Social Welfare Department

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

Executive Summary

30 December 2024

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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, including nurses, health workers (HWs), care workers (CWs) and various types of therapists or visiting professionals. 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 for 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, etc, 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.

Literature Research on the International Situation

2. Internationally, long-term care (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. Ensuring the quality of LTC services in RCHs is a common topic for international research. After years of research, the number of care hours provided to residents is a key indicator to ensure service quality. The average daily care hours per resident in Australia, the United States, and New Zealand range from 2.00 hours to 3.58 hours.

3. In terms of career development for RCH staff, practices vary across countries due to differences in cultural backgrounds, social needs, and policy support. More than two-thirds of member countries of the Organisation for Economic Co-operation and Development (OECD) do not have specific academic requirements for the education and training of personal care workers. On the other hand, in more than three-quarters of OECD member countries have diverse training requirements for individuals working as nurses.

Overview of the Local Industry

4. 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. The entire sector employed more than 44 000 RCH staff.

5. The Residential Care Homes (Elderly Persons) Regulation (Cap. 459 sub. leg. A) and the Residential Care Homes (Persons with Disabilities) Regulation (Cap. 613 sub. leg. A) (the Regulations) 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.

6. To strengthen the monitoring 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. With regard to the key healthcare professionals in RCHs, the SWD is responsible for the registration and regulation of HWs, while the Nursing Council of Hong Kong, the Physiotherapists Board, and the Occupational Therapists Board are responsible for regulating relevant professionals. The main provisions of the Amendment Ordinance introducing a registration system for home managers (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.

7. To enhance the competence of RCH staff, the 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 RCHEs and RCHDs to enrol in Qualifications Framework (QF)-based training courses.

8. To alleviate the workforce shortage, the SWD has fully sponsored the tuition fees of the “Enrolled Nurse (General) Training Programme for the Welfare Sector” since 2006. Currently, the sponsored trainees must undertake to work for the welfare service

units for at least three years. The SWD has implemented a Training Sponsorship Scheme since 2012 to provide funding support for non-governmental organisations (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.

9. The RCH sector has been facing a challenge due to a shortage of professional healthcare staff. Some graduates of the "Enrolled Nurse (General) Training Programme for the Welfare Sector", after spending some time in the welfare sector, have switched to the medical sector for reasons related to personal career development and job nature. Consequently, the welfare sector has found it difficult to establish its own pool of care professionals to continue serving in the sector. 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 job posts unattractive to new entrants (particularly young people). Additionally, the absence of a clear career progression path for HWs in RCHs complicates the sector's ability to retain ambitious and capable talent. According to current estimates, the industry will need to recruit over 2 300 nurses in the next five years to meet the demand for the existing RCHs to comply with the statutory staffing requirements under the Amendment Ordinance, to address the manpower needs for new RCHs and to replenish staff vacancies and attrition.

Results of Data Collection and Analysis on Residential Care Services

10. Between late November 2023 and March 2024, the Consultant sampled 30 RCHEs and 22 RCHDs for fieldwork based on the type, nature, scale of the RCHs, etc. The aim of the fieldwork was to understand the RCH operations, the skills required for various job posts, the workload and distribution of working hours across different job posts, the frequency of health services needed by residents, and the average time and number of staff required for each service. Based on the reply forms and time logs returned from RCHs, the Consultant compiled the statistics on the content and hours of healthcare services provided by various staff, including the job posts that could serve as international benchmarks (i.e. Registered Nurses (RNs), ENs, HWs, and CWs) and other job posts (e.g. social workers, therapists, ancillary workers, etc.). 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.

11. The data analysis results for RCHEs are as follows:

(a) For the sample of 5 Nursing Homes, the average daily care hours 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 care hours provided by other job posts were 1.11 hours, resulting in a total of 4.40 hours.

(b) For the sample of 25 Care-and-Attention Homes and Aged Homes, the

average daily care hours from benchmark job posts 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 care hours provided by other job posts were 1.17 hours, resulting in a total of 3.81 hours.

