非癌症病患的臨終照護

新加坡經驗

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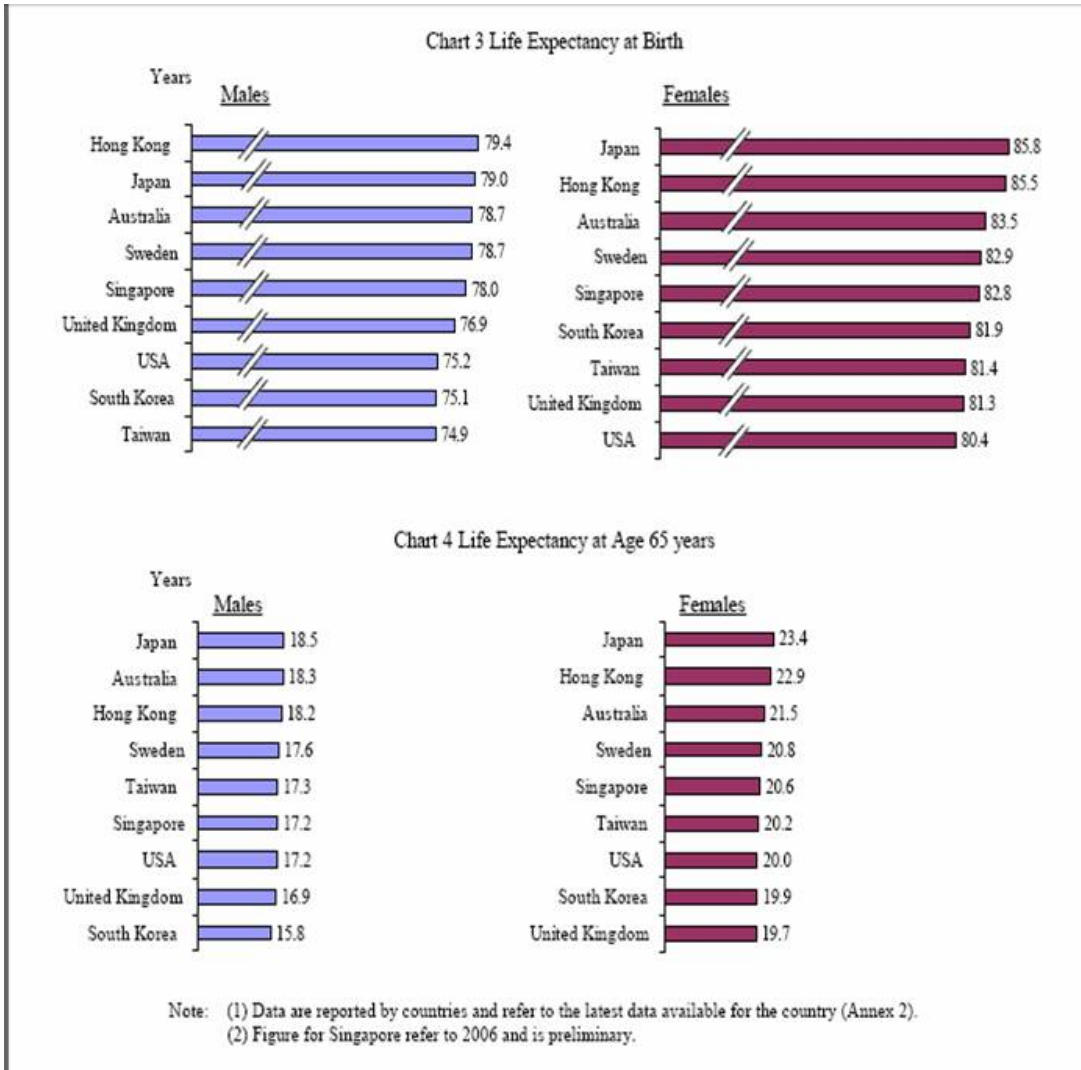
- 新加坡醫療體系總覽
- 新加坡安寧緩和照護簡史
- 慢性疾病末期病患需求
- 照顧非癌症病患面臨的挑戰
- 改善非癌症臨終照護措施

