21.70	38.30
		44.35%	45.35%	48.17%						
Ancillary Worker		87	84	3,963.50	47.18	48.00	45.00	60.00	18.40	41.60
		17.86%	19.05%	19.82%						
Social Worker		8	8	359.80	44.98	44.00	44.00	49.80	44.00	5.80
		1.64%	1.81%	1.80%						
(Physio/Occupational/Speech) Therapist		11	11	293.80	26.71	22.00	22.00	49.80	4.00	45.80
		2.26%	2.49%	1.47%						
Therapy Assistant and Rehabilitation Assistant		5	5	222.00	44.40	44.00	44.00	45.00	44.00	1.00
		1.03%	1.13%	1.11%						
Others		6	6	157.00	26.17	24.50	44.00	44.00	4.00	40.00
		1.23%	1.36%	0.79%						

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table L 2 Total hours worked per week by staff in C&A Homes and Aged Homes (based on job posts)

Job post	Number of sampled homes	Total number of staff	Total number of staff who reported working hours	Total hours worked per week by staff based on reported working hours	Average	Median	Mode	Maximum	Minimum	Range
C&A Homes and Aged Homes (Overall)	**25**	**1,100**	**1,025**	**54,637.85**	**53.31**	**48.00**	**72.00**	**84.00**	**0.25**	**83.75**
		100.00%	**100.00%**	**100.00%**						
Home Manager		34	29	1,375.20	44.19	44.00	44.00	70.00	12.00	58.00
		3.09%	2.83%	2.52%						
Registered Nurse		60	58	2,445.00	42.16	44.00	44.00	66.00	9.00	57.00
		5.45%	5.66%	4.47%						
Enrolled Nurse		84	79	3,345.00	42.34	44.00	44.00	70.00	4.00	66.00
		7.64%	7.71%	6.12%						
Health Worker		145	130	7,164.00	55.11	58.50	66.00	84.00	22.00	62.00
		13.18%	12.68%	13.11%						
Care Worker		445	416	24,085.00	57.90	54.00	72.00	84.00	18.00	66.00
		40.45%	40.59%	44.08%						
Ancillary Worker		248	238	13,177.50	55.37	51.00	72.00	84.00	17.00	67.00
		22.55%	23.22%	24.12%						
Social Worker		17	17	726.00	42.71	44.00	44.00	54.00	4.00	50.00
		1.55%	1.66%	1.33%						
(Physio/Occupational/Speech) Therapist		14	13	375.90	28.92	26.40	44.00	44.00	14.00	30.00
		1.27%	1.27%	0.69%						
Therapy Assistant and Rehabilitation Assistant		24	19	882.50	46.45	48.00	45.00	60.00	17.50	42.50
		2.18%	1.85%	1.62%						
Others		29	26	1,061.75	40.84	44.00	44.00	60.00	0.25	59.75
		2.64%	2.54%	1.94%						

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the samples, 6 RCHEs reported more than 1 Home Manager and/or Deputy Home Manager.

Table L 3 Distribution of staff on their total weekly working hours and average daily working hours in Nursing Homes

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Average	Median	Mode	Max.	Min.	Range	Average daily working hours
Job posts for international benchmarking in nursing homes (Overall)	**369** **75.77%**		**326** **73.92%**		**14,952.35** **74.79%**		**45.87**	**45.00**	**48.00**	**60.00**	**2.30**	**57.70**	**2,136.05**
Home Manager (RN)	4 0.82%		4 0.91%		178.00 0.89%		44.50	44.50	45.00	45.00	44.00	1.00	25.43
Registered Nurse	71 14.58%	75 15.40%	55 12.47%	59 13.38%	2,335.85 11.68%	2,513.85 12.57%	42.47	44.00	44.00	53.30	2.30	51.00	333.69
Enrolled Nurse	46 9.45%	46 9.45%	35 7.94%	35 7.94%	1,559.40 7.80%	1,559.40 7.80%	44.55	44.00	44.00	49.80	27.00	22.80	222.77
Home Manager (HW)	- -		- -		- -		-	-	-	-	-	-	-
Health Worker	32 6.57%		32 7.26%		1,248.00 6.24%		39.00	44.00	44.00	49.80	8.30	41.50	178.29
Care Worker	216 44.35%	248 50.92%	200 45.35%	232 52.61%	9,631.10 48.17%	10,879.10 54.42%	48.16	48.00	48.00	60.00	21.70	38.30	1,375.87
Other job posts in nursing homes (Overall)	**118** **24.23%**		**115** **26.08%**		**5,040.10** **25.21%**		**43.83**	**45.00**	**44.00**	**60.00**	**4.00**	**56.00**	**720.01**
Home Manager (Non-RN/HW)	1 0.21%		1 0.23%		44.00 0.22%		44.00	44.00	N/A	44.00	44.00	-	6.29
Ancillary Worker	87 17.86%		84 19.05%		3,963.50 19.82%		47.18	48.00	45.00	60.00	18.40	41.60	566.21
Social Worker	8 1.64%		8 1.81%		359.80 1.80%		44.98	44.00	44.00	49.80	44.00	5.80	51.40
(Physio/Occupational/Speech) Therapist	11 2.26%		11 2.49%		293.80 1.47%		26.71	22.00	22.00	49.80	4.00	45.80	41.97
Therapy Assistant and Rehabilitation Assistant	5 1.03%		5 1.13%		222.00 1.11%		44.40	44.00	44.00	45.00	44.00	1.00	31.71
Others	6 1.23%	118 24.23%	6 1.36%	115 26.08%	157.00 0.79%	5,040.10 25.21%	26.17	24.50	44.00	44.00	4.00	40.00	22.43
Total	**487** **100.00%**		**441** **100.00%**		**19,992.45** **100.00%**								**2,856.06**

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table L 4 Distribution of staff on their total weekly working hours and average daily working hours in C&A Homes and Aged Homes

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Average	Median	Mode	Max.	Min.	Range	Average daily working hours
Job posts for international benchmarking in C&A homes and aged homes (Overall)	**751** **68.27%**		**698** **68.10%**		**37,803.00** **69.19%**		**54.16**	**48.00**	**72.00**	**84.00**	**4.00**	**80.00**	**5,400.43**
Home Manager (RN)	4 0.36%		4 0.39%		176.00 0.32%		44.00	44.00	44.00	44.00	44.00	-	25.14
Registered Nurse	60 5.45%	64 5.82%	58 5.66%	62 6.05%	2,445.00 4.47%	2,621.00 4.80%	42.16	44.00	44.00	66.00	9.00	57.00	349.29
Enrolled Nurse	84 7.64%	84 7.64%	79 7.71%	79 7.71%	3,345.00 6.12%	3,345.00 6.12%	42.34	44.00	44.00	70.00	4.00	66.00	477.86
Home Manager (HW)	13 1.18%		11 1.07%		588.00 1.08%		53.45	54.00	54.00	66.00	36.00	30.00	84.00
Health Worker	145 13.18%		130 12.68%		7,164.00 13.11%		55.11	58.50	66.00	84.00	22.00	72.00	1,023.43
Care Worker	445 40.45%	603 54.82%	416 40.59%	557 54.34%	24,085.00 44.08%	31,837.00 58.27%	57.90	54.00	72.00	84.00	18.00	66.00	3,440.71
Other job posts in C&A homes and aged homes (Overall)	**349** **31.73%**		**327** **31.90%**		**16,834.85** **30.81%**		**51.48**	**48.00**	**72.00**	**84.00**	**0.25**	**83.75**	**2,404.98**
Home Manager (Non-RN/HW)	17 1.55%		14 1.37%		611.20 1.12%		43.66	44.00	44.00	70.00	12.00	58.00	87.31
Ancillary Worker	248 22.55%		238 23.22%		13,177.50 24.12%		55.37	51.00	72.00	84.00	17.00	67.00	1,882.50
Social Worker	17 1.55%		17 1.66%		726.00 1.33%		42.71	44.00	44.00	54.00	4.00	50.00	103.71
(Physio/Occupational/Speech) Therapist	14 1.27%		13 1.27%		375.90 0.69%		28.92	26.40	44.00	44.00	14.00	30.00	53.70
Therapy Assistant and Rehabilitation Assistant	24 2.18%		19 1.85%		882.50 1.62%		46.45	48.00	45.00	60.00	17.50	42.50	126.07
Others	29 2.64%	349 31.73%	26 2.54%	327 31.90%	1,061.75 1.94%	16,834.85 30.81%	40.84	44.00	44.00	60.00	0.25	59.75	151.68
Total	**1,100** **100.00%**		**1,025** **100.00%**		**54,637.85** **100.00%**								**7,805.41**

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the samples, 6 RCHEs reported more than 1 Home Manager and/or Deputy Home Manager.

Table L 5 Mapping of the job titles in residential care homes

Staff Type	Hong Kong	Australia	United States	New Zealand	Singapore	Japan	South Korea
Registered Nurse (RN)	• Home Manager (HM) • Superintendent	• Director of Nursing • Clinical Care Manager	• Director of Nursing • Nursing Home Administrator	• Care Home Manager • Aged Care Facility Manager	• Director of Nursing • Nursing Manager	• Head Nurse	• Facility Head (may be a Certified Nurse or Social Worker)
	• Nurse In Charge (NIC)	• Nurse Unit Manager		• Aged Care Manager			
	• Registered Nurse (RN)	• Registered Nurse (RN)	• Registered Nurse (RN)	• Registered Nurse (RN)	• Registered Nurse (RN)	• Nurse	• Nurse
Licensed Nursing Staff	• Enrolled Nurse (EN)	• Enrolled Nurse (EN)	• Licensed Practical and Licensed Vocational Nurse (LPN/LVN)	• Enrolled Nurse (EN)	• Enrolled Nurse (EN)		
Nurse Aide/Healthcare Assistant	• Health Worker (HW)	• Assistant in Nursing (AIN)	• Nursing Assistant	• Healthcare Assistant (HCA)	• Nursing Aide (NA)	• Care Worker (Certified/Not certified)	• Nursing Aide (Licensed)
	• Care Worker (CW)	• Personal Care Worker (PCW) (Certified/Not certified)	• Personal Care Aide		• Healthcare Assistant (HCA)		• Care Worker (Certified/Not certified)

The above information about the United States comes from O*NET OnLine and *A Guide for the Consultant Pharmacist, Director of Nursing, Medical Director, and Nursing Home Administrator in Long Term Care Organizations* (achca.org). The information about New Zealand comes from the official government website (careers.govt.nz) and recruitment websites, while the information about Australia, Singapore, Japan, and South Korea is sourced from the *Long Term Care Manpower Study in 2018* (lienfoundation.org).

Table L 6 Distribution of staff on their daily working hours and average HPRD in Nursing Homes

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Number of residents in the third quarter of 2023	Average care hours per resident		Number of beds in the third quarter of 2023	Average care hours per resident	
Job posts for international benchmarking in nursing homes (Overall)	**369** **75.77%**		**326** **73.92%**		**2,136.05** **74.79%**		**649** **84.07%**	**3.29** **74.79%**		**772** **100.00%**	**2.77** **74.79%**	
Home Manager (RN)	4		4		25.43			0.04			0.03	
	0.82%		0.91%		0.89%			0.89%			0.89%	
Registered Nurse	71	75	55	59	333.69	359.12		0.51	0.55		0.43	0.47
	14.58%	15.40%	12.47%	13.38%	11.68%	12.57%		11.68%	12.57%		11.68%	12.57%
Enrolled Nurse	46	46	35	35	222.77	222.77		0.34	0.34		0.29	0.29
	9.45%	9.45%	7.94%	7.94%	7.80%	7.80%		7.80%	7.80%		7.80%	7.80%
Home Manager (HW)	-		-		-			-			-	
	-		-		-			-			-	
Health Worker	32		32		178.29			0.27			0.23	
	6.57%		7.26%		6.24%			6.24%			6.24%	
Care Worker	216	248	200	232	1,375.87	1,554.16		2.12	2.39		1.78	2.01
	44.35%	50.92%	45.35%	52.61%	48.17%	54.42%		48.17%	54.42%		48.17%	54.42%
Other job posts in nursing homes (Overall)	**118** **24.23%**		**115** **26.08%**		**720.01** **25.21%**			**1.11** **25.21%**			**0.93** **25.21%**	
Home Manager (Non-RN/HW)	1 0.21%		1 0.23%		6.29 0.22%			0.01 0.22%			0.01 0.22%	
Ancillary Worker	87 17.86%		84 19.05%		566.21 19.82%			0.87 19.82%			0.73 19.82%	
Social Worker	8 1.64%		8 1.81%		51.40 1.80%			0.08 1.80%			0.07 1.80%	
(Physio/Occupational/Speech Therapist	11 2.26%		11 2.49%		41.97 1.47%			0.06 1.47%			0.05 1.47%	
Therapy Assistant and Rehabilitation Assistant	5 1.03%		5 1.13%		31.71 1.11%			0.05 1.11%			0.04 1.11%	
Others	6 1.23%	118 24.23%	6 1.36%	115 26.08%	22.43 0.79%	720.01 25.21%		0.03 0.79%	1.11 25.21%		0.03 0.79%	0.93 25.21%
Total	**487** **100.00%**		**441** **100.00%**		**2,856.06** **100.00%**			**4.40** **100.00%**			**3.70** **100.00%**	

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

As the manpower requirements of nursing homes is based on number of beds, an estimation based on number of residents is included for reference.

Table L 7 Distribution of staff on their daily working hours and average HPRD in C&A Homes and Aged Homes

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Number of residents in the third quarter of 2023	Average care hours per resident	
Job posts for international benchmarking in C&A homes and aged homes (Overall)	**751** **68.27%**		**698** **68.10%**		**5,400.43** **69.19%**		**2,047** **73.45%**	**2.64** **69.19%**	
Home Manager (RN)	4		4		25.14			0.01	
	0.36%		0.39%		0.32%			0.32%	
Registered Nurse	60	64	58	62	349.29	374.43		0.17	0.18
	5.45%	5.82%	5.66%	6.05%	4.47%	4.80%		4.47%	4.80%
Enrolled Nurse	84	84	79	79	477.86	477.86		0.23	0.23
	7.64%	7.64%	7.71%	7.71%	6.12%	6.12%		6.12%	6.12%
Home Manager (HW)	13		11		84.00			0.04	
	1.18%		1.07%		1.08%			1.08%	
Health Worker	145		130		1,023.43			0.50	
	13.18%		12.68%		13.11%			13.11%	
Care Worker	445	603	416	557	3,440.71	4,548.14		1.68	2.22
	40.45%	54.82%	40.59%	54.34%	44.08%	58.27%		44.08%	58.27%
Other job posts in C&A homes and aged homes (Overall)	**349** **31.73%**		**327** **31.90%**		**2,404.98** **30.81%**			**1.17** **30.81%**	
Home Manager (Non-RN/HW)	17		14		87.31			0.04	
	1.55%		1.37%		1.12%			1.12%	
Ancillary Worker	248		238		1,882.50			0.92	
	22.55%		23.22%		24.12%			24.12%	
Social Worker	17		17		103.71			0.05	
	1.55%		1.66%		1.33%			1.33%	
(Physio/Occupational/Speech) Therapist	14		13		53.70			0.03	
	1.27%		1.27%		0.69%			0.69%	
Therapy Assistant and Rehabilitation Assistant	24		19		126.07			0.06	
	2.18%		1.85%		1.62%			1.62%	
Others	29	349	26	327	151.68	2,404.98		0.07	1.17
	2.64%	31.73%	2.54%	31.90%	1.94%	30.81%		1.94%	30.81%
Total	**1,100** **100.00%**	**100.00%**	**1,025** **100.00%**	**100.00%**	**7,805.41** **100.00%**	**100.00%**		**3.81** **100.00%**	**100.00%**

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the samples, 6 RCHs reported more than 1 Home Manager and/or Deputy Home Manager.

Table L 8 Calculated average hours required for various services provided in RCHEs by sample staff based on fieldwork records

	Average	Median	Mode	Max.	Min.	Range	Number of records
1. Health surveillance services							
1.1 Following up on health condition of residents (including body temperature and blood pressure) as necessary	00:02	00:01	00:01	00:15	00:00	00:14	12
2. Personal care							
2.1 Bathing and hair washing as needed	00:14	00:13	00:20	00:30	00:04	00:26	12
2.2 Hair cutting, shaving, manicuring, dental and oral cleaning as needed	00:03	00:02	00:02	00:10	00:01	00:09	12
2.3 Changing clothes, bed linens and pillows	00:06	00:04	00:15	00:15	00:01	00:14	12
2.4 Changing diapers	00:04	00:04	00:04	00:15	00:02	00:12	26
2.5 Assisting bedridden residents in changing their positions regularly	00:04	00:02	00:01	00:15	00:01	00:14	20
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	00:01	00:01	00:01	00:08	00:00	00:08	63
2.7 Feeding	00:05	00:05	00:03	00:15	00:00	00:14	31
3. Drug management							
3.1 Preparing drugs for residents	00:07	00:04	00:02	00:29	00:00	00:28	21
3.2 Giving (oral) drug	00:02	00:02	00:02	00:05	00:00	00:05	39
3.3 Giving (topical) drug	00:03	00:02	-	00:14	00:01	00:13	11
3.4 Performing (subcutaneous) injection	00:05	00:03	-	00:15	00:01	00:14	6
4. Use of restraint(s)							
4.1 Releasing physical restraint(s)	00:03	00:02	00:02	00:10	00:01	00:08	13
5. Special nursing care procedures							
5.1 Assisting residents in the use of urinary catheters	00:13	00:15	00:15	00:17	00:07	00:09	5
5.2 Performing peritoneal dialysis	00:09	00:06	-	00:20	00:03	00:17	8
5.3 Assisting residents in the use of feeding tubes	00:06	00:05	00:03	00:15	00:02	00:13	30
5.4 Providing dressing for wounds	00:11	00:07	-	00:30	00:03	00:26	7
5.5 Assisting residents in the use of ventilator/oxygen therapy	00:02	00:02	-	00:02	00:02	00:00	1

The data presented above are derived from the Consultant's fieldwork records, which include approximately 210 minutes for each sampled RCHE, with hours measured in minutes. During the fieldwork, the consultants used around 30 minutes observing each type of staff, including but not limited to, nurses, HWs, CWs, and AWs. This information is limited to five categories of care and health services and does not include rehabilitation services (e.g. leading groups and activities, assisting residents with training).

In contrast to other data, the data for "2.7 Feeding" does not fully reflect the time required for a complete feeding session for the following reasons:

- Residents were fed by their families without staff assistance.
- Residents might initially need assistance but were able to feed themselves afterward.
- Residents might have already finished half of the meal independently, with staff only assisting with the remaining food.
- Staff might pause feeding residents who held food in their mouths and did not swallow, attending to other residents or performing other duties. (In this case, after the 30-minute observation period designated by the consultants, the observed staff might return to assist the original resident with feeding.)
- Staff assisted multiple residents during the observation period. (In this case, the consultants divided the total time recorded by the number of residents receiving assistance to calculate the average time required to feed a single resident.)

Table L 9 Estimated care hours required by residents in nursing homes

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Care hours required for general care (minutes)	Care hours required for comprehensive care (minutes)
1. Health surveillance services					
1.1 Following up on health condition of residents (including body temperature and blood pressure) as necessary	652	2.40	2.93	7.04	7.04
2. Personal care					
2.1 Bathing and hair washing as needed	652	0.50	14.23	7.11	7.11
2.2 Hair cutting, shaving, manicuring, dental and oral cleaning as needed	652	1.00	3.65	3.65	3.65
2.3 Changing clothes, bed linens and pillows	652	0.50	6.03	3.02	3.02
2.4 Changing diapers	635	4.50	4.72	21.24	21.24
2.5 Assisting bedridden residents in changing their positions regularly	498	8.40	4.25		35.74
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	326	4.00	1.73		#
2.7 Feeding	326	4.00	5.73		#
3. Drug management					
3.1 Preparing drugs for residents	652	2.06	7.16	14.73	14.73
3.2 Giving (oral) drug	652	4.30	2.13	9.18	9.18
3.3 Giving (topical) drug	618	4.10	3.79	15.54	15.54
3.4 Performing (subcutaneous) injection	169	1.80	5.81		10.46
4. Use of restraint(s)					
4.1 Releasing physical restraint(s)	463	8.00	3.75		29.99
5. Special nursing care procedures					
5.1 Assisting residents in the use of urinary catheters	46	4.10	13.82		56.65
5.2 Performing peritoneal dialysis	1	2.00	9.00		##
5.3 Assisting residents in the use of feeding tubes	125	4.60	6.79		31.26
5.4 Providing dressing for wounds	88	1.40	11.38		15.93
5.5 Assisting residents in the use of ventilator/oxygen therapy	-	-	2.00		###
Total (hours)				**1.36**	**4.36**

The data in the first two columns are from the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by 5 sampled Nursing Homes, reflecting the actual situation from end-November 2023 to mid-March 2024, with a total of 652 residents. Service items 2.6 and 2.7 contain data recorded by the fieldwork, and the third column is the average of the fieldwork (Table L 8). The Consultant converted the recorded average hours into numerical values for subsequent calculation.

Based on fieldwork and data collected, the Consultant estimated the daily care hours required for each resident in need of comprehensive care. The Consultant identified the most commonly used service items among these residents for the estimate (i.e. column six). This column is an estimate derived from multiplying column 3 "Average daily frequency of use" and column 4 "Average time required by staff to provide the service (minutes)". Based on fieldwork and data collected, the Consultant also estimated the daily care hours required for each resident in need of general care (i.e. column 5). Therefore, the care hours required for each resident of nursing homes range from 1.36 hours to 4.36 hours, depending on individual needs.

\# Residents who require "5.3 Assisting residents in the use of feeding tubes" service do not require "2.6 Preparing food/nutritional well-balanced diet or coagulant powder" and "2.7 Feeding" services at the same time.

Residents who require "5.1 Assisting residents in the use of urinary catheters" service do not require "5.2 Performing peritoneal dialysis" service at the same time.

In the sampled Nursing Homes, none of the residents required "5.5 Assisting residents in the use of ventilator/oxygen therapy".