12. The data analysis results for RCHDs are as follows:

(a) For the sample of 11 high care level homes, the average daily care hours from benchmark job posts were 2.39 hours, including 0.10 hours from RNs, 0.25 hours from ENs, and 2.03 hours from HWs and CWs. The average care hours provided by other job posts were 2.03 hours, resulting in a total of 4.42 hours.

(b) 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. After making the aforesaid adjustments, for the sample of 7 medium-care level homes, the average daily care hours from benchmark job posts were 1.34 hours, including 0.02 hours from RNs, 0.13 hours from ENs, and 1.19 hours from HWs and CWs. The average care hours provided by other job posts were 1.24 hours, resulting in a total of 2.58 hours.

(c) Given that residents of low care level homes typically attend school, training, or work outside the home during the day, the Consultant estimated the average daily hours spent in the sampled homes. After making the said adjustments, for the sample of 4 low care level homes, the average daily care hours from benchmark job posts were 0.39 hours as provided by HWs and CWs. The average number of care hours provided by other job posts were 1.81 hours, resulting in a total of 2.20 hours.

13. In terms of the work content of various job posts, the data revealed that the work of ENs and HWs in RCHs was quite similar. In RCHEs, among the 21 items of care and health services being examined, over three-quarters of ENs' and HWs' tasks overlap, with HWs handling more personal care tasks. In areas such as "drug management" and "special nursing care procedures", the hours worked by ENs and HWs are comparable. The non-overlapping tasks include HWs being responsible for the use of restraint(s) and leading group activities, while ENs assist residents in the use of urinary catheters, performing tracheostomy suction and change of stoma bags. In RCHDs, among the 20 items of care and health services being examined, 90% of the work content of ENs and HWs overlapped, with the exception that only HWs are responsible for performing peritoneal dialysis and leading group activities.

Stakeholder Opinions

14. To collect views and suggestions from stakeholders, the Consultant conducted a

total of four workshop(s)/forum(s)/partnership team meeting(s) and 12 focus group discussions. Interviews were held with Legislative Council members, medical officers who provide outreach services to RCHs, nursing academic representatives, RCH operators, RCH staff in different job posts, etc. The Consultant directly engaged with more than 340 stakeholders to discuss topics including career development and training needs of RCH staff, the healthcare service needs of residents, the roles and responsibilities of the new rank, the content, practicality, and feasibility of the training course for the new rank, and factors influencing staff recruitment and retention in RCHs. The opinions collected by the Consultant mainly include:

(a) Regarding career development, most 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, the career progression path for RCH staff is largely hindered by limited job posts, staff usually need to wait for promotion subject to the availability of vacancy at the senior level. Promotion opportunities for HWs are more limited. 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 further education due to the manpower shortage in RCH. As a result, their career development is adversely affected.

(b) In addition, maintaining professional standards and providing adequate training for RCH staff are crucial. Most participants emphasised that HMs need to enhance their comprehensive capabilities in areas such as human resource management, cross-disciplinary coordination, crisis management, innovative thinking financial management, etc. For RNs/ENs, there is a need to strengthen skills in end-of-life care, collaboration among RCHs, hospitals and families, communication skills, organisational cultural awareness, etc. The training for HWs should cover specialised nursing knowledge as well as communication and collaboration skills. As for CWs and other frontline staff, in addition to basic first aid, occupational safety and health, and fostering a people-centred culture, they should also receive training to enhance their understanding of the significance of their work and develop the capability to manage work-related stress. Overall, all job posts require comprehensive enhancement to their professional skills and soft skills such as communication and collaboration skills as well as innovative thinking.

(c) Regarding the establishment of a new professional rank, most participants agreed that it would provide a progression path for HWs. After receiving proper training and qualification certification, their professional roles would be more clearly defined, fostering career development, enhancing job satisfaction, and aiding in talent retention. Stakeholders reflected that HWs currently undertake certain responsibilities, such as drug management and special nursing care procedures, etc. With proper training and assessment, they could further take on the tasks currently performed by ENs in RCHs.