人口統計資料

- 國土面積: 710.2 平方公里
- 人口數: 484萬人 (2008)
- 65歲以上佔人口數: 8.7%
- 種族:　中國人　74.7%
  馬來人　13.6%
  印度人　8.9%
  其他　2.8%
- 平均醫師服務人口比例: 每1000人有1.2位醫師
- 平均護士服務人口比例: 每1000人有4.2位護士

新加坡人平均壽命

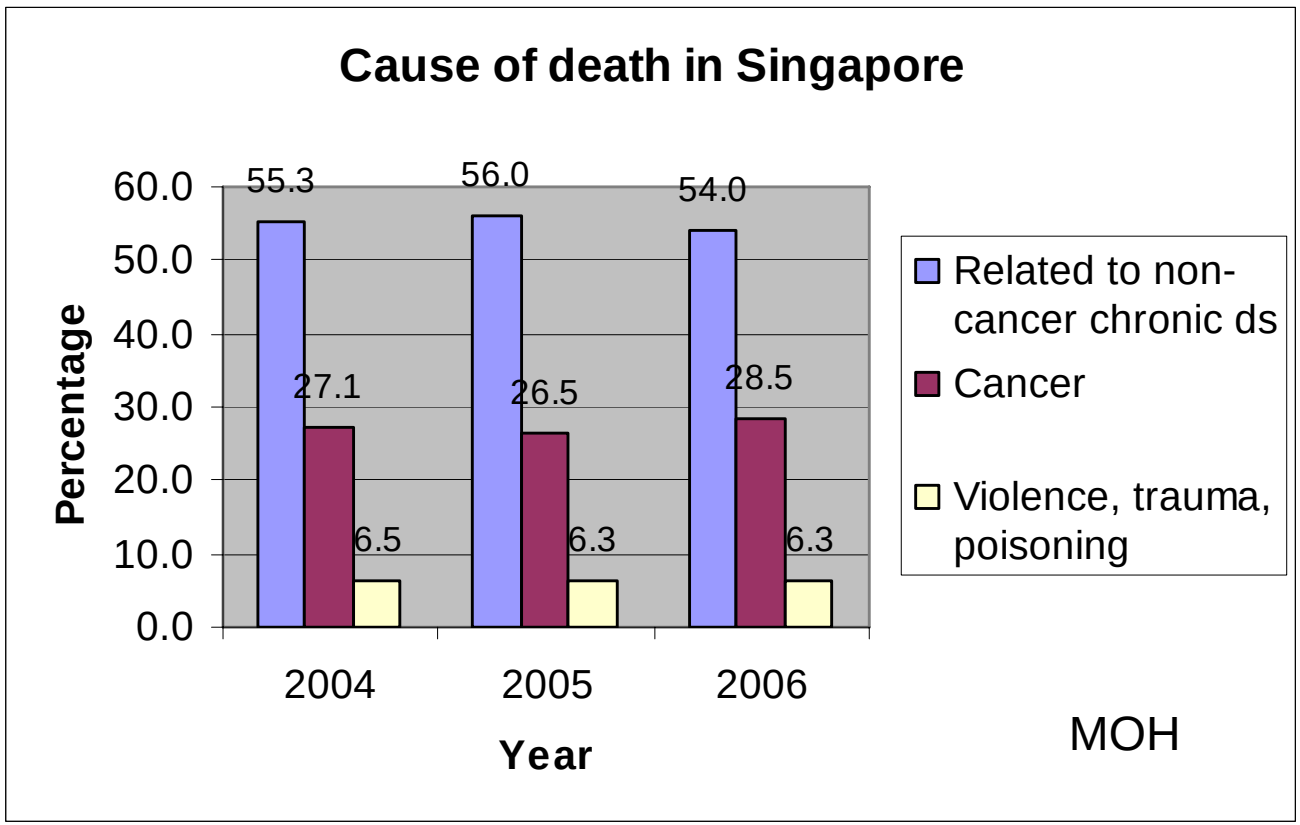
- 出生: 81.89歲
  - 男性: 79.29 歲
  - 女性: 84.68 歲