Table L 10 Estimated care hours required by residents in C&A Homes and Aged Homes

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Care hours required for general care (minutes)	Care hours required for comprehensive care (minutes)
1. Health surveillance services					
1.1 Following up on health condition of residents (including body temperature and blood pressure) as necessary	1,595	1.09	2.93	3.20	3.20
2. Personal care					
2.1 Bathing and hair washing as needed	1,593	0.83	14.23	11.86	11.86
2.2 Hair cutting, shaving, manicuring, dental and oral cleaning as needed	1,593	1.00	3.65	3.65	3.65
2.3 Changing clothes, bed linens and pillows	1,537	0.82	6.03	4.95	4.95
2.4 Changing diapers	1,274	4.50	4.72	21.22	21.22
2.5 Assisting bedridden residents in changing their positions regularly	765	7.43	4.25		31.63
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	392	3.60	1.73		#
2.7 Feeding	392	3.60	5.73		#
3. Drug management					
3.1 Preparing drugs for residents	1,583	1.07	7.16	7.64	7.64
3.2 Giving (oral) drug	1,516	3.75	2.13	8.00	8.00
3.3 Giving (topical) drug	1,113	2.89	3.79	10.96	10.96
3.4 Performing (subcutaneous) injection	135	1.38	5.81		8.05
4. Use of restraint(s)					
4.1 Releasing physical restraint(s)	726	7.20	3.75		26.99
5. Special nursing care procedures					
5.1 Assisting residents in the use of urinary catheters	101	3.13	13.82		43.20
5.2 Performing peritoneal dialysis	8	3.33	9.00		##
5.3 Assisting residents in the use of feeding tubes	86	4.14	6.79		28.12
5.4 Providing dressing for wounds	129	1.21	11.38		13.75
5.5 Assisting residents in the use of ventilator/oxygen therapy	4	1.00	2.00		###
Total (hours)				**1.19**	**3.72**

The data in the first two columns are from the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by 20 of 25 samples of C&A Homes and Aged Homes, reflecting the actual situation from end-November 2023 to mid-March 2024, with a total of 1,595 residents. As the Consultant's fieldwork could not fully cover the use of all the above services in the remaining 5 sampled RCHEs, in order to maintain data consistency, the data of service items 2.6 and 2.7 were only derived from the Consultant's fieldwork records of the 20 samples.

The third column is the average of the fieldwork (Table L 8). The Consultant converted the recorded average hours into numerical values for subsequent calculation.

For residents requiring comprehensive care, the Consultant referenced the estimation method used for nursing homes to estimate the situation in C&A homes and aged homes. The Consultant identified the most commonly used service items among these residents for the estimate (i.e. column six). This column is an estimate derived from multiplying column 3 "Average daily frequency of use" and column 4 "Average time required by staff to provide the service (minutes)". Based on fieldwork and data collected, the Consultant also estimated the daily care hours required for each resident in need of general care (i.e. column 5). Therefore, the care hours required for each resident of C&A homes and aged homes range from 1.19 hours to 3.72 hours, depending on individual needs.

\# Residents who require "5.3 Assisting residents in the use of feeding tubes" service do not require "2.6 Preparing food/nutritional well-balanced diet or coagulant powder" and "2.7 Feeding" services at the same time.

Residents who require "5.1 Assisting residents in the use of urinary catheters" service do not require "5.2 Performing peritoneal dialysis" service at the same time.

In the sample of C&A homes and aged homes, a very small number of residents required "5.5 Assisting residents in the use of ventilator/oxygen therapy".

Table L 11 Estimation of the baseline for staffing in RCHEs

The data in the first four columns are derived from Table L 10 Estimated care hours required by residents in C&A Homes and Aged Homes.

		Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Minimum staff required to perform the process	Total (hours)	Responsible staff
1. Health surveillance services							
1.1	Following up on health condition of residents (including body temperature and blood pressure) as necessary	1,595	1.09	2.93	1	84.95	Health Worker
2. Personal care							
2.1	Bathing and hair washing as needed	1,593	0.83	14.23	2	629.58	Care Worker + Care Worker
2.2	Hair cutting, shaving, manicuring, dental and oral cleaning as needed	1,593	1.00	3.65	1	96.80	Care Worker
2.3	Changing clothes, bed linens and pillows	1,537	0.82	6.03	1	126.90	Care Worker
2.4	Changing diapers	1,274	4.50	4.72	2	901.10	Care Worker + Care Worker
2.5	Assisting bedridden residents in changing their positions regularly	765	7.43	4.25	2	806.48	Care Worker + Care Worker
2.6	Preparing food/nutritional well-balanced diet or coagulant powder	392	3.60	1.73	1	40.67	Care Worker
2.7	Feeding	392	3.60	5.73	1	134.55	Care Worker
3. Drug management							
3.1	Preparing drugs for residents	1,583	1.07	7.16	1	201.55	Nurse
3.2	Giving (oral) drug	1,516	3.75	2.13	2	404.49	Nurse + Health Worker
3.3	Giving (topical) drug	1,113	2.89	3.79	1	203.40	Health Worker
3.4	Performing (subcutaneous) injection	135	1.38	5.81	1	18.14	Nurse
4. Use of restraint(s)							
4.1	Releasing physical restraint(s)	726	7.20	3.75	1	326.56	Care Worker
5. Special nursing care procedures							
5.1	Assisting residents in the use of urinary catheters	101	3.13	13.82	1	72.71	Care Worker
5.2	Performing peritoneal dialysis	8	3.33	9.00	1	4.00	Nurse
5.3	Assisting residents in the use of feeding tubes	86	4.14	6.79	1	40.31	Health Worker
5.4	Providing dressing for wounds	129	1.21	11.38	1	29.55	Nurse
5.5	Assisting residents in the use of ventilator/oxygen therapy	4	1.00	2.00	1	0.13	Health Worker
	Total (hours)					**4,121.88**	

There may be slight deviations in column 4 “Average time required by staff to provide the service (minutes)” and column 6 “Total (hours)” after rounding to the nearest whole number.

Based on the data presented above, the total daily service hours needed by 1,595 residents were 4,121.88 hours. To estimate the baseline for staffing, the Consultant categorised the services by job posts and calculated the manpower requirements by multiplying the values from column 3“Average daily frequency of use”, column 4 “Average time required by staff to provide the service (minutes)” and column 5 “Minimum staff required to perform the process” as follows:

Job post	Daily service hours needed by residents (hours)	Workload allocation percentage	Estimated manpower requirement based on the daily service hours needed by residents and the average daily work hours of each staff, which is 7.73 hours	Total number of staff who reported working hours in Table L 4
Nurse	455.49	44.22%	133	137
Health Worker	531.04	62.29%	110	130
Care Worker	3,135.35	90.00%	451	416

Note: Based on the "Time Logs" voluntarily submitted by staff of the sampled RCHEs as of 13 March 2024, the "Workload allocation percentage" data for nurses was obtained from 5 RNs and 11 ENs. The data for health workers was collected from 21 health workers, while the data for care workers was obtained through fieldwork and focus groups. Please refer to Table L 12 for details. By multiplying the workload allocation percentages (i.e. column 3) by the average daily work hours of 7.73 per staff, we can calculate the number of hours used providing direct care services each day for each type of staff. The estimated manpower requirement (i.e. column 4) is then derived by dividing the daily service hours needed by residents (i.e. column 2) by this calculated number of hours.

"Table L 4 Distribution of staff on their total weekly working hours and average daily working hours in 25 samples of C&A Homes and Aged Homes" shows that 698 (68.10%) of staff with reported working hours could be used as an international benchmark for comparison, with an average daily working hour of 5,400.43. Converted to the average number of hours worked by an individual, i.e. the average daily work of each staff is about 7.73 hours. Additionally, 6 RCHEs in the sample reported having more than one home manager and/or deputy home manager. A total of 238 care workers and 14 home managers (non-RNs/health workers) in "non-care jobs" were excluded from the "Job posts for international benchmarking".

Table L 12 Workload allocation of key staff in RCHEs

Types of care and health services	Allocation of total daily working hours for 16 nurses (minutes)		Allocation of total daily working hours for 21 health workers (minutes)	
1 Health surveillance services (including checking body temperature and blood pressure)	**185.00**	**2.25%**	**841.00**	**6.40%**
2 Personal care (including changing diaper, feeding)	**235.00**	**2.86%**	**1,625.00**	**12.37%**
Drug management	**2,270.00**	**27.62%**	**3,901.00**	**29.69%**
3 Preparing drugs for residents	1,120.00	13.63%	1,602.00	12.19%
4 Giving (oral) drug	815.00	9.91%	1,593.00	12.12%
5 Giving (topical) drug	215.00	2.62%	348.00	2.65%
6 Performing (subcutaneous) injection	80.00	0.97%	43.00	0.33%
7 Cleaning medicine cup	40.00	0.49%	315.00	2.40%
8 Use of restraint(s)	**-**	-	**45.00**	**0.34%**
Special nursing care procedures	**945.00**	**11.50%**	**1,773.00**	**13.49%**
9 Assisting residents in the use of urinary catheters	30.00	0.36%	-	-
10 Performing peritoneal dialysis	120.00	1.46%	210.00	1.60%
11 Assisting residents in the use of feeding tubes	390.00	4.74%	1,210.00	9.21%
12 Providing dressing for wounds	330.00	4.01%	323.00	2.46%
13 Assisting residents in the use of ventilator/oxygen therapy	20.00	0.24%	30.00	0.23%
14 Performing tracheostomy suction	50.00	0.61%	-	-
15 Change of stoma bags	5.00	0.06%	-	-
Administration and Other Services	**4,585.00**	**55.78%**	**4,955.00**	**37.71%**
16 Ward rounds	560.00	6.81%	665.00	5.06%
17 Handling documents and records	1,360.00	16.55%	850.00	6.47%
18 Communicating with various parties (including the families of residents and service providers)	1,205.00	14.66%	655.00	4.98%
19 Providing nursing knowledge to others	30.00	0.36%	10.00	0.08%
20 Leading group activities	-	-	40.00	0.30%
21 Miscellaneous (including wheelchair pushing, personal time, overtime, etc.)	1,430.00	17.40%	2,735.00	20.81%
The ratio of hours used for direct care services to hours used for management and other services	**44.22% : 55.78%**		**62.29% : 37.71%**	

Table D 1 Total hours worked per week by staff in high care level homes for PWDs (based on job posts)

Job post	Number of sampled homes	Total number of staff	Total number of staff who reported working hours	Total hours worked per week by staff based on reported working hours	Average	Median	Mode	Maximum	Minimum	Range
High care level homes for PWDs (Overall)	**11**	**1,164**	**1,066**	**49,128.50**	**46.09**	**45.00**	**44.00**	**78.00**	**12.00**	**66.00**
		100.00%	**100.00%**	**100.00%**						
Home Manager		12	12	510.50	42.54	44.00	44.00	50.00	22.00	28.00
		1.03%	1.13%	1.04%						
Registered Nurse		32	25	1,107.00	44.28	44.00	44.00	54.00	42.50	11.50
		2.75%	2.35%	2.25%						
Enrolled Nurse		79	65	2,802.00	43.11	44.00	44.00	54.00	16.00	38.00
		6.79%	6.10%	5.70%						
Health Worker		70	64	2,856.00	44.63	44.00	44.00	72.00	12.00	60.00
		6.01%	6.00%	5.81%						
Care Worker		428	412	19,697.00	47.81	48.00	45.00	78.00	22.50	55.50
		36.77%	38.65%	40.09%						
Ancillary Worker		454	403	18,474.00	45.84	45.00	44.00	72.00	22.00	50.00
		39.00%	37.80%	37.60%						
Social Worker		62	59	2,593.00	43.95	44.00	44.00	44.00	42.50	1.50
		5.33%	5.53%	5.28%						
(Physio/Occupational/Speech) Therapist		23	22	897.00	40.77	44.00	44.00	44.00	18.00	26.00
		1.98%	2.06%	1.83%						
Others		4	4	192.00	48.00	49.00	#N/A	72.00	22.00	50.00
		0.34%	0.38%	0.39%						

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the sample of high care level homes for PWDs, 1 RCH reported more than 1 Home Manager.

Table D 2 Total hours worked per week by staff in medium care level homes for PWDs (based on job posts)

Job post	Number of sampled homes	Total number of staff	Total number of staff who reported working hours	Total hours worked per week by staff based on reported working hours	Average	Median	Mode	Maximum	Minimum	Range
Medium care level homes for PWDs (Overall)	**7**	**165** **100.00%**	**154** **100.00%**	**6,875.00** **100.00%**	**44.64**	**44.00**	**44.00**	**72.00**	**3.00**	**69.00**
Home Manager		7 4.24%	7 4.55%	317.00 4.61%	45.29	44.00	44.00	54.00	36.00	18.00
Registered Nurse		3 1.82%	3 1.95%	60.00 0.87%	20.00	12.00	#N/A	44.00	4.00	40.00
Enrolled Nurse		9 5.45%	9 5.84%	335.00 4.87%	37.22	44.00	44.00	45.00	4.00	41.00
Health Worker		36 21.82%	36 23.38%	1,521.00 22.12%	42.25	44.00	44.00	72.00	12.00	60.00
Care Worker		31 18.79%	31 20.13%	1,605.00 23.35%	51.77	49.00	49.00	72.00	18.00	54.00
Ancillary Worker		62 37.58%	51 33.12%	2,414.00 35.11%	47.33	44.00	44.00	72.00	16.00	56.00
Social Worker		11 6.67%	11 7.14%	459.00 6.68%		44.00	44.00	45.00	24.00	21.00
(Physio/Occupational/Speech) Therapist		4 2.42%	4 2.60%	101.00 1.47%	25.25	26.50	#N/A	45.00	3.00	42.00
Others		2 1.21%	2 1.30%	63.00 0.92%	31.50	31.50	#N/A	45.00	18.00	27.00

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table D 3 Total hours worked per week by staff in low care level homes for PWDs (based on job posts)

Job post	Number of sampled homes	Total number of staff	Total number of staff who reported working hours	Total hours worked per week by staff based on reported working hours	Average	Median	Mode	Maximum	Minimum	Range
Low care level homes for PWDs (Overall)	**4**	**34**	**32**	**1,388.00**	**43.38**	**44.00**	**44.00**	**72.00**	**2.00**	**70.00**
		100.00%	**100.00%**	**100.00%**						
Home Manager		4	4	115.00	28.75	28.00	#N/A	44.00	15.00	29.00
		11.76%	12.50%	8.29%						
Registered Nurse		-	-	-	-	-	-	-	-	-
		-	-	-						
Enrolled Nurse		-	-	-	-	-	-	-	-	-
		-	-	-						
Health Worker		1	1	44.00	44.00	44.00	#N/A	44.00	44.00	-
		2.94%	3.13%	3.17%						
Care Worker		2	2	120.00	60.00	60.00	#N/A	72.00	48.00	24.00
		5.88%	6.25%	8.65%						
Ancillary Worker		24	22	977.00	44.41	44.50	44.00	72.00	2.00	70.00
		70.59%	68.75%	70.39%						
Social Worker		3	3	132.00	44.00	44.00	44.00	44.00	44.00	-
		8.82%	9.38%	9.51%						
(Physio/Occupational/Speech) Therapist		-	-	-	-	-	-	-	-	-
		-	-	-						
Others		-	-	-	-	-	-	-	-	-
		-	-	-						

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table D 4 Distribution of staff on their total weekly working hours and average daily working hours in high care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Average	Median	Mode	Max.	Min.	Range	Average daily working hours
Job posts for international benchmarking in high care level homes for PWDs (Overall)	**611**		**568**		**26,556.00**		**46.75**	**45.00**	**44.00**	**78.00**	**12.00**	**66.00**	**3,793.71**
	52.49%		**53.28%**		**54.05%**								
Home Manager (RN)	1		1		50.00		50.00	50.00	#N/A	50.00	50.00	-	7.14
	0.09%		0.09%		0.10%								
Registered Nurse	32	33	25	26	1,107.00	1,157.00	44.28	44.00	44.00	54.00	42.50	11.50	158.14
	2.75%	2.84%	2.35%	2.44%	2.25%	2.36%							
Enrolled Nurse	79	79	65	65	2,802.00	2,802.00	43.11	44.00	44.00	54.00	16.00	38.00	400.29
	6.79%	6.79%	6.10%	6.10%	5.70%	5.70%							
Home Manager (HW)	1		1		44.00		44.00	44.00	#N/A	44.00	44.00	-	6.29
	0.09%		0.09%		0.09%								
Health Worker	70		64		2,856.00		44.63	44.00	44.00	72.00	12.00	60.00	408.00
	6.01%		6.00%		5.81%								
Care Worker	428	499	412	477	19,697.00	22,597.00	47.81	48.00	45.00	78.00	22.50	55.50	2,813.86
	36.77%	42.87%	38.65%	44.75%	40.09%	46.00%							
Other job posts in high care level homes for PWDs (Overall)	**553**		**498**		**22,572.50**		**46.02**	**45.00**	**44.00**	**52.00**	**22.50**	**29.50**	**3,224.64**
	47.51%		**46.72%**		**45.95%**								
Home Manager (Non-RN/HW)	10		10		416.50		41.65	44.00	44.00	44.00	22.00	22.00	59.50
	0.86%		0.94%		0.85%								
Ancillary Worker	454		403		18,474.00	18,890.50	45.84	45.00	44.00	72.00	22.00	50.00	2,639.14
	39.00%		37.80%		37.60%	38.45%							
Social Worker	62		59		2,593.00	2,593.00	43.95	44.00	44.00	44.00	42.50	1.50	370.43
	5.33%		5.53%		5.28%	5.28%							
(Physio/Occupational/Speech) Therapist	23		22		897.00		40.77	44.00	44.00	44.00	18.00	26.00	128.14
	1.98%		2.06%		1.83%								
Others	4	553	4	498	192.00	22,572.50	48.00	49.00	#N/A	72.00	22.00	50.00	27.43
	0.34%	47.51%	0.38%	46.72%	0.39%	45.95%							
Total	**1,164**		**1,066**		**49,128.50**								**7,018.36**
	100.00%		**100.00%**		**100.00%**								

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the sample of high care level homes for PWDs, 1 RCH reported more than 1 Home Manager.

Table D 5 Distribution of staff on their total weekly working hours and average daily working hours in medium care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Average	Median	Mode	Max.	Min.	Range	Average daily working hours
Job posts for international benchmarking in medium care level homes for PWDs (Overall)	**80**		**80**		**3,575.00**		**44.69**	**45.00**	**44.00**	**72.00**	**4.00**	**68.00**	**510.71**
	48.48%		**51.95%**		**52.00%**								
Home Manager (RN)	-		-		-		-	-	-	-	-	-	-
	-		-		-								
Registered Nurse	3	3	3	3	60.00	60.00	20.00	12.00	#N/A	44.00	4.00	40.00	8.57
	1.82%	0.26%	1.95%	1.95%	0.87%	0.87%							
Enrolled Nurse	9	9	9	9	335.00	335.00	37.22	44.00	44.00	45.00	4.00	41.00	47.86
	5.45%	0.77%	5.84%	5.84%	4.87%	4.87%							
Home Manager (HW)	1		1		54.00		54.00	54.00	#N/A	54.00	54.00	-	7.71
	0.61%		0.65%		0.79%								
Health Worker	36		36		1,521.00		42.25	44.00	44.00	72.00	12.00	60.00	217.29
	21.82%		23.38%		22.12%								
Care Worker	31	68	31	68	1,605.00	3,180.00	51.77	49.00	49.00	72.00	18.00	54.00	229.29
	18.79%	41.21%	20.13%	44.16%	23.35%	46.25%							
Other job posts in medium care level homes for PWDs (Overall)	**85**		**74**		**3,300.00**		**46.02**	**45.00**	**44.00**	**52.00**	**22.50**	**29.50**	**471.43**
	51.52%		**48.05%**		**48.00%**								
Home Manager (Non-RN/HW)	6		6		263.00		43.83	44.00	44.00	50.00	36.00	14.00	37.57
	3.64%		3.90%		3.83%								
Ancillary Worker	62		51		2,414.00	2,677.00	47.33	44.00	44.00	72.00	16.00	56.00	344.86
	37.58%		33.12%		35.11%	38.94%							
Social Worker	11		11		459.00	459.00	41.73	44.00	44.00	45.00	24.00	21.00	65.57
	6.67%		7.14%		6.68%	6.68%							
(Physio/Occupational/Speech) Therapist	4		4		101.00		25.25	26.50	#N/A	45.00	3.00	42.00	14.43
	2.42%		2.60%		1.47%								
Others	2	85	2	74	63.00	3,300.00	31.50	31.50	#N/A	45.00	18.00	27.00	9.00
	1.21%	51.52%	1.30%	48.05%	0.92%	48.00%							
Total	**165**		**154**		**6,875.00**								**982.14**
	100.00%		**100.00%**		**100.00%**								

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table D 6 Distribution of staff on their total weekly working hours and average daily working hours in low care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Average	Median	Mode	Max.	Min.	Range	Average daily working hours
Job posts for international benchmarking in low care level homes for PWDs (Overall)	**5**		**5**		**248.00**		**49.60**	**44.00**	**44.00**	**72.00**	**40.00**	**32.00**	**35.43**
	14.71%		**15.63%**		**17.87%**								
Home Manager (RN)	-		-		-		-	-	-	-	-	-	-
	-		-		-								
Registered Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-							
Enrolled Nurse	-	-	-	-	-	-	-	-	-	-	-	-	-
	-	-	-	-	-	-							
Home Manager (HW)	2		2		84.00		42.00	42.00	#N/A	44.00	40.00	4.00	12.00
	5.88%		6.25%		6.05%								
Health Worker	1		1		44.00		44.00	44.00	#N/A	44.00	44.00	-	6.29
	2.94%		3.13%		3.17%								
Care Worker	2	5	2	5	120.00	248.00	60.00	60.00	#N/A	72.00	48.00	24.00	17.14
	5.88%	14.71%	6.25%	15.63%	8.65%	17.87%							
Other job posts in low care level homes for PWDs (Overall)	**29**		**27**		**1,140.00**		**42.22**	**44.00**	**44.00**	**72.00**	**2.00**	**70.00**	**162.86**
	85.29%		**84.38%**		**82.13%**								
Home Manager (Non-RN/HW)	2		2		31.00		15.50	15.50	#N/A	16.00	15.00	1.00	4.43
	5.88%		6.25%		2.23%								
Ancillary Worker	24		22		977.00	1,008.00	44.41	44.50	44.00	72.00	2.00	70.00	139.57
	70.59%		68.75%		70.39%	72.62%							
Social Worker	3		3		132.00	132.00	44.00	44.00	44.00	44.00	44.00	-	18.86
	8.82%		9.38%		9.51%	9.51%							
(Physio/Occupational/Speech) Therapist	-		-		-		-	-	-	-	-	-	-
	-		-		-								
Others	-	29	-	27	-	1,140.00	-	-	-	-	-	-	-
	-	85.29%	-	84.38%	-	82.13%							
Total	**34**		**32**		**1,388.00**								**198.29**
	100.00%		**100.00%**		**100.00%**								

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Table D 7 Distribution of staff on their daily working hours and average HPRD in high care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Number of residents in the third quarter of 2023	Average care hours per resident	
Job posts for international benchmarking in high care level homes for PWDs (Overall)	**611**		**568**		**3,793.71**		**1,588**	**2.39**	
	52.49%		**53.28%**		**54.05%**		**70.39%**	**54.05%**	
Home Manager (RN)	1		1		7.14			0.00	
	0.09%		0.09%		0.10%			0.10%	
Registered Nurse	32	33	25	26	158.14	165.29		0.10	0.10
	2.75%	2.84%	2.35%	2.44%	2.25%	2.36%		2.25%	2.36%
Enrolled Nurse	79	79	65	65	400.29	400.29		0.25	0.25
	6.79%	6.79%	6.10%	6.10%	5.70%	5.70%		5.70%	5.70%
Home Manager (HW)	1		1		6.29			0.00	
	0.09%		0.09%		0.09%			0.09%	
Health Worker	70		64		408.00			0.26	
	6.01%		6.00%		5.81%			5.81%	
Care Worker	428	499	412	477	2,813.86	3,228.14		1.77	2.03
	36.77%	42.87%	38.65%	44.75%	40.09%	46.00%		40.09%	46.00%
Other job posts in high care level homes for PWDs (Overall)	**553**		**498**		**3,224.64**			**2.03**	
	47.51%		**46.72%**		**45.95%**			**45.95%**	
Home Manager (Non-RN/HW)	10		10		59.50			0.04	
	0.86%		0.94%		0.85%			0.85%	
Ancillary Worker	454		403		2,639.14			1.66	
	39.00%		37.80%		37.60%			37.60%	
Social Worker	62		59		370.43			0.23	
	5.33%		5.53%		5.28%			5.28%	
(Physio/Occupational/Speech) Therapist	23		22		128.14			0.08	
	1.98%		2.06%		1.83%			1.83%	
Others	4	553	4	498	27.43	3,224.64		0.02	2.03
	0.34%	47.51%	0.38%	46.72%	0.39%	45.95%		0.39%	45.95%
Total	**1,164**		**1,066**		**7,018.36**			**4.42**	
	100.00%		**100.00%**		**100.00%**			**100.00%**	

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

Among the sample of high care level homes for PWDs, 1 RCH reported more than 1 Home Manager.