The training content must be properly designed, including academic entry requirements, curriculum, and assessment standards, etc., to ensure the quality of the new professional rank.

15. To gather broader opinions, the Consultant invited RCH staff across Hong Kong, instructors and trainees of the "Enrolled Nurse (General) Training Programme for the Welfare Sector", representatives from training institutions (TIs), and other stakeholders to participate in a questionnaire survey. The Consultant successfully collected 1 257 valid questionnaire responses from RCH staff and 99 from non-RCH staff, mainly including 297 HWs, 290 HMs/wardens, 159 CWs, and 41 trainees of the "Enrolled Nurse (General) Training Programme for the Welfare Sector".

(a) Regarding the establishment of a new professional rank, the majority of respondents (83.85% of RCH staff and 84.85% of non-RCH staff) indicated that staff of this rank must have Secondary 5 or equivalent qualification (the same academic requirements as for the EN course). Most respondents (87.67% of RCH staff and 54.55% of non-RCH staff) also considered that staff of the new professional rank must have relevant work experience in RCHs.

(b) On training content, 80.99% of the RCH staff respondents expected the curriculum to cover "clinical care nursing", while 55.53% expected it to include "psychological, social, and spiritual services" to equip staff of the new rank to meet various job needs.

(c) More than half of the nurse respondents believed that when proper training was incorporated in the curriculum, staff of the new rank would 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%).

(d) Regarding the relationship between the new rank and existing HWs, over 40% of both RCH staff and non-RCH staff respondents considered that whether there was a subordinate relationship between the two should be flexibly arranged according to the actual situation of individual RCHs.

(e) Regarding the job title of the new professional rank, the three options most supported by respondents were "Health Officer", "Healthcare Practitioner", and "Health Practitioner". Among these, "Health Officer" better highlights the leading role in the field of health services, while "Healthcare Practitioner" and "Health Practitioner" emphasise their nursing professional background and the nature of their practical work.

(f) Regarding whether existing CWs with less than Secondary 3 education should be allowed to pursue the "Certificate in Progression Training for Care Workers" and subsequently enrol in the "Health Worker Training Course" for promotion after completion, the majority of respondents (79.71% of RCH staff and 84.85% of non-RCH staff) considered that the current academic requirements for the "Certificate in Progression Training for Care Workers" should be maintained.

(g) For talent attraction and retention, "providing career development and promotion opportunities" was seen as the most important, with more than 70% of respondents across all professional fields agreeing that it has been effective. Besides, they all regarded "enhancing professional training and continuing education" as the most effective way to promote professionalism within the residential care service industry.

(h) 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%). More than half of the trainee respondents considered that, with proper training and assessment, staff of the new professional rank would be able to perform most of the professional nursing duties listed (except for performing tracheostomy suction and assisting residents with special care needs in rehabilitation exercises).

16. The Consultant also consulted relevant professional bodies, the Rehabilitation Advisory Committee and the Elderly Commission on the preliminary recommendations. 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 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.

Recommendations of the Consultancy Study

Recommendation 1: Establishment of the "Health&Care Practitioner" rank

17. 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 specialised care professionals. In view of the specific circumstances of various RCHs, these care procedures are mostly carried out by ENs and HWs, resulting in an overlap in responsibilities between the two posts. The Consultant recommends establishing a new professional rank to provide specialised 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.

18. 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. It can attract people who aspire to pursue a career in the welfare sector and offer promotion and career prospects for HWs, which is conducive to talent retention. 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.

19. Having regard to the views of multiple parties, the training content and the duties of the new rank, etc., the Consultant suggests designating the new rank as "Health&Care Practitioner (HCP)". The title reflects the fact that the job post covers both care and health duties with due emphasis on practice. After completion of training and registration, "HCPs" can work not only in RCHs, but also perform the care procedures required in elderly/rehabilitation welfare service units (such as day care centres for the elderly). As the working relationship between the new rank and other job posts, 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.