主要死因

Year		2006	2007	2008
Total no. of deaths		16,393	17,140	17,222
% of total deaths				
1	Cancer	28.5	27.7	29.3
2	IHD	18.5	19.8	20.1
3	Pneumonia	13.7	13.9	13.9
4	CVA	8.9	8.7	8.3
5	Accidents, violence and poisoning	6.3	6.0	5.8
6	Other heart diseases	4.3	4.3	4.0
7	DM	3.3	3.6	2.7
8	COPD	3.3	2.6	2.5
9	UTI	2.0	2.2	2.1
10	Nephritis, nephrotic sundrome and nephrosis	1.7	2.0	2.1

死於癌症 VS 非因癌症死亡



不只新加坡，在世界各地發生著...

May 20, 2008

Chronic diseases top causes of deaths globally

GENEVA - CHRONIC conditions such as heart disease and stroke, often associated with a Western lifestyle, have become the chief causes of death globally, the World Health Organisation (WHO) said on Tuesday.

The shift from infectious diseases including tuberculosis, HIV/Aids and malaria - traditionally the biggest killers - to noncommunicable diseases is set to continue to 2030, the UN agency said in a report.

'In more and more countries, the chief causes of deaths are noncommunicable diseases such as heart disease and stroke,' Ties Boerma, director of the WHO department of health statistics and informatics, said in a statement.

The annual report, World Health Statistics 2008, is based on data collected from the WHO's 193 member states.

It documents levels of mortality in children and adults, patterns of disease, and the prevalence of risk factors such as smoking and alcohol consumption.

'As populations age in middle- and low-income countries over the next 25 years, the proportion of deaths due to noncommunicable diseases will rise significantly,' it said.

By 2030, deaths due to cancer, cardiovascular diseases and traffic accidents will together account for about 30 per cent of all deaths, it said.

WHO Director-General Margaret Chan, in a speech to the WHO's annual assembly on Monday,

新加坡醫療體系

公立醫療體系在2000年改組為兩大群組:

- 東部： 新加坡醫療群(Singapore Health Services, SingHealth)
- 西部： 國立醫療群(National Healthcare Group, NHG)

各群組包括了基層醫療群, 區域醫院與醫學中心

各群組包括區域醫院如下:

國立醫療群NHG

- Alexandra Hospital (AH)
- National University Hospital (NUH)
- 陳篤生醫院(Tan Tock Seng Hospital,TTSH)