Table D 8 Distribution of staff on their daily working hours and average HPRD in medium care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Number of residents in the third quarter of 2023	Average care hours per resident	
Job posts for international benchmarking in medium care level homes for PWDs (Overall)	**80**		**80**		**510.71**		**527**	**1.34**	
	48.48%		**51.95%**		**52.00%**		**70.39%**	**52.00%**	
Home Manager (RN)	-		-		-			-	
	-		-		-			-	
Registered Nurse	3	3	3	3	8.57	8.57		0.02	0.02
	1.82%	0.26%	1.95%	1.95%	0.12%	0.12%		0.87%	0.87%
Enrolled Nurse	9	9	9	9	47.86	47.86		0.13	0.13
	5.45%	0.77%	5.84%	5.84%	0.68%	0.68%		4.87%	4.87%
Home Manager (HW)	1		1		7.71			0.02	
	0.61%		0.65%		0.11%			0.79%	
Health Worker	36		36		217.29			0.57	
	21.82%		23.38%		3.10%			22.12%	
Care Worker	31	68	31	68	229.29	454.29		0.60	1.19
	18.79%	41.21%	20.13%	44.16%	3.27%	6.47%		23.35%	27.04%
Other job posts in medium care level homes for PWDs (Overall)	**85**		**74**		**471.43**			**1.24**	
	51.52%		**48.05%**		**48.00%**			**48.00%**	
Home Manager (Non-RN/HW)	6		6		37.57			0.10	
	3.64%		3.90%		0.54%			3.83%	
Ancillary Worker	62		51		344.86			0.91	
	37.58%		33.12%		4.91%			35.11%	
Social Worker	11		11		65.57			0.17	
	6.67%		7.14%		0.93%			6.68%	
(Physio/Occupational/Speech) Therapist	4		4		14.43			0.04	
	2.42%		2.60%		0.21%			1.47%	
Others	2	85	2	74	9.00	471.43		0.02	1.24
	1.21%	51.52%	1.30%	48.05%	0.13%	6.72%		0.92%	48.00%
Total	**165**		**154**		**982.14**			**2.58**	
	100.00%		**100.00%**		**100.00%**			**100.00%**	

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

As residents of the sample of medium care level homes for PWDs usually go out for training or work during the day, the Consultant estimated the average daily hours of stay in the sampled homes to better meet the realistic situation. This was achieved by dividing the total weekly hours by 7 days to calculate the average daily hours a resident spends in the RCH. For example, if a resident attends training from 9:30 a.m. to 4:30 p.m. Monday through Friday, they remain in the RCH for the rest of the time. The average daily

length of stay for a resident is estimated as follows:

Total hours of stay in a week = [(24 hours - 7 hours) × 5 days + (24 hours × 2 days)] = 133 hours
Average hours stay in RCH per day = 133 hours ÷ 7 days = 19 hours = 0.79 day

As a result, the average length of stay per day was 0.79 day.

Through these adjustments, the Consultant obtained the average daily hours actually stay per resident in each RCHD, which assisted in estimating more accurate average daily care hours provided to each resident. The following are the details of 7 sampled medium care homes for PWDs:

- Most of the residents of 6 sampled homes go out for training, work or free time during the day
- All residents of 1 sampled home attend training during the day from Monday to Friday, return home on Saturday, and come back to the RCHD by 6:00 p.m. on Sunday or at the end of the holiday

The average daily length of resident stay in 7 sampled medium care level homes for PWDs range from 0.57 to 0.79 day.

Table D 9 Distribution of staff on their daily working hours and average HPRD in low care level homes for PWDs

Job post	Total number of staff		Total number of staff who reported working hours		Total hours worked per week by staff based on reported working hours		Number of residents in the third quarter of 2023	Average care hours per resident	
Job posts for international benchmarking in low care level homes for PWDs (Overall)	**5**		**5**		**35.43**		**141**	**0.39**	
	14.71%		**15.63%**		**17.87%**		**70.39%**	**17.87%**	
Home Manager (RN)	-		-		-			-	
	-		-		-			-	
Registered Nurse	-	-	-	-	-	-		-	-
	-	-	-	-	-	-		-	-
Enrolled Nurse	-	-	-	-	-	-		-	-
	-	-	-	-	-	-		-	-
Home Manager (HW)	2		2		12.00			0.13	
	5.88%		6.25%		0.17%			6.05%	
Health Worker	1		1		6.29			0.07	
	2.94%		3.13%		0.09%			3.17%	
Care Worker	2	5	2	5	17.14	35.43		0.19	0.39
	5.88%	14.71%	6.25%	15.63%	0.24%	0.50%		8.65%	8.89%
Other job posts in low care level homes for PWDs (Overall)	**29**		**27**		**162.86**			**1.81**	
	85.29%		**84.38%**		**82.13%**			**82.13%**	
Home Manager (Non-RN/HW)	2		2		4.43			0.05	
	5.88%		6.25%		0.06%			2.23%	
Ancillary Worker	24		22		139.57			1.55	
	70.59%		68.75%		1.99%			70.39%	
Social Worker	3		3		18.86			0.21	
	8.82%		9.38%		0.27%			9.51%	
(Physio/Occupational/Speech) Therapist	-		-		-			-	
	-		-		-			-	
Others	-	29	-	27	0.00	162.86		0.00	1.81
	-	85.29%	-	84.38%	-	2.32%		-	82.13%
Total	**34**		**32**		**198.29**			**2.20**	
	100.00%		**100.00%**		**100.00%**			**100.00%**	

Note: "Staff who reported working hours" includes full-time, half-time, part-time, and staff on leave of absence. Staff who do not report hours worked are not counted.

According to the Residential Care Homes (Persons with Disabilities) Regulation, there is no need to employ health workers or nurses in low care level homes for PWDs.

As residents of the sample of low care level homes for PWDs usually go out to school, receive training or work during the day, the Consultant estimated the average daily hours

of stay in the sampled homes respectively. This was achieved by dividing the total weekly hours by 7 days to calculate the average daily hours a resident spends in the RCH. For example, if a resident attends training from 8:00 a.m. to 4:00 p.m. Monday through Friday, they remain in the RCH for the rest of the time. The average daily length of stay for a resident is estimated as follows:

Total hours of stay in a week = [(24 hours - 8 hours) × 5 days + (24 hours × 2 days)] = 128 hours
Average hours stay in RCH per day = 128 hours ÷ 7 days = 18.29 hours = 0.76 day

As a result, the average length of stay per day was 0.76 day.

Through these adjustments, the Consultant obtained the average daily hours actually stay per resident in each RCHD, which assisted in estimating more accurate average daily care hours provided to each resident. The following are the details of 4 sampled low care level homes:

- All residents of the 2 sampled homes will go out to school or receive training during the day from Monday to Friday
- All residents of the 1 residential care home sample will go out to work
- Most of the residents of the 1 sample would go out during the day

The average daily length of resident stay in 4 sampled low care level homes for PWDs range from 0.50 to 0.76 day.

Table D 10 Calculated average hours required for various services provided in RCHDs by sample staff based on fieldwork records

	Average	Median	Mode	Max.	Min.	Range	Number of records
1. Physical training services							
1.1 Providing active physical exercises for residents	00:04	00:03	00:01	00:15	00:01	00:14	12
2. Personal care							
2.1 Bathing and hair washing as needed	00:11	00:13	00:15	00:18	00:03	00:15	13
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	00:02	00:02	-	00:03	00:01	00:02	5
2.3 Changing clothes, bed linens and pillows	00:04	00:02	-	00:15	00:01	00:14	5
2.4 Changing diapers	00:05	00:04	00:04	00:15	00:02	00:13	19
2.5 Assisting bedridden residents in changing their positions regularly	00:03	00:03	-	00:05	00:02	00:03	5
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	00:03	00:01	00:04	00:13	00:00	00:13	31
2.7 Feeding	00:07	00:05	-	00:16	00:03	00:13	6
3. Drug management							
3.1 Preparing drugs for residents	00:07	00:05	00:10	00:30	00:00	00:29	22
3.2 Giving (oral) drug	00:01	00:01	00:02	00:05	00:00	00:04	35
3.3 Giving (topical) drug	00:02	00:03	00:02	00:04	00:01	00:03	15
3.4 Performing (subcutaneous) injection	00:05	00:05	-	00:05	00:05	00:00	1
4. Use of restraint(s)							
4.1 Releasing physical restraint(s)	00:02	00:02	-	00:02	00:02	00:00	1
5. Special nursing care procedures							
5.1 Assisting residents in the use of urinary catheters	00:02	00:02	-	00:02	00:02	00:00	1
5.2 Performing peritoneal dialysis	00:12	00:12	-	00:16	00:08	00:08	2
5.3 Assisting residents in the use of feeding tubes	00:10	00:07	00:01	00:45	00:01	00:44	9
5.4 Providing dressing for wounds	00:12	00:12	-	00:20	00:05	00:15	2
5.5 Emptying stoma bags	00:10	00:10	-	00:10	00:10	00:00	1

The data presented above are derived from the Consultant's fieldwork records, which include approximately 210 minutes for each sampled RCH, with hours measured in minutes. During the fieldwork, the consultants used around 30 minutes observing each type of staff, including but not limited to, nurses, HWs, CWs, and AWs. This information is limited to five categories of care and health services and does not include rehabilitation services (e.g. leading groups and activities, assisting residents with training).

In contrast to other data, the data for "2.7 Feeding" does not fully reflect the time required for a complete feeding session for the following reasons:

- Residents might have already finished half of the meal independently, with staff only assisting with the remaining food.
- Staff assisted multiple residents during the observation period. (In this case, the consultants divided the total time recorded by the number of residents receiving assistance to calculate the average time required to feed a single resident.)

Table D 11 Estimated care hours required by residents in high care level homes for PWDs

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Care hours required for general care (minutes)	Care hours required for comprehensive care (minutes)
1. Physical training services					
1.1 Providing active physical exercises for residents	820	1.00	4.98	4.98	4.98
2. Personal care					
2.1 Bathing and hair washing as needed	851	0.90	11.38	10.25	10.25
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	851	1.80	2.14	3.86	3.86
2.3 Changing clothes, bed linens and pillows	851	0.90	4.80	4.32	4.32
2.4 Changing diapers	485	4.80	5.08	24.38	24.38
2.5 Assisting bedridden residents in changing their positions regularly	161	7.11	3.40		24.18
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	83	4.33	3.00		#
2.7 Feeding	83	4.33	7.00		#
3. Drug management					
3.1 Preparing drugs for residents	1,093	1.23	7.34	9.02	9.02
3.2 Giving (oral) drug	1,093	2.25	1.82	4.09	4.09
3.3 Giving (topical) drug	652	2.27	2.74	6.21	6.21
3.4 Performing (subcutaneous) injection	25	2.00	5.00		10.00
4. Use of restraint(s)					
4.1 Releasing physical restraint(s)	223	8.00	2.00		16.00
5. Special nursing care procedures					
5.1 Assisting residents in the use of urinary catheters	42	4.13	2.00		8.25
5.2 Performing peritoneal dialysis	2	4.00	12.00		##
5.3 Assisting residents in the use of feeding tubes	30	4.13	10.70		44.15
5.4 Providing dressing for wounds	34	1.00	12.50		12.50
5.5 Emptying stoma bags	-	-	10.00		###
Total (hours)				**1.12**	**3.04**

The data in the first two columns are from the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by 10 of 11 samples, reflecting the actual situation from end-November 2023 to mid-March 2024, with a total of 1,093 residents. Service items 2.6 and 2.7 contain data recorded by the fieldwork, and the third column is the average of the fieldwork (Table D 10). The Consultant converted the recorded average hours into numerical values for subsequent calculation.

Based on fieldwork and data collected, the Consultant estimated the daily care hours required for each resident in need of comprehensive care. The Consultant identified the most commonly used service items among these residents for the estimate (i.e. column six). This column is an estimate derived from multiplying column 3 "Average daily frequency of use" and column 4 "Average time required by staff to provide the service (minutes)". Based on fieldwork and data collected, the Consultant also estimated the daily care hours required for each resident in need of general care (i.e. column 5). Therefore, the care hours required for each resident of high care level homes for PWDs range from 1.12 hours to 3.04 hours, depending on individual needs.

\# Residents who require "5.3 Assisting residents in the use of feeding tubes" service do not require "2.6 Preparing food/nutritional well-balanced diet or coagulant powder" and "2.7 Feeding" services at the same time.

Residents who require "5.1 Assisting residents in the use of urinary catheters" service do not require "5.2 Performing peritoneal dialysis" service at the same time.

In the sampled high care level homes for PWDs, none of the residents required "5.5 Emptying stomabags".

Table D 12 Estimated care hours required by residents in medium care level homes for PWDs

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Care hours required for general care (minutes)	Care hours required for comprehensive care (minutes)
1. Physical training services					
1.1 Providing active physical exercises for residents	244	1.04	4.98	5.19	5.19
2. Personal care					
2.1 Bathing and hair washing as needed	132	1.00	11.38	11.38	11.38
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	132	1.00	2.14	2.14	2.14
2.3 Changing clothes, bed linens and pillows	83	1.00	4.80	4.80	4.80
2.4 Changing diapers	47	3.17	5.08		16.08
2.5 Assisting bedridden residents in changing their positions regularly	24	6.67	3.40		22.67
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	-	-	3.00		#
2.7 Feeding	-	-	7.00		#
3. Drug management					
3.1 Preparing drugs for residents	308	0.79	7.34	5.77	5.77
3.2 Giving (oral) drug	420	2.65	1.82	4.82	4.82
3.3 Giving (topical) drug	132	2.25	2.74	6.16	6.16
3.4 Performing (subcutaneous) injection	4	2.00	5.00		##
4. Use of restraint(s)					
4.1 Releasing physical restraint(s)	5	8.00	2.00		##
5. Special nursing care procedures					
5.1 Assisting residents in the use of urinary catheters	3	4.50	2.00		##
5.2 Performing peritoneal dialysis	-	-	12.00		#
5.3 Assisting residents in the use of feeding tubes	1	3.00	10.70		##
5.4 Providing dressing for wounds	4	1.00	12.50		##
5.5 Emptying stoma bags	2	6.00	10.00		##
Total (hours)				**0.67**	**1.32**

The data in the first two columns are from the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by 6 of 7 samples, reflecting the actual situation from end-November 2023 to mid-March 2024, with a total of 420 residents. Service items 2.6 and 2.7 contain data recorded by the fieldwork, and the third column is the average of the fieldwork (Table D 10). The Consultant converted the recorded average hours into numerical values for subsequent calculation.

Based on fieldwork and data collected, the Consultant estimated the daily care hours required for each resident in need of comprehensive care. The Consultant identified the most commonly used service items among these residents for the estimate (i.e. column six). This column is an estimate derived from multiplying column 3 "Average daily frequency of use" and column 4 "Average time required by staff to provide the service (minutes)". Based on fieldwork and data collected, the Consultant also estimated the daily care hours required for each resident in need of general care (i.e. column 5). Therefore, the care hours required for each resident of medium care level homes for PWDs range from 0.67 hours to 1.32 hours, depending on individual needs.

\# In the sampled medium care level homes for PWDs, none of the residents required "2.6 Preparing food/nutritional well-balanced diet or coagulant powder", "2.7 Feeding" and "5.2 Performing peritoneal dialysis".

\## A very small number of residents in the samples need to use these services.

Table D 13 Estimated care hours required by residents in low care level homes for PWDs

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Care hours required for general care (minutes)	Care hours required for comprehensive care (minutes)
1. Physical training services					
1.1 Providing active physical exercises for residents	16	1.00	4.98		4.98
2. Personal care					
2.1 Bathing and hair washing as needed	3	1.00	11.38		##
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	3	1.00	2.14		##
2.3 Changing clothes, bed linens and pillows	1	1.00	4.80		##
2.4 Changing diapers	-	-	5.08		#
2.5 Assisting bedridden residents in changing their positions regularly	-	-	3.40		#
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	-	-	3.00		#
2.7 Feeding	-	-	7.00		#
3. Drug management					
3.1 Preparing drugs for residents	58	0.78	7.34	5.71	5.71
3.2 Giving (oral) drug	58	3.33	1.82	6.06	6.06
3.3 Giving (topical) drug	7	3.00	2.74		##
3.4 Performing (subcutaneous) injection	-	-	5.00		#
4. Use of restraint(s)					
4.1 Releasing physical restraint(s)	-	-	2.00		#
5. Special nursing care procedures					
5.1 Assisting residents in the use of urinary catheters	-	-	2.00		#
5.2 Performing peritoneal dialysis	-	-	12.00		#
5.3 Assisting residents in the use of feeding tubes	-	-	10.70		#
5.4 Providing dressing for wounds	1	1.00	12.50		##
5.5 Emptying stoma bags	-	-	10.00		#
Total (hours)				**0.20**	**0.28**

The data in the first two columns are from the "Reply Form for Daily Health and Rehabilitation Services Received by the Residents" voluntarily submitted by 4 samples, reflecting the actual situation from end-November 2023 to mid-March 2024, with a total of 58 residents. Service items 2.6 and 2.7 contain data recorded by the fieldwork, and the third column is the average of the fieldwork (Table D 10). The Consultant converted the recorded average hours into numerical values for subsequent calculation.

Based on fieldwork and data collected, the Consultant estimated the daily care hours required for each resident in need of comprehensive care. The Consultant identified the most commonly used service items among these residents for the estimate (i.e. column six). This column is an estimate derived from multiplying column 3 "Average daily frequency of use" and column 4 "Average time required by staff to provide the service (minutes)". Based on fieldwork and data collected, the Consultant also estimated the daily care hours required for each resident in need of general care (i.e. column 5). Therefore, the care hours required for each resident of low care level homes for PWDs range from 0.20 hours to 0.28 hours, depending on individual needs.

\# In the sample of low care level homes, none of the residents needed to use these services.
\## A very small number of residents in the sample of low care level homes need to use these services.

There was no significant difference in the care hours required by residents who needed general care compared to those requiring comprehensive care, as residents with lower care needs demonstrated better self-care skills and required fewer services.

Table D 14 Estimation of the baseline for staffing in high care level homes for PWDs

The data in the first four columns are derived from Table D 11 Estimated care hours required by residents in high care level homes for PWDs.

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Minimum staff required to perform the process	Total (hours)	Responsible staff
1. Physical training services						
1.1 Providing active physical exercises for residents	820	1.00	4.98	1	68.05	Care Worker
2. Personal care						
2.1 Bathing and hair washing as needed	851	0.90	11.38	2	290.65	Care Worker + Care Worker
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	851	1.80	2.14	1	54.71	Care Worker
2.3 Changing clothes, bed linens and pillows	851	0.90	4.80	1	61.27	Care Worker
2.4 Changing diapers	485	4.80	5.08	2	394.13	Care Worker + Care Worker
2.5 Assisting bedridden residents in changing their positions regularly	161	7.11	3.40	2	129.75	Care Worker + Care Worker
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	83	4.33	3.00	1	18.01	Care Worker
2.7 Feeding	83	4.33	7.00	1	41.96	Care Worker
3. Drug management						
3.1 Preparing drugs for residents	1,093	1.23	7.34	1	164.34	Nurse
3.2 Giving (oral) drug	1,093	2.25	1.82	2	148.98	Nurse + Health Worker
3.3 Giving (topical) drug	652	2.27	2.74	1	67.46	Health Worker
3.4 Performing (subcutaneous) injection	25	2.00	5.00	1	4.17	Nurse
4. Use of restraint(s)						
4.1 Releasing physical restraint(s)	223	8.00	2.00	1	59.47	
5. Special nursing care procedures						
5.1 Assisting residents in the use of urinary catheters	42	4.13	2.00	1	5.78	Care Worker
5.2 Performing peritoneal dialysis	2	4.00	12.00	1	1.60	Nurse
5.3 Assisting residents in the use of feeding tubes	30	4.13	10.70	1	22.08	Health Worker
5.4 Providing dressing for wounds	34	1.00	12.50	1	7.08	Nurse
5.5 Emptying stoma bags	-	-	10.00	1	-	Health Worker
Total (hours)					**1,539.48**	

There may be slight deviations in column 4 “Average time required by staff to provide the service (minutes)” and column 6 “Total (hours)” after rounding to the nearest whole number.

Based on the data presented above, the total daily service hours needed by 1,093 residents were 1,539.48 hours. To estimate the baseline for staffing, the Consultant categorised the services by job posts and calculated the manpower requirements by multiplying the values from column 3“Average daily frequency of use”, column 4 “Average time required by staff to provide the service (minutes)” and column 5 “Minimum staff required to perform the process” as follows:

Job post	Daily service hours needed by residents (hours)	Workload allocation percentage	Estimated manpower requirement based on the daily service hours needed by residents and the average daily work hours of each staff, which is 6.68 hours	Total number of staff who reported working hours in Table D 4
nurse	251.68	42.36%	89	90
Health Worker	164.03	51.08%	48	64
Care Worker	1,123.77	90.00%	187	412

Note: Based on the "Time logs" voluntarily submitted by staff of the sampled RCHDs as of 13 March 2024, the "Workload allocation percentage" data for nurses was obtained from 8 RNs and 17 ENs. The data for health workers was collected from 25 health workers, while the data for care workers was obtained through fieldwork and focus groups. Please refer to Table D 17 for details. By multiplying the workload allocation percentages (i.e. column 3) by the average daily work hours of 6.68 per staff, we can calculate the number of hours used providing direct care services each day for each type of staff. The estimated manpower requirement (i.e. column 4) is then derived by dividing the daily service hours needed by residents (i.e. column 2) by this calculated number of hours.