(a) Registration and renewal of "HCPs"

Any person who wishes to obtain the qualification of a registered "HCP" must have attended a designated training course approved in writing by the Director of Social Welfare (DSW). The validity period of "HCP" registration and renewal should not exceed five years. In the long run, the SWD may consider integrating the requirement of continuing education into the condition for renewing the registration of a "HCP".

(b) 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. 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. 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. 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.

(c) Training Course for "HCPs"

To ensure that "HCPs" possess the knowledge and competencies required for future care responsibilities, they must complete a training course designated by the DSW. The Consultant recommends that the training course for existing HWs seeking promotion to "HCPs" be titled "Professional Diploma".

At the initial stage of the establishment of the "HCPs", the Consultant recommends inviting serving registered HWs who have served in the position for no less than three years to undergo the training. Trainees are required to complete the recognised Training Course for "HCPs" and attain a Professional Diploma. The diploma concerned is pitched at QF Level 4 with a total of 760 learning hours (including 480 hours of face-to-face teaching and 280 hours of practicum), equivalent to 76 QF credits. The course comprises 2 units of competency (UoCs) at QF Level 3, 33 UoCs at QF Level 4, and 9 UoCs at QF Level 5. The entry requirements for the Training Course for "HCPs" are identical to those of the "EN (General) Training Programme", and in respect of the required healthcare work in the welfare service units, its assessment standards would also be the same as those of ENs. To ensure that "HCPs" are competent to perform the care duties in the future, the Training Course for "HCPs" must include the assessment

of relevant nursing skills (e.g. intramuscular injections, insertion or replacement of indwelling urethral catheters and nasogastric tubes) as core competency topics. Only those trainees who pass all assessments will be awarded a graduation certificate.

(d) Demand forecast for "HCPs"

The Consultant forecasts that the RCH sector will potentially need about 220 "HCPs" by 2029. 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.

Recommendation 2: Adjustment to the training content of the "Certificate in Progression Training for Care Workers"

20. The Consultant recommends maintaining the entry requirements of the "Certificate in Progression Training for Care Workers" (Certificate Training) and adjusting the training content to place greater emphasis on practical experience and operational competences, so as to attract and retain suitable talents and enhance the service quality of the RCHs. Currently, the total face-to-face course time of the Certificate Training is 150 hours, including 35 hours each for Chinese and English, and 28 hours each for Numeracy and Information Technology. The other 24 hours are for "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, the Consultant proposes to reduce the number of learning hours in language subjects with a corresponding increase in those training hours on vocational-related knowledge (e.g. the prevention of elder abuse, assisting elderly persons in using assistive devices). The proposal has been submitted to the QF Secretariat and the Hong Kong Council for Accreditation of Academic and Vocational Qualifications (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.

Recommendation 3: Amendments to the statutory staffing requirements

21. The consultancy study indicates that, according to the existing statutory staffing requirements of the Residential Care Homes (Elderly Persons) Regulation and the Residential Care Homes (Persons with Disabilities) Regulation, the staffing provision of RCHs can meet residents' care needs. The Consultant thus recommends introducing the new HCP rank into the relevant Regulations without altering the existing statutory

staffing requirements. In addition, the Consultant recommends that the basis of calculating statutory staffing requirement for nursing homes (NHs) be changed from the total number of beds as currently adopted to the number of residents in the future, so as to align with international practice and the statutory staffing requirements for RCHs of other levels of care in Hong Kong; and that the staffing requirement for HWs should also be clearly set out to reflect their important role in the NHs.

Recommendation 4: Staff recruitment and retention

22. The Consultant recommends that RCH operators attract and retain staff by enhancing career development and promotion opportunities, applying information technology and gerontechnology, encouraging RCH staff to undergo training, improving the work environment and culture, as well as establishing staff engagement and incentive mechanisms.

Conclusion

23. This consultancy study analysed the skill and qualification requirements for key RCH staff providing health and rehabilitation services. As Hong Kong will become one of the areas with the most ageing population in the world by 2050, it is essential to take prompt actions to alleviate the manpower shortage in the RCH sector, thus ensuring the quality of residential care services.