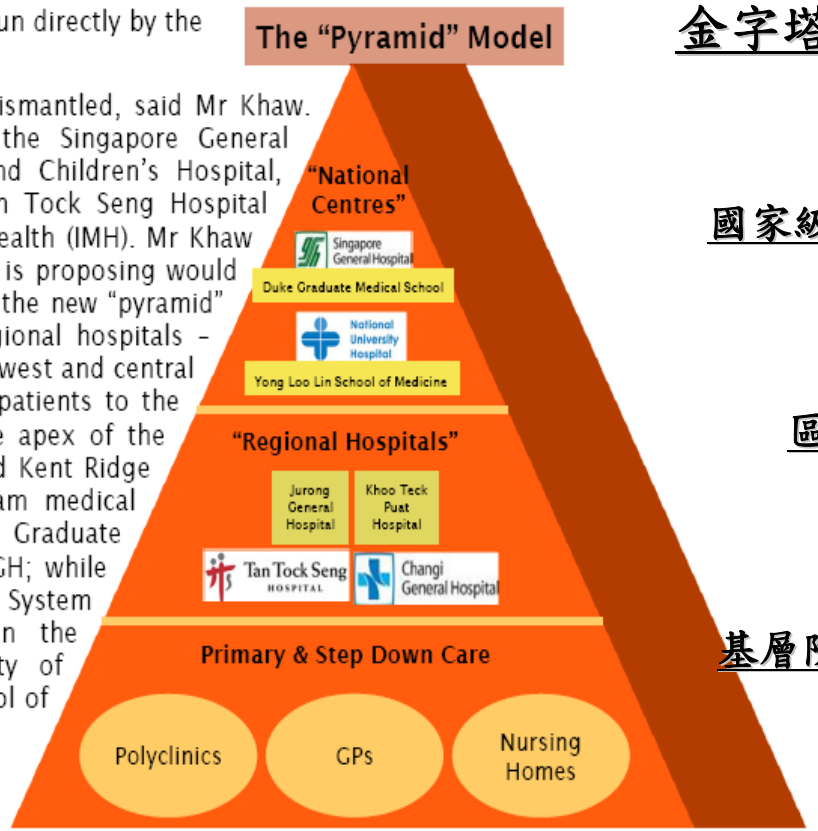
新加坡醫療群SingHealth

- Changi General Hospital (CGH)
- Singapore General Hospital (SGH)
- KK Women's & Children's Hospit

新加坡醫療體系

Health Services (SingHealth) and National Healthcare Group (NHG). Before that, they were run directly by the Ministry of Health (MOH).

The two clusters will not be dismantled, said Mr Khaw. SingHealth will focus on running the Singapore General Hospital (SGH) and KK Women's and Children's Hospital, while NHG will continue to run Tan Tock Seng Hospital (TTSH) and the Institute of Mental Health (IMH). Mr Khaw elaborated saying that the model he is proposing would be "a logical evolution". The base of the new "pyramid" model will be anchored by four regional hospitals – each serving the island's north, east, west and central zones. These hospitals would refer patients to the national centres – which occupy the apex of the pyramid – located at the Outram and Kent Ridge sites. SingHealth will run the Outram medical research campus, where the Duke Graduate Medical School is co-located with SGH; while the National University Health System (NUHS), the joint venture between the National University Hospital, Faculty of Dentistry and the Yong Loo Lin School of Medicine will operate at Kent Ridge.



金字塔模式

國家級醫學中心

區域醫院

基層院所與養護機

醫療照護花費

- 醫療支出: 國民所得4%
- 3M 架構: Medisave, Medishield and Medifund
- 基層醫療群, 區域醫院, 與國家級醫學中心經費主要來自衛生署, 病人需部份負擔
- 社區醫院、私立護理之家與安寧院等養護機構由非政府福利組織經營(voluntary welfare organizations, VWOs)

安寧緩和照護花費

- 居家式安寧院(Home hospice):
  - 入住免費
  - 需經評估決定(means-tested)
  -政府衡量經營狀況決定補助多少

- 安寧住院服務(Inpatient hospice):
  - 病人需部份負擔
  - 需經評估決定(means-testing)
  - Medisave保險有給付; 政府衡量經營狀況決定補助多少

政府僅補助安寧院花費一部分，其他需靠慈善募款

新加坡安寧緩和照護發展簡史

新加坡安寧緩和照護發展簡史

- 安寧緩和照護- 安寧緩和照護運動源自1985年
- 1985: 聖喬治之家(St Joseph's Home, 由天主教 Canossian 修女會經營, 主要照顧老人) 挪出16床照顧臨終病人
- 1987: 新加坡癌症協會裡一批志工組成安寧照護組, 募款成立安寧居家服務隊

新加坡安寧緩和照護發展簡史

- 1988: Franciscan聖母傳教士成立了Assisi 安寧院
- 1989: 前述安寧照護組志工發起成立安寧照護協會
- 1995: 安寧照護中心成立(包括了安寧住院服務Dover Park Hospice, 居家安寧組織Hospice Care Association, 與安寧日間照護)