"Table D 4 Distribution of staff on their total weekly working hours and average daily working hours in 11 sampled high care level homes for PWDs" shows that 568 (53.28%) of staff with reported working hours could be used as an international benchmark for comparison, with an average daily working hour of 3,793.71. Converted to the average number of hours worked by an individual, i.e. the average daily work of each staff is about 6.68 hours.

Table D 15 Estimation of the baseline for staffing in medium care level homes for PWDs

The data in the first four columns are derived from Table D 12 Estimated care hours required by residents in medium care level homes for PWDs.

	Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Minimum staff required to perform the process	Total (hours)	Responsible staff
1. Physical training services						
1.1 Providing active physical exercises for residents	244	1.04	4.98	1	21.09	Care Worker
2. Personal care						
2.1 Bathing and hair washing as needed	132	1.00	11.38	2	50.09	Care Worker + Care Worker
2.2 Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	132	1.00	2.14	1	4.71	Care Worker
2.3 Changing clothes, bed linens and pillows	83	1.00	4.80	1	6.64	Care Worker
2.4 Changing diapers	47	3.17	5.08	2	25.20	Care Worker + Care Worker
2.5 Assisting bedridden residents in changing their positions regularly	24	6.67	3.40	2	18.13	Care Worker + Care Worker
2.6 Preparing food/nutritional well-balanced diet or coagulant powder	-	-	3.00	1	-	Care Worker
2.7 Feeding	-	-	7.00	1	-	Care Worker
3. Drug management						
3.1 Preparing drugs for residents	308	0.79	7.34	1	29.62	Nurse or health worker
3.2 Giving (oral) drug	420	2.65	1.82	2	67.42	Nurse + Health Worker
3.3 Giving (topical) drug	132	2.25	2.74	1	13.56	Nurse or health worker
3.4 Performing (subcutaneous) injection	4	2.00	5.00	1	0.67	Nurse or health worker
4. Use of restraint(s)						
4.1 Releasing physical restraint(s)	5	8.00	2.00	1	1.33	
5. Special nursing care procedures						
5.1 Assisting residents in the use of urinary catheters	3	4.50	2.00	1	0.45	Nurse or health worker
5.2 Performing peritoneal dialysis	-	-	12.00	1	-	Nurse or health worker
5.3 Assisting residents in the use of feeding tubes	1	3.00	10.70	1	0.54	Nurse or health worker
5.4 Providing dressing for wounds	4	1.00	12.50	1	0.83	Nurse or health worker
5.5 Emptying stoma bags	2	6.00	10.00	1	2.00	Nurse or health worker
Total (hours)					**242.29**	

There may be slight deviations in column 4 “Average time required by staff to provide the service (minutes)” and column 6 “Total (hours)” after rounding to the nearest whole number.

Based on the data presented above, the total daily service hours needed by 420 residents were 242.29 hours. To estimate the baseline for staffing, the Consultant categorised the services by job posts and calculated the manpower requirements by multiplying the values from column 3“Average daily frequency of use”, column 4 “Average time required by staff to provide the service (minutes)” and column 5 “Minimum staff required to perform the process” as follows:

Job post	Daily service hours needed by residents (hours)	Workload allocation percentage	The manpower requirement is estimated based on the daily service hours required by residents and the average daily work of each staff of 6.38 hours	Total number of staff who reported working hours in Table D 5
Nurse	114.63	42.36%	42	12
Health workers		51.08%	35	36
Care Worker	127.65	90.00%	22	31

Note: Based on the "Time logs" voluntarily submitted by staff of the sampled RCHDs as of 13 March 2024, the "Workload allocation percentage" data for nurses was obtained from 8 RNs and 17 ENs. The data for health workers was collected from 25 health workers, while the data for care workers was obtained through fieldwork and focus groups. Please refer to Table D 17 for details. By multiplying the workload allocation percentages (i.e. column 3) by the average daily work hours of 6.38 per staff, we can calculate the number of hours used providing direct care services each day for each type of staff. The estimated manpower requirement (i.e. column 4) is then derived by dividing the daily service hours needed by residents (i.e. column 2) by this calculated number of hours.

"Table D 5 Distribution of staff on their total weekly working hours and average daily working hours in 7 sampled medium care level homes for PWDs" shows that 80 (51.95%) of staff with reported working hours could be used as an international benchmark for comparison, with an average daily working hour of 510.71. Converted to the average number of hours worked by an individual, i.e. the average daily work of each staff is about 6.38 hours.

Table D 16 Estimation of the baseline for staffing in low care level homes for PWDs

The data in the first four columns are from Table D 13 Estimated care hours required by residents in low care level homes for PWDs.

		Number of residents using the service	Average daily frequency of use	Average time required by staff to provide the service (minutes)	Minimum staff required to perform the process	Total (hours)	Responsible staff
1. Physical training services							
1.1	Providing active physical exercises for residents	16	1.00	4.98	1	1.33	
2. Personal care							
2.1	Bathing and hair washing as needed	3	1.00	11.38	1	0.57	
2.2	Hair cutting, hair blow-drying, shaving, manicuring, dental and oral cleaning as needed	3	1.00	2.14	1	0.11	
2.3	Changing clothes, bed linens and pillows	1	1.00	4.80	1	0.08	
2.4	Changing diapers	-	-	5.08	1	-	
2.5	Assisting bedridden residents in changing their positions regularly	-	-	3.40	N/A	-	
2.6	Preparing food/nutritional well-balanced diet or coagulant powder	-	-	3.00	1	-	
2.7	Feeding	-	-	7.00	1	-	
3. Drug management							
3.1	Preparing drugs for residents	58	0.78	7.34	1	5.53	Care Worker
3.2	Giving (oral) drug	58	3.33	1.82	2	11.72	
3.3	Giving (topical) drug	7	3.00	2.74	1	0.96	
3.4	Performing (subcutaneous) injection	-	-	5.00	1	-	
4. Use of restraint(s)							
4.1	Releasing physical restraint(s)	-	-	2.00	1	-	
5. Special nursing care procedures							
5.1	Assisting residents in the use of urinary catheters	-	-	2.00	1	-	
5.2	Performing peritoneal dialysis	-	-	12.00	1	-	
5.3	Assisting residents in the use of feeding tubes	-	-	10.70	1	-	
5.4	Providing dressing for wounds	1	1.00	12.50	1	0.21	
5.5	Emptying stoma bags	-	-	10.00	1	-	
Total (hours)						**21.07**	

There may be slight deviations in column 4 “Average time required by staff to provide the service (minutes)” and column 6 “Total (hours)” after rounding to the nearest whole number.

Based on the data presented above, the total daily service hours needed by 58 residents were 21.07 hours. According to the Schedule to the Residential Care Homes (Persons with Disabilities) Regulation, no health worker or nurse is required in low-level care homes. To estimate the baseline for staffing, the Consultant thus categorised the services by job posts and calculated the manpower requirements by multiplying the values from column 3“Average daily frequency of use”, column 4 “Average time required by staff to provide the service (minutes)” and column 5 “Minimum staff required to perform the process” as follows:

Job post	Daily service hours needed by residents (hours)	Workload allocation percentage	Estimated manpower requirement based on the daily service hours needed by residents and the average daily work hours of each staff, which is 7.09 hours	Total number of staff who reported working hours in Table D 6
Nurse (not necessary)			N/A	0
Health Worker (not necessary)				1
Care Worker	20.50	90.00%	3	2

Note: The data of "Workload allocation percentage" about care workers were obtained from the fieldwork and focus groups. By multiplying the workload allocation percentages (i.e. column 3) by the average daily work hours of 7.09 per staff, we can calculate the number of hours used providing direct care services each day for each type of staff. The estimated manpower requirement (i.e. column 4) is then derived by dividing the daily service hours needed by residents (i.e. column 2) by this calculated number of hours.

"Table D 6 Distribution of staff on their total weekly working hours and average daily working hours in 4 sampled low care level homes for PWDs" shows that only 5 (15.63%) of staff with reported working hours could be used as an international benchmark for comparison, with an average daily working hour of 35.43. Converted to the average number of hours worked by an individual, i.e. the average daily work of each staff is about 7.09 hours.

Table D 17 Workload allocation of key staff in RCHDs

Types of care and health services		Allocation of total daily working hours for 25 nurses (minutes)		Allocation of total daily working hours for 25 health workers (minutes)	
1 Physical training services (including checking body temperature and blood pressure)		**425.00**	**3.41%**	**575.00**	**4.46%**
2 Personal care (including changing diaper, feeding)		**638.00**	**5.12%**	**525.00**	**4.07%**
Drug management		**3,541.00**	**28.44%**	**4,989.00**	**38.67%**
3	Preparing drugs for residents	1,530.00	12.29%	2,175.00	16.86%
4	Giving (oral) drug	1,289.00	10.35%	1,833.00	14.21%
5	Giving (topical) drug	392.00	3.15%	820.00	6.36%
6	Performing (subcutaneous) injection	90.00	0.72%	35.00	0.27%
7	Cleaning medicine cup	240.00	1.93%	126.00	0.98%
8 Use of restraint(s)		**70.00**	**0.56%**	**10.00**	**0.08%**
Special nursing care procedures		**600.00**	**4.82%**	**490.00**	**3.80%**
9	Assisting residents in the use of urinary catheters	75.00	0.60%	10.00	0.08%
10	Performing peritoneal dialysis	-	-	20.00	0.16%
11	Assisting residents in the use of feeding tubes	345.00	2.77%	330.00	2.56%
12	Providing dressing for wounds	160.00	1.29%	80.00	0.62%
13	Assisting residents in the use of ventilator/oxygen therapy	5.00	0.04%	10.00	0.08%
14	Change of stoma bags	15.00	0.12%	40.00	0.31
6. Administration and Other Services		**7,176.00**	**57.64%**	**6,311.00**	**48.92%**
15	Ward rounds	630.00	5.06%	920.00	7.13%
16	Handling documents and records	2,675.00	21.49%	2,316.00	17.95%
17	Communicating with various parties (including the families of residents and service providers)	2,135.00	17.15%	1,298.00	10.06%
18	Providing nursing knowledge to others	60.00	0.48%	10.00	0.08%
19	Leading group activities	-	-	60.00	0.47%
20	Miscellaneous (including wheelchair pushing, personal time, overtime, etc.)	1,676.00	13.46%	1,707.00	13.23%
The ratio of hours used for direct care services to hours used for management and other services		**42.36% : 57.64%**		**51.08% : 48.92%**	

Key Factors for Consideration and Methods of Obtaining Relevant Information to Address the Objectives of the Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong

Key factors for consideration		Methods of obtaining relevant information
1. Baseline of manpower allocation	a. Number of staff in various types of the homes b. Staff structure c. Staff-to-resident ratio in various types of the homes d. Working hours of staff in various types of RCHs	• Before **fieldwork**: o A copy of "Staff List" submitted on 30 September 2023 (hid the name, HKID No., start date of current post). Only home information (including number of residents and number of beds on the day of report), as well as the index number, sex, current job post, total working hours per week, daily working time and qualifications, a total of 7 types of information are required) o Reply Form for Daily Health and Rehabilitation Services Received by the Residents (Annexes 8 & 9) • **Desktop research** (e.g. 安老事務及開設安老或殘疾院舍「香港安老院驚人的進化歷史」, "Tips to help you to decide safe staffing levels for your service" by Skills for Social Care, 香港理工大學專業及持續教育學院院長、理大管理及市場學系教授阮博文——政府的醫療公帑應該跟病人走　便利跨境醫療發展).
2. Responsibilities and workload	e. The amount of time required to perform demanding and repetitive tasks f. Workload of the most important job posts (e.g. how much time does an enrolled nurse need to take care of a resident per day) g. Capacity of the most important job posts (e.g. how many residents can a health worker care for per day)	• Before **fieldwork**: o Reply Form for Daily Health and Rehabilitation Services Received by the Residents (Annexes 8 & 9) o Duty/job descriptions for various types of staff o Staff handbook • Conduct time motion studies during **fieldwork** • Request for Time Logs after **fieldwork** (Annex 12) • **Focus groups** • **Desktop research** (e.g. Code of Practice for Residential Care Homes (Elderly Persons) January 2020 (Revised Edition), "Guidance for providers on the assessment of staffing" by Care Inspectorate)
3. Division of labour and collaboration	h. Coordination and support between different job posts	Seek the most recent staff opinion or staff experience survey results prior to **fieldwork** • Conduct time motion studies during **fieldwork** • Request for Time Logs after **fieldwork** (Annex 12) • **Focus groups** • **Desktop research** (e.g. "Reimagining the nursing workload" by McKinsey & Company, "From staff-mix to skill-mix and beyond: towards a systemic approach to health workforce management" by Dubois and Singh, Human Resources for Health)
4. Career development	i. Confidence level in promoting the professionalism of the residential care service industry	• Before **fieldwork**: o Recruitment news/advertisement (Sample) o Staff appraisal form (Sample) o Tools for staff exit interviews (Sample) • **Focus groups** • **Stakeholder opinion survey** • **Desktop research** (e.g. "Care workforce pathway for adult social care" by Skills for Care, UK, "Who Cares? Attracting and Retaining Care Workers for the Elderly" OECD iLibrary, "Workforce: recruitment, training and retention in health and social care" by House of Commons Health and Social Care Committee, UK)
5. Qualifications required	j. Average ratio of staff qualifications in various types of RCHs	• Before **fieldwork**: o A copy of "Staff List" submitted on 30 September 2023 (hid the name, HKID No., start date of current post). Only home information (including

Key factors for consideration		Methods of obtaining relevant information
		number of residents and number of beds on the day of report), as well as the index number, sex, current job post, total working hours per week, daily working time and qualifications, a total of 7 types of information are required) o Staff training records in the past two years (please hide staff personal information) • **Stakeholder opinion survey** • **Desktop research** (e.g. Vocational Qualifications Pathway in Elderly Care Service industry, "Skills for Care & Development Assessment principles" by Skills for Care, UK)
6. Training and qualifications	k. Levels of interest and readiness of existing staff to take on expanded roles l. The trend of promoting professionalism of the industry, and the training and qualification requirements for existing staff and the new job rank	• **Project Initiation Workshop** • **Individual interviews** • **Focus groups** • **Stakeholder opinion survey** • **Desktop research** (e.g. Specification of Competency Standards in Elderly Care Service industry, "Staffing guidance for residential care homes" by Social Care Institute for Excellence, "Does diverse staff and skill mix of teams impact quality of care in long-term elderly healthcare? An exploratory case study" by Koopmans et al. BMC Health Services Research, "Workforce: recruitment, training and retention in health and social care" by House of Commons Health and Social Care Committee, UK)
7. Customer needs	m. Average frequency and percentage of various types of health and rehabilitation services received by residents	• Reply Form for Daily Health and Rehabilitation Services Received by the Residents prior to **fieldwork** (Annexes 8 & 9) • **Desktop research** (e.g. "Creating a better post-pandemic future for adolescents with disabilities" by Sarah Baird and colleagues, The BMJ, 香港 01：人口老化｜何啟明：跨境安老是多一個選擇　不會減慢興建安老院)
8. Service demand	n. Trends in demand for residential care services	• Annual reports for the past 3 years prior to **fieldwork** • **Individual interviews** • **Stakeholder opinion survey** • **Desktop research** (e.g. "Internal & External Factors Affecting Internal Staffing" by Neil Kokemuller, CHRON,"5 Key Factors to Consider When Staffing Your Company" by Burnett's Staffing Inc., "7 steps for creating staffing strategies that work" by Jessica Leyshon, Sage)
9. Regulation of key RCH staff	o. Regulatory framework	• **Individual interviews** • **Desktop research** (e.g. "Residential Care Homes (Elderly Persons) Regulation (Cap. 459, Section 23)", "Health and Social Care Act 2008 (Regulated Activities) Regulation 2014: Regulation 18" by Care Quality Commission, "Human factors: Staffing levels" by Health and Safety Executive UK, "Health and Social Care Standards" by Scottish Government)

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Invitation to the "Project Initiation Workshop"

To: RCH Operator/Home Manager

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff in RCHEs and RCHDs, as well as establish professional standards and a career progression path for them, so as to attract more local talents to join the residential care homes and retain the required talents. On 1 July 2023, the Social Welfare Department (SWD) has commissioned our company to conduct the review.

To help relevant stakeholders understand the consultancy study, the Consultant will organise a Project Initiation Workshop themed "Partnering for Future Success". This workshop aims to introduce the overall project details, establish common goals and expectations, as well as facilitate preliminary discussions on key issues. Details of the Project Initiation Workshop are as follows:

Date	:	15 November 2023 (Wednesday)
Time	:	2:30 pm – 5:30 pm
Place	:	Gymnasium, Lady Trench Training Centre, 44 Oi Kwan Road, Wan Chai, Hong Kong
Agenda	:	Part I: Introduction of the objectives and preparation work of the consultancy study Part II: Shared vision, mission and core values of the residential care service industry Part III: Five success dimensions, drivers, and training needs for enhancement Part IV: Four strategies for roles and skills management Part V: Collaborative spirit, implementation, and maintenance Part VI: Summary, follow-up, and evaluation

We cordially invite you to attend the Project Initiation Workshop. If appropriate, you may nominate a staff representative to join as well. Your participation will offer us valuable insights and support. Please submit the enrolment form via hyperlink (https://forms.gle/bAzE5iLUGsPnv9Xy8), email info@LRT.com.hk or fax 2890 9015 by 6 November 2023 (Monday). If you have any questions or inquiries, please feel free to contact us at 2890 9887.

Sincerely,

Stanley CHAK
Managing Consultant
LRT Consulting

24 October 2023

To : LRT Consulting (email info@LRT.com.hk or fax 2890 9015）

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
"Project Initiation Workshop" Enrolment Form

I would like to register for the Project Initiation Workshop for the consultancy study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong. The workshop will be held on 15 November 2023 (Wednesday) from 2:30 pm to 5:30 pm at Gymnasium, Lady Trench Training Centre, 44 Oi Kwan Road, Wan Chai, Hong Kong.

Name of the home : _____

	Participant 1	Participant 2*
Name :		
Title :		
Phone :		
Email :		

Date : _____

* Due to venue constraints, if the number of enrolments exceeds 150, only the first 150 participants will be admitted on a first-come, first-served basis. Remaining registrants will be placed on a waitlist. If there are any withdrawals, waitlisted participants will be offered a place.

Confirmation letter will be sent to successful registrants via email on 10 November 2023.

“Project Initiation Workshop” Group Discussion Worksheets

Group Discussion (1):
Shared Vision, Mission and Core Values of the Residential Care Service Industry

What do we consider to be the shared vision, mission and core values of the residential care service industry?

Vision What do we want to achieve and what kind of industry do we want to be?	
Mission What (should) we do now to achieve what we want?	
Core Values This is the principle of making smart choices and reflects the organisational culture.	

Group Discussion (2):
Five Success Dimensions, Drivers, and Training Needs for Enhancement

The success model for long-term care institutions consists of five dimensions and their associated drivers. This discussion integrates the training needs related to core clinical and counselling competencies, as well as technical expertise, as outlined in the suggestions for each dimension. This approach aims to address the overall development needs of different job posts.

The job posts we focus on include: Registered Nurse, Enrolled Nurse, Health Worker, Care Worker, Ancillary Worker, and a hypothetical new rank "Senior Health Worker" (please delete any posts that are not applicable).

Success dimensions	Drivers	Training needs for enhancement for this job post
Personalised care	Respect for autonomy, personalised care, social activities	
Clinical excellence	Best practices, staff training, continuous improvement	
Operational efficiency	Staffing, cost control, technology, processes	
Institutional culture	Shared vision, mission and core values, communication, learning culture	
Innovation and collaboration	New nursing models, technology, research	

Group Discussion (3):
Four Strategies for Roles and Skills Management

The following table outlines four strategies for skills management. We will discuss how these strategies can be effectively applied based on the professional qualifications and competencies of each staff level in order to maximise their potential.

Four Strategies for Roles and Skills Management:

Enhancement: This involves developing the skills and responsibilities of RCH staff through ongoing education and training that align with clinical needs.
Expansion: This refers to training staff to acquire a broader range of generic skills, such as resident education and teamwork.
Substitution: This pertains to roles commonly shared across different occupations/functions; for example, nurses may perform tasks traditionally assigned to medical officers.
Delegation: This involves reallocating less skilled nursing tasks to frontline staff.

Strategies for roles and skills management	**The job posts we focused on included:** RNs/ENs / HWs / CWs / AWs (please delete the inappropriate)
Enhancement	
Expansion	
Substitution	
Delegation	

List of RCHs for Fieldwork Pilot Testing

Nature/Type of the Home	Name of the Home
Hostel for Severely Mentally Handicapped Persons (HSMH)	1. FU HONG SOCIETY CHAK ON ADULT TRAINING CENTRE
Private Homes joining Enhanced Bought Place Scheme (EBPS) and/or RCSV	2. SHUI OI CONVALESCENT HOME 1ST BRANCH

List of Sampled RCHEs for Fieldwork

Type of the Home	Home Nature	Name of RCHE
Nursing Home	Contract Home	1. PO LEUNG KUK COMFORT COURT FOR THE SENIOR CUM EVERGREEN DAY CARE CENTRE FOR THE ELDERLY 2. THE METHODIST CHURCH, HONG KONG YANG MEMORIAL METHODIST SOCIAL SERVICE SHAM SHUI PO NURSING HOME CUM DAY CARE SERVICE 3. OASIS NURSING HOME 4. TUNG CHUNG SILVERJOY
	Self-financing nursing homes (Not joining Nursing Home Purchase Scheme (NHPPS) operated by NGOs)	5. ST. JAMES' SETTLEMENT TRUE LIGHT HOME FOR THE AGED
Care and Attention Home	Subvented Homes/subvented cum self-financing home	6. TUNG SIN TAN HOME FOR THE AGED 7. ASIA WOMEN'S LEAGUE LIMITED CHAN KWUN TUNG CARE AND ATTENTION HOME FOR THE ELDERLY 8. HONG KONG LUTHERAN SOCIAL SERVICE, LC-HKS MR. & MRS. LAWRENCE WONG SECOND LUTHERAN HOME FOR THE ELDERLY 9. WAN HO KAN CARE AND ATTENTION HOME
	Self-financing residential care homes for the elderly participating in the Residential Care Service Voucher Scheme for the Elderly (RCS).	10. SIN TIN TOA HOME FOR THE AGED LIMITED
	Self-financing residential care homes for the elderly that do not participate in the Residential Care Service Voucher Scheme for the Elderly	11. CHI LIN NUNNERY CHI LIN HOME FOR THE ELDERLY 12. THE HKCCCU KWONG YUM CARE HOME (INTEGRATED AGED CARE SERVICE) 13. LIGHT AND LOVE HOME LIMITED - LIGHT AND LOVE ELDERLY HOSTEL
	Self-financing Homes joining RCSV	14. FUNG KAI CARE AND ATTENTION HOME FOR THE ELDERLY - C & A SECTION
	Private residential care homes for the elderly participating in the Enhanced Bought Place Scheme and/or the Residential Care Service Voucher for the Elderly (RCS) Scheme	15. OI KWAN CARE FOR THE AGED HOME LIMITED 16. CITY NURSING CENTRE 17. WAH FUNG NURSING CENTRE LIMITED 18. HIU KWONG (TO KWA WAN) NURSING CENTRE 19. EVERGREEN NURSING HOUSE NO.8
	Private residential care homes for the elderly that do not participate in the Enhanced Bought Place Scheme (EAS) or the Residential Care Service Voucher for the Elderly (RCS) Scheme	20. CAINE HOME FOR THE ELDERLY LIMITED 21. KAY LOK YUEN CENTRE FOR AGED LIMITED 22. MING SUM HOME FOR AGED LIMITED 23. WEALTHY HOME FOR AGED - JOCKEY CLUB ROAD BRANCH 24. JOYFUL ELDERLY HOME 25. SHEUNG ON ELDERLY HOME 26. PINE RESIDENCE 27. WONDERFUL LIVING ELDERLY HOME LIMITED 28. GLORIOUS CLOUD ELDERLY CENTRE LIMITED
Aged Home	Self-financing Homes	29. UNITED MUSLIM ASSOCIATION OF HONG KONG HAJI OMAR RAMJU SADICK CARE AND ATTENTION HOME 30. LITTLE SISTERS OF THE POOR ST. JOSEPH'S HOME FOR THE AGED

List of Sampled RCHDs for Fieldwork

Nature of the Home	Type of the Home		
	High care level	Medium care level	Low care level
Care and Attention Home for Severely Disabled Persons (C&A/SD)	1. WAI JI CHRISTIAN SERVICE TSEUNG KWAN O INTEGRATED REHABILITATION SERVICES CENTRE	-	-
Care and Attention Home for the Aged Blind (C&A/AB)	2. THE HONG KONG SOCIETY FOR THE BLIND JOCKEY CLUB TUEN MUN HOME FOR THE AGED BLIND	-	-
Long Stay Care Home (LSCH)	3. THE PROVIDENCE GARDEN FOR REHAB (I)	-	-
Hostel for Severely Mentally Handicapped Persons (HSMH)	4. YAN CHAI HOSPITAL BUDDHA LIGHT ASSOCIATION OF HONG KONG DAY ACTIVITY CENTRE CUM HOSTEL FOR MENTALLY HANDICAPPED 5. TWGHS JOCKEY CLUB TSIN CHEUNG DAY ACTIVITY CENTRE CUM HOSTEL	-	-
Hostel for Severely Physically Handicapped Persons (HSPH)	6. PO LEUNG KUK PADMA & HARI HARILELA INTEGRATED REHABILITATION CENTRE	-	-
Hostel for Severely Physically Handicapped Persons with Mental Handicap (HSPH/MH)	7. FU HONG SOCIETY YI LOK ADULT TRAINING CENTRE	-	-
Transitional Care and Support Centre for Tetraplegic Patients (TCSC)	8. SAHK JOCKEY CLUB NEW PAGE INN	-	-
Halfway House (HWH)	-	12. BAPTIST OI KWAN SOCIAL SERVICE YUK KWAN HALFWAY HOUSE	-
Hostel for Moderately Mentally Handicapped Persons (HMMH)	-	13. THE NEIGHBOURHOOD ADVICE-ACTION COUNCIL TAI HING HOSTEL	-
Supported Hostel (SHOS)	9. ST. JAMES' SETTLEMENT REHABILITATION SERVICES PARKSIDE RESIDENCE AND PARKSIDE INTEGRATED SERVICE TEAM	-	-
Integrated Vocational Training Centre [IVTC] - Residential Service	-	-	19. HONG CHI PINEHILL INTEGRATED VOCATIONAL TRAINING CENTRE - KWONG FUK HOSTEL
Small Group Home for Mildly Mentally Handicapped Children (SGH(MMHC))	-	-	20. CHRISTIAN FAMILY SERVICE CENTRE SHING OI SMALL GROUP HOME AND SHING HIM SMALL GROUP HOME
LWB-subvented Home	-	14. SHINE SKILLS CENTRE (TUEN MUN) - BOARDING SECTION	-
Self-financing Home	10. EBENEZER CARE AND ATTENTION HOME	15. NEW LIFE PSYCHIATRIC REHABILITATION ASSOCIATION JOYOUS PLACE	21. THE MENTAL HEALTH ASSOCIATION OF HONG KONG JOCKEY CLUB SUNNY PLACE
Private Home joining Bought Place Scheme (BPS)	11. IMPERIAL GARDENS	16. HOME OF JOY LIMITED	-
Private Home without joining BPS	-	17. GREEN GARDEN REHABILITATION CENTRE 18. THE SOCIETY OF GLORY AND PLEASURE REHABILITATION ORLINS HOSTEL	22. THE NEVER-LAND FOR MENTAL HEALTH SERVICES OF HONG KONG

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Fieldwork

To: Home Manager

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff in RCHEs and RCHDs, as well as establish professional standards and a career progression path for them, so as to attract more local talents to join the residential care homes and retain the required talents. On 1 July 2023, the Social Welfare Department has commissioned our company to conduct the review.

We will collect information through a variety of channels, fieldwork is one of the most important channels. The consultants will visit your home between mid-November 2023 and March 2024 for about 210 minutes **to understand the operation of the home, the skills required for various types of jobs, and daily workload**, etc. During the observation period, the consultants will only observe and record the work process of the staff. When the task/activity involves the residents' privacy, the consultants will suspend the observation. In addition, the consultants will also take part of the time to discuss with you and your staff on the above aspects. The information collected will only be used for the purpose of this consultancy study, and the results of the analysis will only be reported on an aggregate basis. All collected data will be destroyed within one month after completion of the consultancy study.

We are very much looking forward to this fieldwork and we believe it will provide us with valuable data to support the development of residential care homes and the upskilling of staff. In order to have a certain level of understanding of your home before the fieldwork, please provide as much information as possible two weeks before the visit of the consultants (please refer to the attached sheet) through email info@LRT.com.hk or fax 2890 9015. If you have any questions or enquiries, please contact us at 2890 9887.

Sincerely,

Stanley CHAK
Managing Consultant
LRT Consulting

_____2023

To : LRT Consulting (email info@LRT.com.hk or fax 2890 9015）

From : Name of the home : _____

Name of Home Manager : _____

Phone : _____ Email: _____

Date : _____

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Checklist of Documents Requested prior to Fieldwork – Reply Form

We are happy to provide the following documents (with ✓ sign) two weeks prior to the consultants' visit:

Document	Please see the attachment	No relevant information is available, or providing it is inconvenient
1. Reply Form for Daily Health and Rehabilitation Services Received by the Residents		
2. Time table		
3. Job descriptions/specifications for various types of staff a. Registered Nurse		
b. Enrolled Nurse		
c. Health Worker		
d. Care Worker		
e. Ancillary Worker		
f. Social Worker		
g. Physiotherapist		
h. Occupational therapist		
i. Dietitian		
4. Staff handbook		
5. The most recent staff opinion or staff experience survey results		
6. Recruitment news/advertisement (Template)		
7. Staff appraisal form (Sample)		
8. Tools for staff exit interviews (Sample)		
9. Staff training records in the past two years (please hide staff personal information)		
10. Annual reports for the past three years		

We understand that the Consultant will destroy the above collected information within one month after completion of the consultancy study.

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong

Reply Form for Daily Health and Rehabilitation Services Received by the Residents (Applicable to RCHEs)

Name of the home : _____

Age distribution of residents

	Under 60	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 years old and above
Number of male residents								
Number of female residents								
Total number of residents								

Provision of health and rehabilitation services received by residents on a daily basis

Types of care and health services	Staff involved (Note 1)	Number of residents receiving this service	Average frequency of service use per resident (Note 2)	Average length of service per session (Note 3)
1. Health surveillance services				
1.1 Following up on health condition of residents (including body temperature and blood pressure) as necessary, in addition to regular health checks or medical appointments			1 time per _____ day/hour	Approx. 120/60/30/15/min
2. Personal care				
2.1 Hair cutting, shaving, manicuring, dental and oral cleaning as needed			1 time per _____ day/hour	Approx. 120/60/30/15/min
2.2 Changing clothes			1 time every _____ day	Approx. 120/60/30/15/min
2.3 Changing diapers			1 time every _____ hour	Approx. 120/60/30/15/min
2.4 Assisting bedridden residents in changing their positions regularly, and assisting them to keep their skin and clothing clean and dry to avoid skin breakage, infection or pressure injury (pressure ulcers) caused by prolonged exposure to sweat or excreta			1 time every _____ hour	Approx. 120/60/30/15/min
3. Drug management				
3.1 Preparing drugs for residents			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.2 Recording and signing on the MAR immediately after giving (oral) drug for each resident			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.3 Recording and signing on the MAR immediately after giving (topical) drug for each resident			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.4 Recording and signing on the MAR immediately after performing (subcutaneous) injection for each resident			_____ every _____ week/day/hour	Approx. 120/60/30/15/min

Types of care and health services	Staff involved (Note 1)	Number of residents receiving this service	Average frequency of service use per resident (Note 2)	Average length of service per session (Note 3)
4. Use of restraint(s)				
4.1 During the use of restraints, the physical restraint(s) shall be released for examination and allowing the resident for relaxation and body movement, checking and recording the blood circulation, skin condition, respiratory condition and degree of restraint of the residents			1 time every _____ hour	Approx. 120/60/30/15/min
5. Special nursing care procedures				
5.1 Assisting residents in the use of urinary catheters			1 time per _____ day/hour	Approx. 120/60/30/15/min
5.2 Performing peritoneal dialysis			_____ per _____ week/day	Approx. 120/60/30/15/min
5.3 Assisting residents in the use of feeding tubes			Every _____ day/hour	Approx. 120/60/30/15/min
5.4 Providing dressing for wounds			_____ per _____ week/day	Approx. 120/60/30/15/min
6. Rehabilitation services				
6.1 Physiotherapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
6.2 Occupational therapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
6.3 Speech and language therapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
7. Other health and rehabilitation services not mentioned above, but required on a daily basis (if applicable)				
			1 time every _____ year/month/week	Approx. 120/60/30/15/min

Note 1: Registered Nurse (RN), Enrolled Nurse (EN), Health Worker (HW), Care Worker (CW), Ancillary Staff (AW), Social Worker (SW), Physiotherapist (PT), Occupational Therapist (OT), Dietitian (DT), Speech Therapist (ST). For others, please indicate the job titles.

Note 2: Please remove units of time that do not apply (e.g. daily.)~~/hour 1 time). In other cases, please specify (Example 1: each~~ **2** day~~1 time per hour; Example 2: Every~~ **1** week~~/day/hour~~ **2** times).

Note 3: Please remove the time that does not apply (e.g. about 120~~/ 60 / 30 / 15 /~~ minutes), or indicate the time (e.g. about 120~~/ 60 / 30 / 15 /~~ **10** minutes).

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong

Reply Form for Daily Health and Rehabilitation Services Received by the Residents (Applicable to RCHDs)

Name of the home : _____

Age distribution of residents

	6 to 14	15 to 17	18 to 29	30 to 39	40 to 49	50 to 59	60 to 64	65 to 69	70 to 74	75 to 79	80 to 84	85 to 89	90 years old and above
Number of male residents													
Number of female residents													
Total number of residents													

Provision of health and rehabilitation services received by residents on a daily basis

Types of care and health services	Staff involved (Note 1)	Number of residents receiving this service	Average frequency of service use per resident (Note 2)	Average length of service per session (Note 3)
1. Physical training services				
1.1 Providing physical activity exercise for residents			1 time per _____ day/hour	Approx. 120/60/30/15/min
2. Personal care				
2.1 Hair cutting, shaving, manicuring, dental and oral cleaning as needed			1 time per _____ day/hour	Approx. 120/60/30/15/min
2.2 Changing clothes			1 time every _____ day	Approx. 120/60/30/15/min
2.3 Changing diapers			1 time every _____ hour	Approx. 120/60/30/15/min
2.4 Assisting bedridden residents in changing their positions regularly, and assisting them to keep their skin and clothing clean and dry to avoid skin breakage, infection or pressure injury (pressure ulcers) caused by prolonged exposure to sweat or excreta			1 time every _____ hour	Approx. 120/60/30/15/min
3. Drug management				
3.1 Preparing drugs for residents			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.2 Recording and signing on the MAR immediately after giving (oral) drug for each resident			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.3 Recording and signing on the MAR immediately after giving (topical) drug for each resident			1 time per _____ day/hour	Approx. 120/60/30/15/min
3.4 Recording and signing on the MAR immediately after performing (subcutaneous) injection for each resident			_____ every _____	Approx. 120/60/30/15/min

Types of care and health services	Staff involved (Note 1)	Number of residents receiving this service	Average frequency of service use per resident (Note 2)	Average length of service per session (Note 3)
			week/day/hour	
4. Use of restraint(s)				
4.1 During the use of restraints, the physical restraint(s) shall be released for examination and allowing the resident for relaxation and body movement, checking and recording the blood circulation, skin condition, respiratory condition and degree of restraint of the residents			1 time every _____ hour	Approx. 120/60/30/15/min
5. Special nursing care procedures				
5.1 Assisting residents in the use of urinary catheters			1 time per _____ day/hour	Approx. 120/60/30/15/min
5.2 Performing peritoneal dialysis			_____ per _____ week/day	Approx. 120/60/30/15/min
5.3 Assisting residents in the use of feeding tubes			1 time per _____ day/hour	Approx. 120/60/30/15/min
5.4 Providing dressing for wounds			_____ per _____ week/day	Approx. 120/60/30/15/min
6. Rehabilitation services				
6.1 Physiotherapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
6.2 Occupational therapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
6.3 Speech and language therapy services			1 time per _____ week/day	Approx. 120/60/30/15/min
7. Other health and rehabilitation services not mentioned above, but which are required to be provided on a regular basis (if applicable)				
			1 time every _____ year/month/week	Approx. 120/60/30/15/min

Note 1: Registered Nurse (RN), Enrolled Nurse (EN), Health Worker (HW), Care Worker (CW), Ancillary Staff (AW), Social Worker (SW), Physiotherapist (PT), Occupational Therapist (OT), Dietitian (DT), Speech Therapist (ST). For others, please indicate the job titles.

Note 2: Please remove units of time that do not apply (e.g. daily.)~~/hour 1 time). In other cases, please specify (Example 1: each~~ **2** day~~1 time per hour; Example 2: Every~~ **1** week~~/day/hour~~ **2** times).

Note 3: Please remove the time that does not apply (e.g. about 120~~/ 60 / 30 / 15 /~~ minutes), or indicate the time (e.g. about 120~~/ 60 / 30 / 15 /~~ **10** minutes).

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Fieldwork – Time Motion Study Form (Applicable to RCHEs)

Objective

This study aims to collect high-quality data on the time required to perform demanding and repetitive tasks through standardised observation. The data will be compared with reply forms for daily health and rehabilitation services received by the residents and time logs submitted by RCHs.

Observation process

- Adhere to the infection control measures of the RCH (e.g. wear protective equipment).
- Maintain a respectful distance from the subject and the occupant, and observe quietly.
- Do not interfere with normal operating procedures.
- Use a watch/timer and the observation form to document the data obtained.
- Observe each subject for 30 minutes.
- Observe the same subject 3-5 times for each task/activity at different times and with varying residents

Timing method

- Two observers simultaneously observe and time the same subject and their tasks/activities to ensure reliability.
- Observers should synchronise their watches/timers prior to timing to ensure accuracy.
- Use a watch/timer. Record start and finish times using a 12-hour format (e.g. 2:20-2:26 pm).
- Include timestamps for key milestones of more complex or lengthy tasks/activities in addition to the total duration.

Confidentiality

- The identities and details of staff and residents will be kept confidential and recorded using codes.
- Maintain proper records of the observation form. Complete data entry within 24 hours, ensuring no one else is present during this process. Once data entry is finished, return the observation form to the reviewer within 24 hours.

Conformance

- Use the same watch/timer and method for timekeeping throughout the study.
- When feasible, employ random sampling (e.g. observing different staff performing the same task/activity 3-5 times) to enhance data reliability.

Daily Task/activity Codes (Applicable to RCHEs)

1. Health surveillance services

    1.1 Following up on health condition of residents (including body temperature and blood pressure) as necessary, in addition to regular health checks or medical appointments

2. Personal care

    2.1 Hair cutting, shaving, manicuring, dental and oral cleaning as needed
    2.2 Changing clothes
    2.3 Changing diapers
    2.4 Assisting bedridden residents in changing their positions regularly, and assisting them to keep their skin and clothing clean and dry to avoid skin breakage, infection or pressure injury (pressure ulcers) caused by prolonged exposure to sweat or excreta

3. Drug management

    3.1 Preparing drugs for residents
    3.2 Recording and signing on the MAR immediately after giving (oral) drug for each resident
    3.3 Recording and signing on the MAR immediately after giving (topical) drug for each resident
    3.4 Recording and signing on the MAR immediately after performing (subcutaneous) injection for each resident

4. Use of restraint(s)

    4.1 During the use of restraints, the physical restraint(s) shall be released for examination and allowing the resident for relaxation and body movement, checking and recording the blood circulation, skin condition, respiratory condition and degree of restraint of the residents

5. Special nursing care procedures

    5.1 Assisting residents in the use of urinary catheters
    5.2 Performing peritoneal dialysis
    5.3 Assisting residents in the use of feeding tubes
    5.4 Providing dressing for wounds

6. Rehabilitation services

    6.1 Physiotherapy services
    6.2 Occupational therapy services
    6.3 Speech and language therapy services

Observation Form

RCH code : _____ Name of the home : _____

Subject code : _____ Job post : RN / EN / HW / CW / AW / Other (please specify _____).

Name of observer : _____ Date : (YY/MM/DD)

Time : am / pm

Task/activity	Client Code	Do it alone	Start time	End time	Timestamps of key milestones	Memo/Note
		Yes/No				
		Yes/No				
		Yes/No				
		Yes/No				
		Yes/No				

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Fieldwork – Time Motion Study Form (Applicable to RCHDs)

Objective

This study aims to collect high-quality data on the time required to perform demanding and repetitive tasks through standardised observation. The data will be compared with reply forms for daily health and rehabilitation services received by the residents and time logs submitted by RCHs.

Observation process

- Adhere to the infection control measures of the RCH (e.g. wear protective equipment).
- Maintain a respectful distance from the subject and the occupant, and observe quietly.
- Do not interfere with normal operating procedures.
- Use a watch/timer and the observation form to document the data obtained.
- Observe each subject for 30 minutes.
- Observe the same subject 3-5 times for each task/activity at different times and with varying residents

Timing method

- Two observers simultaneously observe and time the same subject and their tasks/activities to ensure reliability.
- Observers should synchronise their watches/timers prior to timing to ensure accuracy.
- Use a watch/timer. Record start and finish times using a 12-hour format (e.g. 2:20-2:26 pm).
- Include timestamps for key milestones of more complex or lengthy tasks/activities in addition to the total duration.

Confidentiality

- The identities and details of staff and residents will be kept confidential and recorded using codes.
- Maintain proper records of the observation form. Complete data entry within 24 hours, ensuring no one else is present during this process. Once data entry is finished, return the observation form to the reviewer within 24 hours.

Conformance

- Use the same watch/timer and method for timekeeping throughout the study.
- When feasible, employ random sampling (e.g. observing different staff performing the same task/activity 3-5 times) to enhance data reliability.

Daily Task/activity Codes (Applicable to RCHDs)

1. Physical training services

    1.1 Providing physical activity exercise for residents

2. Personal care

    2.1 Hair cutting, shaving, manicuring, dental and oral cleaning as needed
    2.2 Changing clothes
    2.3 Changing diapers
    2.4 Assisting bedridden residents in changing their positions regularly, and assisting them to keep their skin and clothing clean and dry to avoid skin breakage, infection or pressure injury (pressure ulcers) caused by prolonged exposure to sweat or excreta

3. Drug management

    3.1 Preparing drugs for residents
    3.2 Recording and signing on the MAR immediately after giving (oral) drug for each resident
    3.3 Recording and signing on the MAR immediately after giving (topical) drug for each resident
    3.4 Recording and signing on the MAR immediately after performing (subcutaneous) injection for each resident

4. Use of restraint(s)

    4.1 During the use of restraints, the physical restraint(s) shall be released for examination and allowing the resident for relaxation and body movement, checking and recording the blood circulation, skin condition, respiratory condition and degree of restraint of the residents

5. Special nursing care procedures

    5.1 Assisting residents in the use of urinary catheters
    5.2 Performing peritoneal dialysis
    5.3 Assisting residents in the use of feeding tubes
    5.4 Providing dressing for wounds

6. Rehabilitation services

    6.1 Physiotherapy services
    6.2 Occupational therapy services
    6.3 Speech and language therapy services

Observation Form

RCH code : _____ Name of the home : _____

Subject code : _____ Job post : RN / EN / HW / CW / AW / Other (please specify _____).

Name of observer : _____ Date : (YY/MM/DD)

Time : am / pm

Task/activity	Client Code	Do it alone	Start time	End time	Timestamps of key milestones	Memo/Note
		Yes/No				
		Yes/No				
		Yes/No				
		Yes/No				
		Yes/No				

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Time Log

To: Respondents

Introduction

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff in RCHEs and RCHDs, as well as establish professional standards and a career progression path for them, so as to attract more local talents to join the residential care homes and retain the required talents. On 1 July 2023, the Social Welfare Department (SWD) has commissioned Learning Resources & Technologies Limited (also known as LRT Consulting) (the Consultant) to conduct the review.

Instruction

Please provide information about your tasks and activities in **one of the days** of your typical shift. Your response will help the Consultant **understand the skills and daily workload required for your job post**. The information collected will only be used for the objectives of the consultancy study, and the Consultant will only report the results of the analysis on an aggregate basis. All collected data will be destroyed within one month after completion of the consultancy study.

Examples for completing the Time Log as follows:

Task/activity	Client	Do it alone (Delete the inappropriate)	Service duration (minutes)
Answering calls from resident's family member ...	-	Yes~~/No~~	*10*
...	-	Yes~~/No~~	……
Bathing, hair washing	*Resident A*	~~Yes/~~No	*20*
Shaving, manicuring	*Resident A*	Yes~~/No~~	*10*
Dental and oral care	*Resident A*	Yes~~/No~~	*5*
Changing diapers	*Resident B*	~~Yes/~~No	*8*
Assisting bedridden residents in changing their positions	*Resident B*	Yes~~/No~~	*5*
...	*Resident C*	~~Yes/~~No	……

Please provide as accurate and detailed information as possible. If the space in the table form is insufficient, please make a photocopy. Kindly return the completed time log to the Consultant within 3 days of receiving the invitation. Thank you.

To : LRT Consulting (email info@LRT.com.hk or fax 2890 9015）

Personal information

Name : _____ (Optional)

Job post : RN / EN / HW (Please delete the inappropriate)

Name of the home : _____

Shift dates : _____ (YY/MM/DD)

Shift time : _____

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Time Log

Task/activity	Client	Do it alone (Delete the inappropriate)	Service duration (minutes)
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Yes/No	
		Total Shift Time (min):	

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Guidelines for Conducting Interview with Discussion Questions

Objective:

- Keep stakeholders informed about the progress of the consultancy study;
- Gain a deeper understanding of stakeholders' concerns; and
- Explore the issues from a strategic perspective.

Format:

- Interview 10-15 stakeholders from various groups at senior, executive, or board levels;
- Ensure at least one stakeholder from each group is included; and
- Conduct interviews with each stakeholder for about 60 minutes.

Moderator Guidelines:

1. Introduce yourself and your peer.
2. Briefly introduce the objectives and progress of the consultancy study and explain the importance of individual interviews.
3. Introduce the scope of the discussion, the method of recording the information (including audio recordings) and the principle of confidentiality (including all collected data will be destroyed within one month after completion of the consultancy study).
4. Keep track of the discussion time for each issue.
5. Summarise the key points.
6. Thank the interviewees for their time and reiterate the principle of confidentiality.

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Operator / Home Manager of RCHE / RCHD (please specify: _____)

Discussion questions:

A. Staff recruitment
   1. What are the main factors influencing staff recruitment at your home?
   2. What challenges did you face during the recruitment process?
   3. How do you attract and recruit high-quality staff?

B. Staff retention
   4. What are the current factors influencing staff retention at your home?
   5. How do you enhance staff loyalty and retention?

C. Training and development
   6. What skills and knowledge do you consider most important for your staff to develop?
   7. How do you provide professional training and development opportunities for your staff?

D. Feasibility of establishing the rank of "Senior Health Worker"
   8. What do you think of the new rank of "Senior Health Worker"?
   9. What value do you think this rank can bring to your home?

E. Other comments
   10. Do you have any additional comments or recommendations regarding the consultancy study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Elderly Care Service Industry Training Advisory Committee

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. What role do you think ITAC can play in providing staff training?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. How do you think industry training providers can help RCHs to increase staff retention?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. How do you think industry training providers can design and deliver training programmes to meet the needs of RCH staff?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think industry training providers can complement and support the training and development of this rank?
   9. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?

E. Other comments
   10. Do you have any additional comments or recommendations regarding the consultancy study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Employees Retraining Board

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. How do you think re-training providers can help enhance the recruitment capacity of RCHs?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. How do you think re-training providers can help RCHs to increase staff retention?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. How do you think retraining providers can design and provide training programmes to meet the needs of RCH staff?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think re-training providers can complement and support the training and development of this rank?
   9. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?

E. Other comments
   10. Do you have any additional comments or recommendations regarding the consultancy study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Relevant training institutions (please specify: _____)

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. As a training institution, what measures do you think can attract a wider range of talent to join the industry?
   3. How can training institutions collaborate with RCHs to provide more effective recruitment support?

B. Staff retention
   4. What do you think are the main factors influencing staff retention in RCHs?
   5. As a training institution, what measures do you think can enhance staff retention?
   6. How can training institutions assist RCHs in providing staff retention programmes and support?

C. Training and development
   7. What skills and knowledge do you consider most important for RCH staff to develop?
   8. As a training institution, are there areas in staff training that you believe could be strengthened?
   9. What suggestions do you have for the training programmes for RCH staff?

D. Feasibility of establishing the rank of "Senior Health Worker"
   10. What do you think of the new rank of "Senior Health Worker"?
   11. How should the new rank of "Senior Health Worker" be linked to the qualifications, training requirements, professional standards, and career progression path of existing key RCH staff (e.g. HMs, RNs, ENs, HW, CWs, and support staff)?
   12. How can training institutions assist in developing the professional competence of the "Senior Health Worker" rank?
   13. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?

E. Other comments
   14. As a training institution, what additional issues do you think need to be discussed or focused on?
   15. Do you have any other suggestions or comments regarding the current area of health and rehabilitation services?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Relevant professional bodies (please specify: _____)

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. How do you think professional bodies can enhance the recruitment capacity of RCHs and attract a wider range of talent to the service industry?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. How do you think professional bodies can assist residential care homes in developing effective staff retention strategies?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. As a professional body, what measures do you think can be taken to enhance the training of RCH staff? What recommendations do you have for providing training and development resources?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think the new rank of "Senior Health Worker" should be linked to the qualifications and training requirements, professional standards and career progression path of the existing key RCH staff (e.g. HMs, RNs, ENs, HW, CWs, and support staff)?
   9. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?
   10. How do you think professional bodies can participate in and promote the development of the "Senior Health Worker" rank?

E. Other comments
   11. As a professional body, what additional issues do you think need to be discussed or focused on?
   12. Do you have any other suggestions or comments regarding the current area of health and rehabilitation services?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Relevant government departments (please specify: _____)

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. What measures do you think the government can take to promote staff recruitment for RCHs that provide health and rehabilitation services?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. What policies or measures can the government implement to enhance RCH staff loyalty?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. In what ways can government departments enhance the training of RCH staff to facilitate the upgrading of their skills and knowledge?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think the new rank of "Senior Health Worker" should be linked to the qualifications and training requirements, professional standards and career progression path of the existing key RCH staff?
   9. What are the recommendations for the development of a regulatory framework for the new rank of "Senior Health Worker"?

E. Other comments
   10. Apart from the above questions, do you have any other comments or suggestions on the skills and qualifications required for RCH staff providing health and rehabilitation services in Hong Kong?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: Advisory Committees

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. What support or advice do you think the advisory committees can provide to attract a wider range of talent for RCHs?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. What measures or initiatives can the advisory committees promote to enhance RCH staff loyalty?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. In what areas can the advisory committees provide support or advice to facilitate staff training and development?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think the new rank of "Senior Health Worker" should be linked to the qualifications and training requirements, professional standards and career progression path of the existing key RCH staff?
   9. What are the advisory committee's recommendations or observations on the development of a regulatory framework to support the feasibility of establishing the rank of "Senior Health Worker"?
   10. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?

E. Other comments
   11. Apart from the above questions, as a member of the Advisory Committee, do you have any other comments or suggestions on the skills and qualifications required for RCH staff providing health and rehabilitation services in Hong Kong?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Name of interviewee: _____

Group: LegCo Panel on Welfare Services

Discussion questions:

A. Staff recruitment
   1. What do you think are the main factors influencing staff recruitment in RCHs?
   2. What measures do you think the LegCo Panel on Welfare Services can take to promote staff recruitment?

B. Staff retention
   3. What do you think are the main factors influencing staff retention in RCHs?
   4. What policies or measures do you think the LegCo Panel on Welfare Services can propose to enhance RCH staff loyalty?

C. Training and development
   5. What skills and knowledge do you consider most important for RCH staff to develop?
   6. What support or suggestions do you think the LegCo Panel on Welfare Services can provide to promote staff training and development?

D. Feasibility of establishing the rank of "Senior Health Worker"
   7. What do you think of the new rank of "Senior Health Worker"?
   8. How do you think the new rank of "Senior Health Worker" should be linked to the qualifications and training requirements, professional standards and career progression path of the existing key RCH staff?
   9. What are the recommendations for the development of a regulatory framework for the new rank of "Senior Health Worker"?
   10. Under the Qualifications Framework, a home manager is classified at Level 4, while a health worker is classified at Level 3. If a new rank of "Senior Health Worker" is established, how should its qualifications be defined?

E. Other comments
   11. Apart from the above questions, as a member of the LegCo Panel on Welfare Services, do you have any other comments or suggestions on the skills and qualifications required for RCH staff providing health and rehabilitation services in Hong Kong?

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Guidelines for Conducting Focus Group with Discussion Questions

Objective:

- Keep stakeholders informed about the progress of the consultancy study;
- Gain a deeper understanding of stakeholders' concerns; and
- Explore the issues from a practical perspective.

Format:

- 15-18 delegates per group
- Approximately 90 minutes of discussion with each group of delegates

Moderator Guidelines:

1. Welcome participants and introduce yourself and your peer.
2. Briefly introduce the progress of the consultancy study and explain the objectives of the focus group.
3. Introduce the scope of the discussion, the method of recording the information (including audio recordings) and the principle of confidentiality (including all collected data will be destroyed within one month after completion of the consultancy study).
4. Ensure that everyone has the opportunity to speak, encouraging quieter participants to contribute without pressuring them.
5. Remind participants to refocus on the main discussion if their comments drift off-issue.
6. Keep track of the discussion time for each issue.
7. Summarise the key points.
8. Thank the participants and reiterate the principle of confidentiality.

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Group: HMs | RNs/ENs | HWs | CWs | PTs/OTs/STs & TAs | SWs

1. Please tell us a little about yourself (e.g. how many years have you been working in RCHs?).
2. What is it like to work with staff in other posts?

A. Career prospects and progression path in the industry

3. Please describe your career prospects and opportunities for advancement in your home.
4. How clear are you about the promotion requirements in your home? What is the career progression path?
5. What has facilitated or hindered your career development?

B. Qualifications, skills, and training of RCH staff

6. What training and career development opportunities are available in your current home? Are you involved? Why or why not?
7. What do you think is the current relevance and quality of on-the-job training? How well does it fit your job needs and career development?
8. What qualifications, job skills, and knowledge do you think need to be enhanced to effectively meet the needs of residents and their families?

C. Proposal for the establishment of the rank of "Senior Health Worker"

9. To enhance the professional standards and career development opportunities for HWs and CWs, it is proposed to introduce the rank of "Senior Health Worker" to enable trained staff to be responsible for higher level professional health and rehabilitation services. What is your opinion on the establishment of this rank? How do you think the industry can better support the long-term career development of HWs and CWs?
10. Do you see any overlap between the tasks of nurses and HWs? If so, what is it?
11. With proper training, what tasks of nurses do you think can be performed by HWs?
12. In addition to the nursing tasks mentioned earlier, what other responsibilities can HWs share in RCHs? What is the role, and what skills and qualifications are required to meet these demands?

D. Staff recruitment and retention

13. What attracted you to the industry initially, and what factors might lead you to change careers? Why?
14. In addition to the salary factor, how do you think the industry should attract new talent and retain existing staff?

E. Other comments

15. Overall, how do you think the industry should improve career development, enhance training, and promote professionalism within the industry?

Name of moderator: _____ Name of recorder: _____

Date: _____ Time: _____

Group: Medical Officers

A. Impression on the industry

1. Please describe in one word or sentence what it is like to work as a visiting medical officer in a residential care facility.

B. Skills of RCH staff

2. What kind of staff do you interact with in the facility you visit?
3. How do you collaborate with them? How does their work relate to your outreach services?
4. What skills do you think are necessary for RCH staff to meet service needs?
5. (Use a Zoom whiteboard or screen sharing to list all proposals) Rank these skills in order of importance.
6. What skills do staff need to strengthen or supplement to enhance the quality of services?

C. Proposal for the establishment of the new rank of "Senior Health Worker"

7. Do you see any overlap between the tasks of nurses and HWs? If so, what is it?
8. What tasks of nurses do you think can be performed by HWs?
9. To enhance the professional standards and career development opportunities for HWs and CWs, it is proposed to introduce the rank of "Senior Health Worker" to enable trained staff to be responsible for higher level professional health and rehabilitation services. What is your opinion on the establishment of this rank? How do you think the industry can better support the long-term career development of HWs and CWs?
10. What types of care tasks can "Senior Health Workers" perform with proper training? For example: insertion or replacement of indwelling urethral catheters (currently performed by RNs or ENs), insertion or replacement of nasogastric tubes (currently performed by RNs or ENs), peritoneal dialysis, insulin injections, tracheostomy suction, end-of-life care, and advance directives.
11. Which of the nursing tasks mentioned above that may be performed by "Senior Health Workers" must be conducted under the supervision of an RN or EN?

D. Other comments

12. Do you have any additional suggestions regarding the establishment of professional standards and career progression path in the industry?

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Stakeholder Opinion Survey Questionnaire (RCH Staff Version)

Introduction

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff responsible for health and rehabilitation services in residential care homes for the elderly (RCHEs) and residential care homes for persons with disabilities (RCHDs) to establish professional standards and career progression path, as well as to attract more locals to join the profession and retain talent. The Social Welfare Department has commissioned Learning Resources & Technologies Ltd., also known as LRT Consulting, (the Consultant) to conduct the consultancy study in July 2023.

The survey aims to collect valuable opinions from various stakeholders on the career progression path for residential care home staff, the training required to enhance professionalism in the industry, and the qualification requirements.

Instruction

This is an anonymous opinion questionnaire. Relevant government departments and the Consultant will keep all information you provide strictly confidential and will not disclose your personal or employment details. Your responses will be used for this consultancy study only and will not be used for any other purpose.

Your reply is crucial to the development of the residential care service industry. It will take approximately 15 minutes to complete the questionnaire. Thank you for your time and participation.

Please put a "✓" sign in the appropriate option. If you have any questions, please contact us at 2890 9887. Please submit the completed questionnaire by email to info@LRT.com.hk or fax to 2890 9015 **on or before 15 June 2024**. Thank you!

Part I: Personal Background

1. Job post

- ❑ Operator/Management
- ❑ Home Manager
- ❑ Registered Nurse
- ❑ Enrolled Nurse
- ❑ Health Worker
- ❑ Care Worker
- ❑ Social Worker
- ❑ Physiotherapist
- ❑ Occupational Therapist
- ❑ Speech Therapist
- ❑ Therapy/Rehabilitation Assistant
- ❑ Dietitian
- ❑ Dispenser
- ❑ Ancillary Worker (please specify _____)

2. Qualifications (you may select more than one option)

- ❑ Registered Nurse
- ❑ Enrolled Nurse
- ❑ Registered Health Worker
- ❑ Registered Physiotherapist
- ❑ Registered Occupational Therapist
- ❑ Registered Social Worker
- ❑ Others (please specify_____)

3. Experience in your current job post

- ❑ Less than half a year
- ❑ Half a year - less than 1 year
- ❑ 1 year - less than 3 years
- ❑ 3 years - less than 6 years
- ❑ 6 years - less than 11 years
- ❑ 11 years - less than 16 years
- ❑ 16 years - less than 21 years
- ❑ 21-25 years
- ❑ More than 25 years

4. Type of the home

RCHE

Type:
- ❑ Nursing Home
- ❑ Care and Attention Home
- ❑ Aged Home
- ❑ Not sure

Operator:
- ❑ Non-governmental Organisation (NGO)
- ❑ Private operator

RCHD

Type:
- ❑ High care level home
- ❑ Medium care level home
- ❑ Low care level home
- ❑ Not sure

Operator:
- ❑ Non-governmental Organisation (NGO)
- ❑ Private operator

Part II: Opinions about the development of professional standards and career progression path in the residential care service industry

5. To enhance the professionalism and career development opportunities for health workers, it is proposed to introduce the rank of "Senior Health Workers". In this context, what responsibilities do you think should be assigned to "Senior Health Workers" who are empowered to expand their functional scope through proper training included in the curriculum? (You may select more than one option)

- ❑ Insulin injections
- ❑ Intramuscular injections
- ❑ Performing peritoneal dialysis
- ❑ Performing tracheostomy suction
- ❑ Special nursing care procedures (including insertion or replacement of indwelling urethral catheters and nasogastric tubes)
- ❑ Developing care plans (including psychological/spiritual/hospice care plan)
- ❑ Supervising frontline staff (including provision of frontline staff training)
- ❑ Home administration and management (including handling complaints from service users and compiling frontline staff duty rosters)
- ❑ Case management
- ❑ Assisting residents with special care needs in rehabilitation exercises
- ❑ Swallowing training
- ❑ Others (please specify_____)

6. What qualifications do you think "Senior Health Workers" should possess to effectively carry out the responsibilities outlined in Question 5?

6.1 Qualification requirements
- ❑ Secondary 5 or an equivalent level
- ❑ Others (please specify_____)

and

6.2 Completion of the "Training Course for Senior Health Workers", which includes the following content in addition to the "Health Worker Training Course"
- ❑ Clinical care nursing (e.g. elderly care for special needs of the elderly/persons with disabilities, emergency care, rehabilitation care, chronic illness care, cognitive and mental healthcare)
- ❑ Psychological, social, and spiritual services (e.g. hospice care, organising group activities, planning to promote continuous learning for residents)
- ❑ Management (e.g. operations management, quality management, case management, risk management)
- ❑ Gerontechnology (e.g. technology that enhances human functionality, improves quality of life and safety, monitors health conditions, disseminates information, and supports training and treatment)
- ❑ Others (please specify_____)

and

6.3 Working experience requirements
- ❑ No prior experience in residential care homes is required
- ❑ Must be health workers in residential care homes
  - ❑ No less than three years

- ❑ No less than five years
- ❑ The health worker experience can be substituted by those working as care worker, therapy assistant or rehabilitation assistant in residential care homes
  - ❑ No less than five years
  - ❑ No less than eight years
- ❑ Others (please specify_____)

7. Should there be a subordinate relationship between "Senior Health Workers" and existing Health Workers?

- ❑ "Senior Health Workers" should support Home Managers in supervising Health Workers and other frontline staff
- ❑ Both "Senior Health Workers" and Health Workers should report directly to Home Managers, maintaining a non-subordinate relationship
- ❑ Flexible arrangements should be considered based on the specific needs of the homes (e.g. "Senior Health Workers" assist the Home Manager to supervise Health Workers and/or other frontline staff, or no subordinate relationship between the two)
- ❑ No comments

8. If the rank of "Senior Health Worker" is established, what job title do you think would best reflect the duties and professionalism associated with this position, as described in Question 5?

- ❑ Healthcare Practitioner
- ❑ Health Practitioner
- ❑ Health Officer
- ❑ Others (please specify_____)

9. Should the title of "Health Worker" be adjusted accordingly?

- ❑ No adjustment is required; the title "Health Worker" should be maintained
- ❑ Proposed title adjustments as follows:
  - ❑ Assistant Healthcare Practitioner
  - ❑ Assistant Health Practitioner
  - ❑ Assistant Health Officer
  - ❑ Health Assistant
  - ❑ Others (please specify_____)

10. Persons who have completed Secondary 3 or above, have at least three years of experience as Care Workers in residential care homes for the elderly or for persons with disabilities, and have successfully finished the "Certificate in Progression Training for Care Workers" may apply for the "Health Worker Training Course." Should the requirement for a minimum qualification of Secondary 3 be reconsidered?

- ❑ Should not lower the admission requirements for "Certificate in Progression Training for Care Workers"
- ❑ Lower the admission requirements to primary school graduation and increase the required experience for Care Workers accordingly:
  - ❑ No less than five years
  - ❑ No less than eight years
- ❑ Other comments (please specify_____)

Part III: Opinions about attracting and retaining staff

11. Apart from economic factors, what do you think is a more effective way to attract and retain staff? (You may select more than one option)

- ❑ Providing career development and promotion opportunities
- ❑ Flexible working hours and work arrangements
- ❑ Good working environment and support system, communication and feedback mechanisms, as well as team culture and values
- ❑ Implementation of staff recognition and incentive schemes
- ❑ Using technology to improve the working environment
- ❑ Others (please specify_____)

12. Apart from economic factors, what do you think can be an effective way to enhance professionalism of the industry? (You may select more than one option)

- ❑ Media promotion to raise industry awareness (e.g. encouraging staff to share their professional knowledge and skills on social media in areas like clinical care nursing and gerontechnology
- ❑ Collaboration with training institutions to help young people understand career development opportunities and pathway in the residential care service industry
- ❑ Enhancing professional training and continuing education
- ❑ Establishing professional standards and regulatory mechanisms
- ❑ Others (please specify_____)

13. In addition, do you have any other opinions about career progression path, recruitment and staff retention, qualifications and training requirements for staff in residential care homes?

_____
_____
_____

Thank you for your time and opinions.

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong Stakeholder Opinion Survey Questionnaire (Non-RCH Staff Version)

Introduction

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff responsible for health and rehabilitation services in residential care homes for the elderly (RCHEs) and residential care homes for persons with disabilities (RCHDs) to establish professional standards and career progression path, as well as to attract more locals to join the profession and retain talent. The Social Welfare Department has commissioned Learning Resources & Technologies Ltd., also known as LRT Consulting, (the Consultant) to conduct the consultancy study in July 2023.

The survey aims to collect valuable opinions from various stakeholders on the career progression path for residential care home staff, the training required to enhance professionalism in the industry, and the qualification requirements.

Instruction

This is an anonymous opinion questionnaire. Relevant government departments and the Consultant will keep all information you provide strictly confidential and will not disclose your personal or employment details. Your responses will be used for this consultancy study only and will not be used for any other purpose.

Your reply is crucial to the development of the residential care service industry. It will take approximately 15 minutes to complete the questionnaire. Thank you for your time and participation.

Please put a "✓" sign in the appropriate option. If you have any questions, please contact us at 2890 9887. Please submit the completed questionnaire by email to info@LRT.com.hk or fax to 2890 9015 **on or before 15 June 2024**. Thank you!

Part I: Personal Background

1. Which stakeholder group you belong to

- ❑ In-charge of training institution
- ❑ Nursing professional body
- ❑ Trainee
- ❑ Other (please specify_____)

Part II: Opinions about the development of professional standards and career progression path in the residential care service industry

2. To enhance the professionalism and career development opportunities for health workers, it is proposed to introduce the rank of "Senior Health Workers". In this context, what responsibilities do you think should be assigned to "Senior Health Workers" who are empowered to expand their functional scope through proper training included in the curriculum? (You may select more than one option)

- ❑ Insulin injections
- ❑ Intramuscular injections
- ❑ Performing peritoneal dialysis
- ❑ Performing tracheostomy suction
- ❑ Special nursing care procedures (including insertion or replacement of indwelling urethral catheters and nasogastric tubes)
- ❑ Developing care plans (including psychological/spiritual/hospice care plan)
- ❑ Supervising frontline staff (including provision of frontline staff training)
- ❑ Home administration and management (including handling complaints from service users and compiling frontline staff duty rosters)
- ❑ Case management
- ❑ Assisting residents with special care needs in rehabilitation exercises
- ❑ Swallowing training
- ❑ Others (please specify_____)

3. What qualifications do you think "Senior Health Workers" should possess to effectively carry out the responsibilities outlined in Question 2?

3.1 Qualification requirements
- ❑ Secondary 5 or an equivalent level
- ❑ Others (please specify_____)

and

3.2 Completion of the "Training Course for Senior Health Workers", which includes the following content in addition to the "Health Worker Training Course"
- ❑ Clinical care nursing (e.g. elderly care for special needs of the elderly/persons with disabilities, emergency care, rehabilitation care, chronic illness care, cognitive and mental healthcare)
- ❑ Psychological, social, and spiritual services (e.g. hospice care, organising group activities, planning to promote continuous learning for residents)
- ❑ Management (e.g. operations management, quality management, case management, risk management)
- ❑ Gerontechnology (e.g. technology that enhances human functionality, improves quality of life and safety, monitors health conditions, disseminates information, and supports training and treatment)
- ❑ Others (please specify_____)

and

3.3 Working experience requirements
- ❑ No prior experience in residential care homes is required
- ❑ Must be health workers in residential care homes
  - ❑ No less than three years
  - ❑ No less than five years
- ❑ The health worker experience can be substituted by those working as care worker, therapy assistant or rehabilitation assistant in residential care homes
  - ❑ No less than five years
  - ❑ No less than eight years
- ❑ Others (please specify_____)

4. Should there be a subordinate relationship between "Senior Health Workers" and existing Health Workers?

- ❑ "Senior Health Workers" should support Home Managers in supervising Health Workers and other frontline staff
- ❑ Both "Senior Health Workers" and Health Workers should report directly to Home Managers, maintaining a non-subordinate relationship
- ❑ Flexible arrangements should be considered based on the specific needs of the homes (e.g. "Senior Health Workers" assist the Home Manager to supervise Health Workers and/or other frontline staff, or no subordinate relationship between the two)
- ❑ No comments

5. If the rank of "Senior Health Worker" is established, what job title do you think would best reflect the duties and professionalism associated with this position, as described in Question 2?

- ❑ Healthcare Practitioner
- ❑ Health Practitioner
- ❑ Health Officer
- ❑ Others (please specify_____)

6. Should the title of "Health Worker" be adjusted accordingly?

- ❑ No adjustment is required; the title "Health Worker" should be maintained
- ❑ Proposed title adjustments as follows:
  - ❑ Assistant Healthcare Practitioner
  - ❑ Assistant Health Practitioner
  - ❑ Assistant Health Officer
  - ❑ Health Assistant
  - ❑ Others (please specify_____)

7. Persons who have completed Secondary 3 or above, have at least three years of experience as Care Workers in residential care homes for the elderly or for persons with disabilities, and have successfully finished the "Certificate in Progression Training for Care Workers" may apply for the "Health Worker Training Course." Should the requirement for a minimum qualification of Secondary 3 be reconsidered?

- ❑ Should not lower the admission requirements for "Certificate in Progression Training for Care Workers"
- ❑ Lower the admission requirements to primary school graduation and increase the required experience for Care Workers accordingly:
  - ❑ No less than five years
  - ❑ No less than eight years
- ❑ Other comments (please specify_____)

Part III: Opinions about attracting and retaining staff

8. Apart from economic factors, what do you think is a more effective way to attract and retain staff? (You may select more than one option)

- ❑ Providing career development and promotion opportunities
- ❑ Flexible working hours and work arrangements
- ❑ Good working environment and support system, communication and feedback mechanisms, as well as team culture and values
- ❑ Implementation of staff recognition and incentive schemes
- ❑ Using technology to improve the working environment
- ❑ Others (please specify_____)

9. Apart from economic factors, what do you think can be an effective way to enhance professionalism of the industry? (You may select more than one option)

- ❑ Media promotion to raise industry awareness (e.g. encouraging staff to share their professional knowledge and skills on social media in areas like clinical care nursing and gerontechnology
- ❑ Collaboration with training institutions to help young people understand career development opportunities and pathway in the residential care service industry
- ❑ Enhancing professional training and continuing education
- ❑ Establishing professional standards and regulatory mechanisms
- ❑ Others (please specify_____)

10. In addition, do you have any other opinions about career progression path, recruitment and staff retention, qualifications and training requirements for staff in residential care homes?

_____
_____
_____

Thank you for your time and opinions.

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
Invitation to the "Strategy Forum"

To: RCH Operator/Home Manager
In-charge of Training Institution/Organisations

The Government announced in the 2022 Policy Address that it would conduct a holistic review of the skill and qualification requirements of staff in RCHEs and RCHDs, as well as establish professional standards and a career progression path for them, so as to attract more local talents to join the residential care homes and retain the required talents. On 1 July 2023, the Social Welfare Department (SWD) has commissioned our company to conduct the review.

From the end of November 2023 to March 2024, the Consultant visited 52 residential care homes (RCHs) to conduct fieldwork to understand the operation of the home, the skills required for various types of jobs, and daily workload, etc. During the same period, the Consultant also conducted individual interviews with various stakeholders, including the Legislative Council members, representatives from the nursing training sector and RCH operators, to collect views from a wide range of stakeholders. On the other hand, from April to June, the Consultant held focus group discussions with more than 100 representatives from different ranks. Staff in RCHEs and RCHDs, as well as in-charge of relevant training institutions/organisations and trainees were invited to participate in the stakeholder opinion survey. In this survey, the Consultant successfully collected 1 257 valid questionnaire responses from RCH staff and 99 from non-RCH staff.

As a result of the aforementioned diversified research activities, the Consultant has consolidated the data and information obtained, completed the data analysis report and made preliminary recommendations. Stakeholders of the sector are cordially invited to attend the "Strategy Forum" to further discuss the findings and preliminary proposed directions. The theme of the forum is "Partnering for Future Success", details of which are as follows:

Date	:	5 September 2024 (Thursday)
Time	:	2:30 pm – 4:30 pm (Registration at 1:45 pm)
Place	:	Auditorium, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong
Agenda	:	• Introduction of the Consultancy Study's objectives • Comprehensive report of the study's results • Presentation of the preliminary proposed directions • Group discussion • Summary

We cordially invite you to attend this "Strategy Forum". You are welcome to nominate one or two staff representatives who are responsible for management or supervision. Please submit the attachment form via the online form (https://forms.gle/ngg7ZrFP8PdpwWGq8), email info@LRT.com.hk, or fax 2890 9015 **on or before 30 August 2024 (Friday)**. If you have any questions or inquiries, please feel free to contact us at 2890 9887.

Sincerely,

Stanley CHAK
Managing Consultant
LRT Consulting

8 August 2024

To : LRT Consulting (email info@LRT.com.hk or fax 2890 9015）

Consultancy Study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong
"Strategy Forum" Enrolment Form

We, the RCH/institute/institution, is pleased to recommend the following persons to attend the "Strategy Forum" for the consultancy study on the Skill and Qualification Requirements of Residential Care Home Staff Providing Health and Rehabilitation Services in Hong Kong. The forum will be held **on 5 September 2024 (Thursday) from 2:30 pm to 4:30 pm at Auditorium, Duke of Windsor Social Service Building, 15 Hennessy Road, Wan Chai, Hong Kong**.

Name of the RCH/institute/institution : _____

	Participant 1	Participant 2*
Name :		
Title :		
Phone :		
Email :		
Date :		

* Due to venue constraints, if the number of enrolments exceeds 150, only the first 150 participants will be admitted on a first-come, first-served basis. Remaining registrants will be placed on a waitlist. If there are any withdrawals, waitlisted participants will be offered a place.

Confirmation letter will be sent to successful registrants via email on 3 September 2024.

Registration and Renewal Requirements for "Health&Care Practitioner (HCP)"

Registration

- **Designated Training Course:** Individuals wishing to obtain registration as a "HCP" must have completed a designated training course approved in writing by the Director of Social Welfare (DSW). This course is specifically designed to cultivate "HCP", covering both theory and practice, aimed at equipping trainees with the core skills and knowledge required for advanced professional care services. Applicants must pass standardised course assessments, including written assessment and practical assessment, achieving a score that meets the qualification standards set by the training institution (TI), and be awarded a certificate.

- **Background Check:** Criminal records at the time of registration, such as:
  a. be convicted of an offence involving deception or dishonesty or a sexual offence anywhere;
  b. be convicted of an indictable offence in Hong Kong;
  c. be sentenced to imprisonment (however described) outside Hong Kong, whether or not the sentence is suspended; or
  d. be convicted of an offence under the Residential Care Homes for the Elderly Ordinance/Residential Care Homes for Persons with Disabilities Ordinance.

- **Registration Procedure:** Applicants may submit an application for registration as a "HCP" through a training body or by themselves in the manner specified by SWD

  Applicants are required to submit the following relevant documents at the same time:
  a. Completed and signed application form
  b. Copy of Hong Kong Identity Card
  c. Copy of certificate in the Training Course for "HCPs"
  d. Copy of the employment proof of Health Worker in residential care home for the elderly (RCHE)/residential care home for persons with disabilities (RCHD)
  e. Copy of Health Worker Registration Card/Health Worker Registration Certificate
  f. Supporting documents in relation to change of name (if any)
  g. Copy of prosecution documents or court documents of the relevant conviction (if any)

Applicants are required to complete the registration process of "HCP" through interview, assessment, verification of documents, and payment of registration fee before they can practise in RCHEs, RCHDs, or elderly care/rehabilitation welfare service units

- **Reporting requirements:** Registered "HCPs" are required to report to the DSW as soon as possible during the validity period of their registration if:
  a. a prosecution is started against the applicant for an indictable offence in Hong Kong;
  b. the applicant is convicted of an indictable offence in Hong Kong;
  c. a prosecution is started against the applicant for an offence punishable with imprisonment (however described) in a place outside Hong Kong; or
  d. the applicant is sentenced to imprisonment (however described) in a place outside Hong Kong, whether or not the sentence is suspended.

Renewal of registration

- The validity period of renewal of registration of "HCP" shall not exceed five years. If the applicant fails to renew the registration on time, the registration will lapse.

- The DSW may impose any conditions he thinks fit in relation to the renewal of registration, including those relating to continuing education.

- Added a new type of application for Registered "HCP" to the existing "Application for Renewal as a Registered Home Manager/Registered Health Worker". The application form has already contained the declaration of personal data and reporting requirements required for renewal.

- Through the existing online registration system, help "HCPs" to self-track the validity period of registration and remind them of the renewal deadline.

Syllabus of the "Enrolled Nurse (General) Training Programme" offered by the Hospital Authority

Competence Area	Learning Topic	Minimum hours	
1: Professional, Legal and Ethical Nursing Practice	Professional Nursing Practice • Nursing profession • Personal qualities of a nurse • Concepts of nursing and caring • Introduction to theories of nursing and caring • Introduction to evidence-based nursing practice	30	80
	Legal and Ethical • Legal aspects pertinent to enrolled nurse practice • Professional conduct and nursing ethics • International and local nursing organisations • Principles of safe practice • Contemporary ethical practice	30	
	Communication • Introduction to concepts of communication and counselling, interpersonal relationship and team work	10	
	Fundamental Principles on • Human rights and responsibilities • Patients' rights and responsibilities	10	
2: Provision of Care	Basic Understanding of Biological, and Integrated Life Sciences • Anatomy and physiology • Growth and development • Microbiology • Pharmacology • Nutrition and dietetics	125	653
	Introduction to Behavioural and Social Sciences Pertaining to Healthcare • Psychology • Sociology	30	

	Concepts of Health and Health Care
	• Health care system
	  o Primary Health Care
	  o Secondary Health Care
	  o Tertiary Health Care
	• Personal and community health
	• Health promotion
	• Prevention of communicable and non-communicable diseases
		40	

	Principles and Practice of Nursing
	• Basic nursing care
	• First Aid and Emergency Nursing
	• Infection Control
	• Assisting in the care of clients with alteration in various body system functions. This includes:
	  o Health assessment and nursing process
	  o Medical and surgical nursing
	  o Paediatric and adolescent health
	• Preventive and promotive care
		360	

	Introduction to Specialty Nursing • Gerontological nursing • Obstetric nursing • Public health and community nursing • Mental health nursing	50	
	Basic Knowledge on • Quality assurance • Occupational safety and health practice • Risk identification • Patient safety • Incidents reporting	30	

Competence Area	Learning Topic	Minimum hours	
	Communication • Basic skills on effective communication	10	
	Introduction to Information Technology in Health Care • Basic understanding on information technology (IT) • Application of IT in nursing and health care	8	
3: Personal and professional attribute	Personal Attributes • Knowledge of self, environment, stress coping, responsibility and accountability, and adaptation to change	10	25
	Professional Attributes • Knowledge of professional development and lifelong learning • Knowledge of professional organisations and strategies in achieving professionalism • Fundamental principles on evidence-based practice and nursing research	15	
4: Teamwork	Effective Communication	4	22
	Basic Principles of Team Building	8	
	Basic Principles of Coaching and Mentoring	10	
		Total:	**780**

Clinical Practice Requirements

Clinical Areas	Minimum Practice Requirement (Hours)
Medical Nursing	800
Surgical Nursing	700
Night Duty	100
Total:	**1 600**

Course Content and Related Requirements for Training Course for "Health&Care Practitioners"

(A) Introduction

Training Course for "Health&Care Practitioners" is applicable to residential care homes (RCHs) for the Elderly (RCHEs) and RCHs for Persons with Disabilities (RCHDs). Trainees who have completed the Training Course for "Health&Care Practitioners" approved by the Social Welfare Department (SWD) can apply for registrations as "Health&Care Practitioners" in accordance with the Residential Care Homes (Elderly Persons) Regulation (Cap. 459A) and the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613A) so as to serve as a "Health&Care Practitioner" in RCHEs and RCHDs.

(B) Entry Requirements

Trainees must

(a) Applicable to applicants with Hong Kong Certificate of Education Examination results: having completed Secondary 5 or equivalent; or
(b) Applicable to applicants with Hong Kong Diploma of Secondary Education Examination results: having obtained Level 2 or above in 5 subjects, including Chinese Language, English Language and Mathematics and any two other subjects in Category A (Core/Elective Subjects) and Category B (Applied Learning Subjects), or equivalent,

and have no less than three years of experience as a health worker in RCH.

Trainees are required to submit original copies of their academic qualifications and health worker registration certificates as proof. Training institutions must ensure that trainees meet the above entry requirements, otherwise the SWD reserves the right to refuse to process registration applications for individuals.

(C) QF Level and Award Title

"Professional Diploma" at Level 4

(D) Course Accreditation

All training institutions must obtain course accreditation from the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (unless the institution has self-accrediting status) to demonstrate compliance with Qualifications Framework (QF) Level 4 requirements. Only then can the Training Course for "Health&Care Practitioners" be approved by the SWD for implementation.

(E) Course Hours and Instructor Experience

The total contact hours of the Training Course for "Health&Care Practitioners" must be no less than 760 hours, which consists of classroom learning (including 480 hours in total of lecture, demonstration, skill practice, and assessment) and practicum (280 hours in total). Trainees must complete all course components (including lectures, practicums, and assessments). Training institutions must arrange persons with relevant professional qualifications to serve as instructors (including social workers, nurses (general/psychiatric), medical officers, pharmacists, physiotherapists/occupational therapists, etc.).

(F) Conditions for Issuing Graduation Certificates

Trainees must attend at least 90% of the lectures and achieve a passing score (i.e. at least 60%) in both the written examination and the practical examination. All skills designated as "Core Competence" in the remark's column of section "(G) Course Outline" must be included as compulsory topics in the practical examination. Trainees must pass all assessments related to these core competences to be awarded a graduation certificate by the training institution.

(G) Course Outline

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
(1) Introduction			
• Course introduction	1		
• Application and compliance with Hong Kong laws and regulations relating to residential care home services, e.g. the Residential Care Homes for the Elderly Ordinance, the Residential Care Homes for Persons with Disabilities Ordinance, the Code of Practice for Residential Care Homes for the Elderly, the Code of Practice for Residential Care Homes for Persons with Disabilities, the Personal Data (Privacy) Ordinance, the Mental Health Ordinance, the Prevention of Bribery Ordinance, the EPD Waste Disposal Ordinance, the Occupational Safety and Health Ordinance	6	Apply Ordinances and Codes of Practice (106164L5)	
• Duties and registration of "Health&Care Practitioner"	1		Supplementary materials in addition to those in the specified UoCs will be required.
(2) Introduction to nursing			
• Evidence-based nursing principles include the nursing process, relevant policies, codes and guidelines, skills required, relevant assessment tools, etc.	12	Monitor the Personal Basic Care Plan (106006L4)	
(3) Physical condition and care of the elderly and persons with disabilities			
• The structure and function of the human body, including: circulatory system, respiratory system, urinary system, excretory system, abdominal cavity, skin musculoskeletal system, digestive system	1		Supplementary content on human body structure and function that was covered in the "Combined Health Worker Training Course" will be required.
• Human respiratory system: the basic physiological structure of the mouth, nose, pharynx and trachea • Precautions and techniques for performing tracheostomy suction • Performing tracheostomy suction procedure	9	Perform Tracheostomy Suction (106044L4)	Core Competence
• Human urinary system: the structure of the bladder, urethra, and reproductive organs • Common adaptations to the use of urinary catheters and reasons for replacing them • Types of urinary catheters and related appliances • Aseptic technique and infection control measures • Urinary catheter replacement method • Possible complications of urinary catheter replacement and management methods	30	Replace Urinary Catheter (through the urethra into the bladder) (106050L4)	Core Competence

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
• Care measures after urinary catheter replacement			
• Human excretory system, abdominal anatomy, and peritoneal dialysis theory • Procedures and guidelines for performing peritoneal dialysis care • Methods for assessing the health of the peritoneum and peritoneal dialysis tubing • Peritoneal dialysis related equipment • Common adaptations and complications of peritoneal dialysis, as well as management methods • Methods for attaching and removing peritoneal dialysis tubing and system • Care of peritoneal dialysis tubing in the skin of the abdomen	30	Perform Peritoneal Dialysis Care (106051L4)	Core Competence
• Human skin musculoskeletal system • Characteristics and nature of complex wounds • Principles and methods of wound care, as well as the uses and characteristics of different dressings • The progress of wound healing and the care process	32	Perform Complicated Wounds Care (106056L5)	Core Competence
• Anatomy of the human digestive system • Common reasons for nasogastric tube replacement • Types of nasogastric tubes and related utensils • Procedures and guidelines for nasogastric tube replacement • Nasogastric tube replacement methods and nursing measures, including: confirming the position of the nasogastric tube, recording the replacement process, etc. • Possible complications of nasogastric tube replacement and management methods	30	Replace Nasogastric Tube (106067L4)	Core Competence
• Common types of disability and their physical needs, e.g. specialised nursing knowledge and care skills related to physical disability, etc.	1		Supplementary materials in addition to those in the specified UoCs will be required.
(4) Psychological and psychiatric conditions and care for the elderly and persons with disabilities			
• Meaning and manifestations of mental instability, e.g. speech, thinking, perception • The crisis phase of the mental state, e.g. anxious, defensive • Appropriate intervention for the crisis phase of the mental state • Considerations when performing interventional work • Assessing the impact of mentally unstable service users on the operation of the institution and to take relevant follow-up	7	Manage Mentally Unstable Cases (110910L4)	

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
• Definition, types, possible causes and symptoms of mental illness • Skills in assessing the psychological condition of mentally ill patients and analysing their psychological needs • Skills in building trusting relationships with people with mental illness • Principles of psychosocial rehabilitation for mentally ill patients • Promote the mental rehabilitation of patients and establish an environment that supports physical, mental and social rehabilitation, e.g. integrating rehabilitation treatment elements and mitigating the wandering crisis	15	Provide Psychological Support to Mentally Impaired Patients (106224L4) Design a Suitable Living Environment for Psychiatric (106060L4)	
• Chronic care and psychological support • Types of common chronic diseases, symptoms, possible causes and treatments • Assessing the patient's ability to manage themselves • Methods and techniques to improve the effectiveness of patient self-management • Review on various ways to enhance the effectiveness of patients' self-management of chronic diseases • Use of relevant instruments and scales • Recording and reporting of the patient's health status • Guidelines and procedures for support services for patients with chronic illnesses and their carers • Knowledge and skills in analysing the psychological conditions of patients with chronic diseases and their caregivers • Different psychological support activities to relieve the knowledge and skills of emotional and stress of patients with chronic sexually transmitted diseases and their caregivers	32	Educate elderlies on the Self-management of Chronic Diseases (106012L4) Follow-up on the Health Conditions of Elderly Persons with Chronic Diseases (110802L4) Provide Psychological Support for Patients with Chronic Diseases and their Carers (110906L4)	
• Common types of disability and their psychological needs, e.g. specialized nursing knowledge and care skills related to physical disability, intellectual disability, etc.	1		Supplementary materials in addition to those in the specified UoCs will be required.
• Psychosocial and spiritual well-being • The process, connotation and significance of developing a care plan • Individualised care plans designed with goals in mind • Community resources for mental/spiritual well-being for supporters • Skills and tools for assessing the mental/spiritual well-being of the elderly	15	Design Care Plans for Psychological/Spiritual Well-being (106117L4)	

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
• Skills in writing a care plan • Establish effective communication channels to enable relevant staff, elderlies and their families to have a clear understanding of the content of the care plan			
(5) Issues related to nursing work			
• Basic pharmacological knowledge, including: types of drugs, efficacy, side effects, general dosage and route, expected effect, etc • Factors that affect chemical decomposition, e.g. light, temperature, humidity • Common drug risks, e.g. mislabelling and storage • The section of the Dangerous Drugs Ordinance relating to the management of the stockpiling of dangerous drugs • Assessing and analysing the risks of storing medicines • Skills in using a computerised medication management system • Principles of verifying drugs • The security, storage, and management of medication • Dosage unit of different medication, the measurement and calculation • Different names of medication, including: the generic names, brand names • Medical officers' prescription, including: recognised abbreviations medication, dosage units, frequency, route of administration, etc.	24	Manage Storage of Medicines (106035L5)	
• Handling medication injection and the use of injection tools • Nursing procedures before and after medication injection • Skills required to document medication injection • Dispose of the used injection tools properly • Adverse reactions caused by medications	15	Perform Subcutaneous Injection (106033L4) Perform Intramuscular Injection (106034L4)	Core Competence
• Principle of evidence-based practice in emergency care • The latest guidelines on the cardiopulmonary resuscitation issued by relevant professional and academic organisations, e.g. American Heart Association, St. John Ambulance • Procedures for administering first aid, e.g. cardiopulmonary resuscitation, automated external defibrillation (AED) • Instructions for the use of automated external defibrillator • Types, possible causes, pathologies and symptoms of stroke	24	Perform Cardiopulmonary Resuscitation (106071L3) Perform Automated External Heart Defibrillation (106079L3) Acute Stroke Management (106081L4) Traumatic Bleeding Management (106082L4) Monitor the Quality of Emergency Care (106083L5)	

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
• Management of acute stroke • Types of bleeding, symptoms of blood loss and impact on life • Definition of trauma and how to deal with trauma in different parts of the body • Skills in providing emergency care and using relevant assessment tools • Providing the ambulance staff with an elaboration on what happened, the patient's vital signs, and the treatment given, and recording the entire emergency process in writing			
• Evidence-based principles of rehabilitation • Procedures and guidelines for assessing the ADLs • Definition and scope of life functioning, including: Basic Activities of Daily Living (BADLs), Instrumental Activities of Daily Living (IADLs) • Objective assessment tools for assessing ADLs and their uses, e.g. Barthel Index • Procedures and guidelines for conducting preliminary cognitive assessment, e.g. Mini-mental State Examination, Montreal Cognitive Assessment • Analysing and integrating the assessment results to identify the limitations and causes of the elderly's functional ADLs, as well as the degree of daily cognitive ability • Types of group activities for the elderly, e.g. psychological counselling, recreational activities, social interaction, health education • Procedures and techniques for planning elderly group activities • Methods for evaluating the effectiveness of the group activities • Skills in writing group activity proposals/manuals • Content of rehabilitation plans for the elderly • Different types of rehabilitation treatments and skills for application • Assessment tools used in rehabilitation treatments • Commonly used methods to improve the quality of rehabilitation treatments	32	Assess the Activities of Daily Living (ADLs) (106104L4) Conduct Preliminary Cognitive Assessment (106105L4) Plan Elderly Group Activities (106219L4) Monitor the Quality of Rehabilitative Care (106106L5)	
• Definition, core values, principle, objectives, and strategy of case management • Workflow and protocols regarding case referral • Understanding of relevant information on elderly abuse, e.g. definition, mode,	9	Implement Case Management (106198L4) Assess Suspected Abuse Cases (106120L4) Refer the Elderly Persons in Need to Specialist Care Assessments (110907L5)	In addition to those specified in the UoCs, supplementary materials will be required to extend the service target from the elderly to persons with

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
risk factors, and signs of elderly abuse • Identifying any major risk factors that may lead to abuse, previous abuse, and possible modes of abuse • Mechanism, implementation procedures and guidelines for service assessment and referral • Types of specialist care assessment services, referral conditions and procedures • Initial assessment of the service user's physical condition and self-care ability, e.g. vision and hearing assessment, wound assessment, diabetes assessment, nutrition and water intake • Confirming the types of specialist care assessment services required, e.g. health and illness assessment, nutrition assessment, fall risk assessment • Skills in writing referral records			disabilities
• The causes and preventions of different diseases • The updated immunization guidelines from local and international health organisations • Proper methods to store vaccines • Procedures and techniques of vaccine injection • Assessing the infection risks and possible side effects of residents in residential care homes • Implement the immunization measures to ensure the health of residents and reduce the infection risks	15	Understand and Implement the Immunization Measures (106023L4)	
• Guidance on standard infection control measures • Infection control procedures and standards, e.g. common infectious diseases, transmission routes of infectious diseases • Establishing infection prevention and control measures and guidelines, e.g. handling of suspected infectious diseases, notification mechanism for infectious diseases, handling of contaminated articles • Staff supervision on infection control procedures • Reviewing infection control measures and updating relevant guidelines to ensure a safe environment in organisations	22	Formulate guidelines for frontline staff to implement Infection Control and Monitor Such Implementation (106169L5)	
• Practice Guidelines on Human Resource and Management as well as relevant labour legislation, e.g. Employment Ordinance • Work processes and precautions of editing and creating duty rosters • Skills in supervising staff in	24	Establish Duty Rosters (110837L4) Supervise Occupational Safety and Health (106161L4) Handle Staff Accidents or Injuries (106162L4)	

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
accordance with the Occupational Safety and Health Work Guidelines • The types and causes of common staff accidents or injuries in residential care as well as community care and support services, and the corresponding treatment and prevention methods • Occupational safety and health-related aids and proper use, e.g. personal protective equipment, harnesses, transfer machines • Work-related injury reporting mechanism to report staff injury information, including: process and handling methods • Educate staff on the institutional culture and a sense of responsibility to always "work with care and be considerate to themselves and others" • Technologies for community support and health monitoring		Prevent General Accidents (106163L4)	
• Common crisis management policies and mechanisms • Risk identification and management skills, including: assessment and identification of potential risks, preventive methods to avoid risks, methods of analysing the degree of risks, etc.	15	Manage Risks (106184L5)	
• Customer service management policy • Guidelines for handling complaints from service users • Skills in maintaining a good relationship with service users • Skills in handling complaints properly and objectively • Skills in documenting complaints and the handling process	7	Handle Complaints from Service Users (106188L4)	
(6) End-of-life care			
• Professional, legal and ethical end-of-life care • The aims, benefits, focus and content of palliative care • The physical and psychological effects of pain • Non-pharmacological treatments for pain relief, e.g. physiotherapy, massage, acupuncture, hypnotherapy • Types of non-pharmacological treatments for relieving symptoms other than pain and their efficacy • Community resources and other support for palliative care • Contents of individual palliative care packages • The purpose and importance of life and death education • Assessing the skills needed in life and death education • Providing life education-related skills	40	Provide Non-pharmacological Pain Management (106221L4) Apply Non-pharmaceutical Treatments to Relieve Symptoms other than Pain (106222L4) Provide Palliative Care (106223L4) Provide Life-Death Education to Elderlies (106128L5) Execute and Cooperate with the Elderly's Advance Directives (110815L4)	

Learning Topic	Hours	Relevant UoCs in Specification of Competency Standards	Remark
• Knowledge related to death education, including making a will, inheritance, posthumous arrangements, views of life and death in different cultures and religions, relevant legislation and legal procedures, etc. • Relevant community resources and procedures for using them • The content of the default directive and its effect • Following the advance directives, clearly explain them to family members and employees, and implement the appropriate arrangements			
(7) Introduction to information technology in the area of residential care as well as community care and support services			
• Basic knowledge of information technology and its application in residential care as well as community care and support services	3		Supplementary materials in addition to those in the specified UoCs will be required.
• Execute electronic health record projects • Identifying potential health issues of service users by analysing electronic health record data and compiling reports for health management follow-up	5	Execute Electronic Health Record Projects (110935L4)	
(8) Personal and professional attribute			
• Knowledge of self, environment, stress management, duties and responsibilities, and adaptability to change	1		Supplementary materials in addition to those in the specified UoCs will be required.
• Knowledge of professional development and lifelong development, knowledge of professional organisations and strategies for professional development	1		Supplementary materials in addition to those in the specified UoCs will be required.
(9) Teamwork			
• Basic principles of guidance and coaching • Supervisory and managerial competence	5		Supplementary materials in addition to those in the specified UoCs will be required.
• Range of clinical care training, e.g. infection control, distribution and provision of medications • Preparation for clinical care worker training scheme, including: concrete training content, training mode • Indicators for assessing the effectiveness of staff training	15	Provide Training to Clinical Care Workers (106220L4)	
Total classroom contact hours (including lecture, demonstration, skill practice, and assessment)	**480**		

All of the above UoCs should include corresponding skill practices, requiring trainees to apply their knowledge in simulated training and clinical environments, and to assess their skill applications.

(H) Practicum

Since trainees already have at least three years of experience working in residential care homes, the practicum should focus on the tasks performed by nurses in these settings (e.g. intramuscular injections, insertion or replacement of indwelling urethral catheters and nasogastric tubes).

Practice Content	**Hours**
Under the supervision and guidance of a registered nurse (with a supervisor-to-trainee ratio of 1:6), complete a 15-day practicum in a nursing home or a care and attention home	120
Under the supervision and guidance of a registered nurse (with a supervisor-to-trainee ratio of 1:6), complete a 15-day practicum in a high care level home for persons with disabilities	120
Under the supervision and guidance of a registered nurse (with a supervisor-to-trainee ratio of 1:6), complete a 5-day practicum in an elderly care/rehabilitation welfare service unit	40
Total practicum hours	**280**

(I) Assessment Methods and Criteria

Written Assessment	Quiz (40%) Examination (60%)	Each trainee is allowed one opportunity to retake the examination
Practical Assessment	Practical examination at a RCHE (10%) Practical examination at a RCHD (10%) Practical examination at an elderly care/rehabilitation welfare service unit (10%) Practical examination at classroom (70%)	Each trainee is allowed one opportunity to retake the examination

Mapping of the Learning Topics for the Training Course for "Health&Care Practitioners" with the "Enrolled Nurse (General) Training Programme" offered by the Hospital Authority

Functional Area			Level	UoC Title	Code	Credit	Cluster of UoCs and Code	Matching with the "EN (General) Training Programme" offered by the HA
Clinical Care	Basic Health Care		4	1. Monitor the Personal Basic Care Plan	106006L4	5		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care		4	2. Educate elderlies on the Self-management of Chronic Diseases	106012L4	5	Chronic Disease Care Psychological Support and Follow-up for Chronic Diseases ECCC401A	2: Provision of Care Introduction to Specialty Nursing Gerontological nursing
Clinical Care	Special Needs Care		4	3. Provide Training to Clinical Care Workers	106220L4	6		4: Teamwork Basic Principles of Coaching and Mentoring
Clinical Care	Emergency Care							
Management	Operations Management							
Clinical Care	Special Needs Care		4	4. Apply Non-pharmaceutical Treatments to Relieve Symptoms other than Pain	106222L4	6	End-of-life Care Palliative care ECEL402A	1: Professional, Legal and Ethical Nursing Practice Communication Introduction to concepts of communication and counselling, interpersonal relationship and team work
Psychosocial and Spiritual Care	End-of-life Care							
Clinical Care	Special Needs Care		4	5. Provide Palliative Care	106223L4	6	End-of-life Care Palliative Care ECEL402A	1: Professional, Legal and Ethical Nursing Practice Communication Introduction to concepts of communication and counselling, interpersonal relationship and team work
Psychosocial and Spiritual Care	End-of-life Care							
Clinical Care	Special Needs Care		4	6. Provide Psychological Support to Mentally Impaired Patients	106224L4	3		2: Provision of Care Introduction to Specialty Nursing Mental health nursing
Psychosocial and Spiritual Care	Psychosocial and Spiritual Well-being							
Clinical Care	Special Needs Care	Infection Control	4	7. Understand and Implement the Immunization Measures	106023L4	6		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Medicine Treatment	4	8. Perform Subcutaneous Injection	106033L4	3		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Medicine Treatment	4	9. Perform Intramuscular Injection	106034L4	3		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Medicine Treatment	5	10. Manage Storage of Medicines	106035L5	9		2: Provision of Care Basic Understanding of Biological, and Integrated Life Sciences Pharmacology
Clinical Care	Special Needs Care	Respiratory System	4	11. Perform Tracheostomy Suction	106044L4	3		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Urinary System	4	12. Replace Urinary Catheter (through the urethra into the bladder)	106050L4	6		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body

Functional Area			Level	UoC Title	Code	Credit	Cluster of UoCs and Code	Matching with the "EN (General) Training Programme" offered by the HA
Clinical Care	Special Needs Care	Urinary System	4	13. Perform Peritoneal Dialysis Care	106051L4	6		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Skin and Musculoskeletal System	5	14. Perform Complicated Wounds Care	106056L5	6		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Special Needs Care	Nervous System	4	15. Design a Suitable Living Environment for Psychiatric	106060L4	3		2: Provision of Care Introduction to Specialty Nursing Mental health nursing
Clinical Care	Special Needs Care	Digestive System	4	16. Replace Nasogastric Tube	106067L4	6		2: Provision of Care Principles and Practice of Nursing Assisting in the care of clients with alteration in various body
Clinical Care	Emergency Care		3	17. Perform Cardiopulmonary Resuscitation	106071L3	1		2: Provision of Care Principles and Practice of Nursing First aid and emergency nursing
Clinical Care	Emergency Care		3	18. Perform Automated External Heart Defibrillation	106079L3	1		2: Provision of Care Principles and Practice of Nursing First aid and emergency nursing
Clinical Care	Emergency Care		4	19. Acute Stroke Management	106081L4	2		2: Provision of Care Principles and Practice of Nursing First aid and emergency nursing
Clinical Care	Emergency Care		4	20. Traumatic Bleeding Management	106082L4	1		2: Provision of Care Principles and Practice of Nursing First aid and emergency nursing
Clinical Care	Emergency Care		5	21. Monitor the Quality of Emergency Care	106083L5	6		2: Provision of Care Basic Knowledge Quality assurance
Clinical Care	Rehabilitation Care		4	22. Assess the Activities of Daily Living (ADLs)	106104L4	3		2: Provision of Care Principles and Practice of Nursing Basic nursing care
Clinical Care	Rehabilitation Care		4	23. Conduct Preliminary Cognitive Assessment	106105L4	3		2: Provision of Care Principles and Practice of Nursing Basic nursing care
Clinical Care	Rehabilitation Care		4	24. Plan Elderly Group Activities	106219L4	9		2: Provision of Care Introduction to Specialty Nursing Mental health nursing
Psychosocial and Spiritual Care	Psychosocial and Spiritual Well-being							
Psychosocial and Spiritual Care	Daily Care and Leisure Activities							
Clinical Care	Rehabilitation Care		4	25. Provide Non-pharmacological Pain Management	106221L4	6	End-of-life Care Palliative Care ECEL402A	1: Professional, Legal and Ethical Nursing Practice Communication Introduction to concepts of communication and counselling, interpersonal relationship and team work
Psychosocial and Spiritual Care	End-of-life Care							
Clinical Care	Rehabilitation Care		5	26. Monitor the Quality of Rehabilitative Care	106106L5	5		2: Provision of Care Basic Knowledge Quality assurance
Psychosocial and Spiritual Care	Psychosocial and Spiritual Well-being		4	27. Design Care Plans for Psychological/Spiritual Well-being	106117L4	6		2: Provision of Care Introduction to Specialty Nursing Mental health nursing
Psychosocial and Spiritual Care	End-of-life Care		4	28. Execute and Cooperate with the Elderly's Advance Directives (New Version)	110815L4	3	End-of-life Care End-of-life Care ECEL403A	1: Professional, Legal and Ethical Nursing Practice Communication Introduction to concepts of communication and counselling, interpersonal relationship and team work
Psychosocial and Spiritual Care	End-of-life Care		5	29. Provide Life-Death Education to Elderlies	106128L5	3		1: Professional, Legal and Ethical Nursing Practice Communication Introduction to concepts of communication and counselling, interpersonal relationship and team work
Management	Operations Management		4	30. Establish Duty Rosters (New Version)	110837L4	3	Operations Management Daily Management	4: Teamwork Basic Principles of Team Building

Functional Area			Level	UoC Title	Code	Credit	Cluster of UoCs and Code	Matching with the "EN (General) Training Programme" offered by the HA
							ECOM401B	
Management	Operations Management		4	31. Supervise Occupational Safety and Health	106161L4	6		2: Provision of Care Basic Knowledge Occupational safety and health practice
Management	Operations Management		4	32. Handle Staff Accidents or Injuries	106162L4	6	Operations Management Accident Handling ECOM402A	2: Provision of Care Basic Knowledge Incidents reporting
Management	Operations Management		4	33. Prevent General Accidents	106163L4	6	Operations Management Accident Handling ECOM402A	2: Provision of Care Basic Knowledge Incidents reporting
Management	Operations Management		5	34. Apply Ordinances and Codes of Practice	106164L5	6		1: Professional, Legal and Ethical Nursing Practice Legal and Ethical Professional conduct and nursing ethics
Management	Operations Management		5	35. Formulate guidelines for frontline staff to implement Infection Control and Monitor Such Implementation	106169L5	9		2: Provision of Care Principles and Practice of Nursing Infection Control
Management	Operations Management		5	36. Manage Risks	106184L5	9		2: Provision of Care Basic Knowledge Risk identification
Management	Quality Management		4	37. Handle Complaints from Service Users	106188L4	3	Quality Management Providing Quality Customer Service ECOM301A	2: Provision of Care Basic Knowledge Quality assurance
Management	Case Management		4	38. Implement Case Management	106198L4	2		2: Provision of Care
Clinical Care	Chronic Illness Care		4	39. Follow-up on the Health Conditions of Elderly Persons with Chronic Diseases (New)	110802L4	3	Chronic Illness Care Psychological Support and Follow-up for Chronic Diseases ECCC401A	2: Provision of Care Introduction to Specialty Nursing Gerontological nursing
Clinical Care	Special Needs Care		4	40. Provide Psychological Support for Patients with Chronic Diseases and their Carers (New)	110906L4	6	Chronic Illness Care Psychological Support and Follow-up for Chronic Diseases ECCC401A	2: Provision of Care Introduction to Specialty Nursing Gerontological nursing
Clinical Care	Chronic Illness Care							
Clinical Care	Special Needs Care		5	41. Refer the Elderly Persons in Need to Specialist Care Assessments	110907L5	1		2: Provision of Care Introduction to Specialty Nursing Public health and community nursing
Clinical Care	Cognitive and Mental Health Care							
Management	Case Management							
Clinical Care	Emergency Care		4	42. Manage Mentally Unstable Cases (New)	110910L4	3	Risk Management Special Incident Handling ECRM401A	2: Provision of Care Basic Knowledge Risk identification
Clinical Care	Cognitive and Mental Health Care							
Management	Risk Management							
Management	Operations Management		4	43. Execute Electronic Health Record Projects	110935L4	2		2: Provision of Care Introduction to Information Technology in Health Care Application of IT in nursing and health care
Gerontechnology	Technologies for Community Support and							

Functional Area			Level	UoC Title	Code	Credit	Cluster of UoCs and Code	Matching with the "EN (General) Training Programme" offered by the HA
	Health Monitoring							
Psychosocial and Spiritual Care	Psychosocial and Spiritual Well-being			44. Assess Suspected Abuse Cases	106120L4	6		2: Provision of Care Introduction to Specialty Nursing Mental health nursing

The syllabus of the aforementioned Training Course for "Health&Care Practitioners" comprises 2 UoCs at QF Level 3, 33 UoCs at QF Level 4, and 9 UoCs at QF Level 5, totalling 44 UoCs. To address the needs for clinical care skills, the course will also include corresponding practicum in residential care homes.

In addition to the UoCs identified above, the following learning topics should also be included in the Training Course for "Health&Care Practitioners":

- Introduction to Information Technology in Residential Care Services: Basic understanding on information technology, Application of IT in residential care services
- Personal Attributes: Knowledge of self, environment, stress coping, responsibility and accountability, and adaptation to change
- Professional Attributes: Knowledge of professional development and lifelong learning, knowledge of professional organisations and strategies in achieving professionalism, and fundamental principles on evidence-based practice and nursing research
- Teamwork：Basic principles of coaching and mentoring, supervisory and management skills
- Special Needs of Persons with Disabilities: Understanding common types of disabilities and their physical and psychological needs, as well as specialised nursing knowledge and care skills for persons with physical disabilities, mental disabilities, mental illness, etc.

● End ●

Course Content and Related Requirements for "Certificate in Progression Training for Care Workers"

(A) Introduction

The "Certificate in Progression Training for Care Workers" is a bridging course for Health Workers, providing a career progression path for Care Workers who wish to serve and develop in residential care homes (RCHs) for the elderly (RCHEs) or RCHs for persons with disabilities (RCHDs). Successful completion of this course is eligible to apply for "Health Worker Training Course" approved by the Director of Social Welfare to meet the development needs of vocational qualification advancement in the residential care service industry.

(B) Entry Requirements

Trainees are required to have completed the local Secondary 3 curriculum and possess at least three years of working experience in RCHEs or RCHDs. They must submit original copies of their academic qualifications as proof. Training institutions must ensure that trainees meet the minimum entry requirements, otherwise the Social Welfare Department reserves the right to refuse to process registration applications for individuals.

(C) QF Level

Level 2

(D) Course Accreditation

Any training institution offering the "Certificate in Progression Training for Care Workers" must obtain course accreditation from the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (unless the institution has self-accrediting status) to demonstrate compliance with Qualifications Framework (QF) Level 2 requirements. Only then can the Training Course be considered for approval by the Social Welfare Department (SWD) as a recognised course.

(E) Course Content

"Certificate in Progression Training for Care Workers" consists of Chinese, English, Numeracy, Information Technology, basic knowledge of medications and communication skills.

(F) Units of Competency (UoCs) and Contact Hours

Scope	Existing Course		Recommended Adjustments	
	Hours	Relevant UoCs in Specification of Competency Standards	Hours	Relevant UoCs in Specification of Competency Standards
Specification of Generic (Foundation) Competencies: Chinese	35	能聽懂熟悉話題的對話 [GCCH201A(C)] 能就熟悉的話題進行報告 [GCCH206A(C)] 能讀懂熟悉情境中的指示說明材料 [GCCH208A] 能在熟悉情境中寫作事務紀實文書 [GCCH210A]	25	Remain Unchanged
Specification of Generic (Foundation) Competencies: English	35	Handle predictable information, ideas and related explanations in oral interactions (Listening and speaking) [GCEN203A] Understand predictable written information, ideas, related explanations, discussion/argument, and evaluation (Reading) [GCEN205A] Handle predictable information, ideas and related explanations in written correspondence (Reading and writing) [GCEN206A]	25	Remain Unchanged

Scope	Existing Course		Recommended Adjustments	
	Hours	**Relevant UoCs in Specification of Competency Standards**	**Hours**	**Relevant UoCs in Specification of Competency Standards**
Specification of Generic (Foundation) Competencies: Numeracy	28	Calculate with numbers expressed in various forms [GCNU201A] Calculate percentages and percentage changes [GCNU203A] Construct and use statistical graphs [GCNU211A] Calculate means, medians, modes and ranges of grouped and ungrouped data [GCNU212A]	Remain Unchanged	Remain Unchanged
Specification of Generic (Foundation) Competencies: Information Technology	28	Produce word processing documents by following instructions [GCIT208A] Produce spreadsheets by following instructions [GCIT209A] Produce presentations by following instructions [GCIT210A] Exchange information using emails [GCIT213A]	Remain Unchanged	Remain Unchanged
Specification of Competency Standards for Elderly Care Service Industry	24	Knowing Basic Knowledge of Medications [111499L2] Master Communication Skills with Elderlies [106214L2] Master Communication Skills with the Families of the Elderlies [106215L2]	44	Additional UoCs: Comply with Guidelines to Prevent Elderly Abuse [106114L2] Assist Elderlies to Perform Muscles Training [106087L2] Help Elderlies Use Assistive Devices [106208L2]
Total contact hours of the course	**150**		**150**	

Note: Through the above adjustments, trainees can not only deepen their understanding of the existing units of competency (UoCs), particularly the basic knowledge of medications, but also master the prevention of elder abuse and how to assist elderly persons in using assistive devices. Even with limited understanding of the Chinese or English manuals, they can learn the correct usage techniques through the demonstration and guidance of the instructors, ensuring they can skilfully assist the elderly in receiving training and using assistive devices in the future.