新加坡安寧緩和照護發展簡史

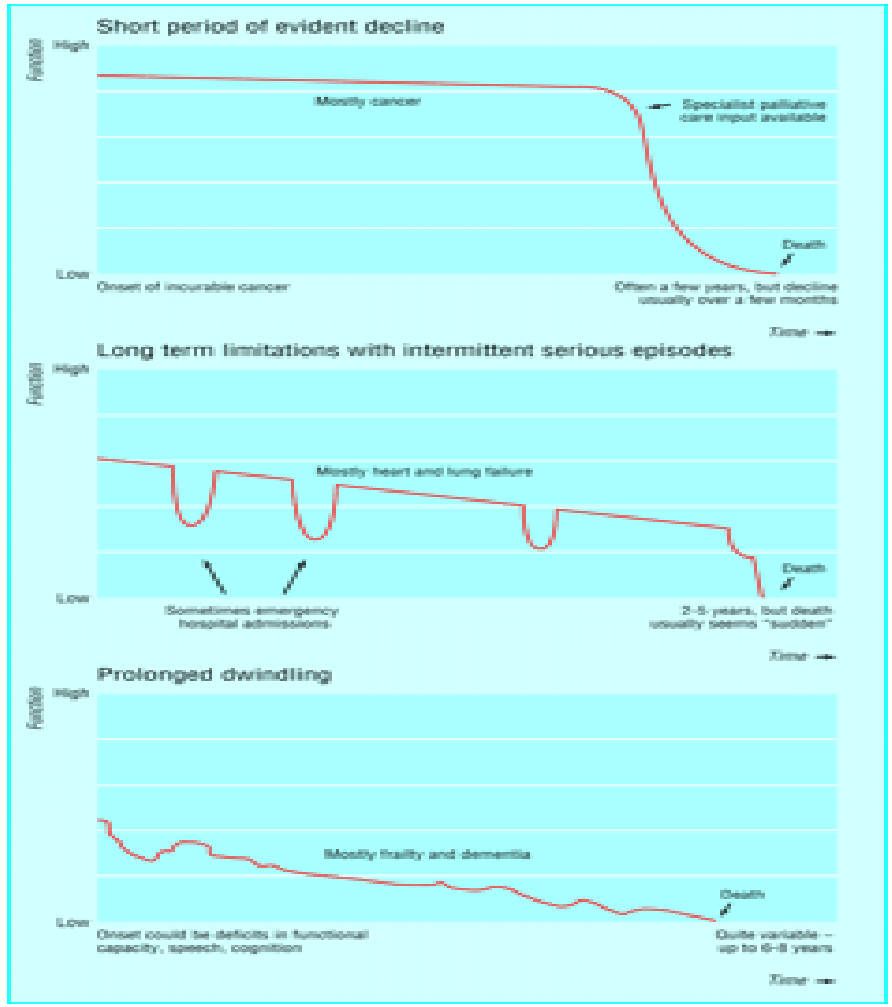
- 1995: 五個提供安寧緩和照護服務的慈善組織組成'新加坡安寧緩和照護協會' (Singapore Hospice Council)
- 現況:
  - 4 所提供安寧養護中心服務
  - 5 所提供安寧居家服務
  - 2 所提供安寧日間照護服務
  - 5 所提供安寧住院服務

慢性疾病末期病患需求

慢性病與癌症的不同?

- 非癌症病患數目超過癌症患者數
- 慢性病患者病程較長且變化不易預估
  -對於服務計劃的意義
  -對於照顧者的意義
- 即使在生命末期，積極照顧之下病人仍有可能恢復健康

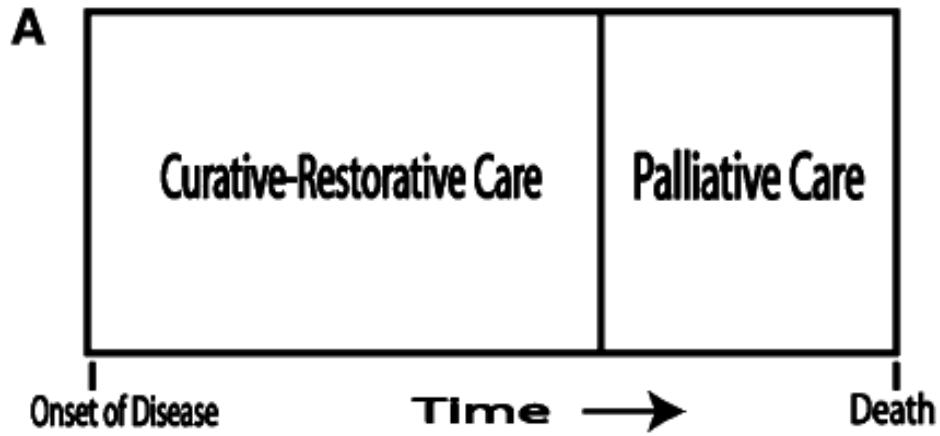
疾病病程軌跡



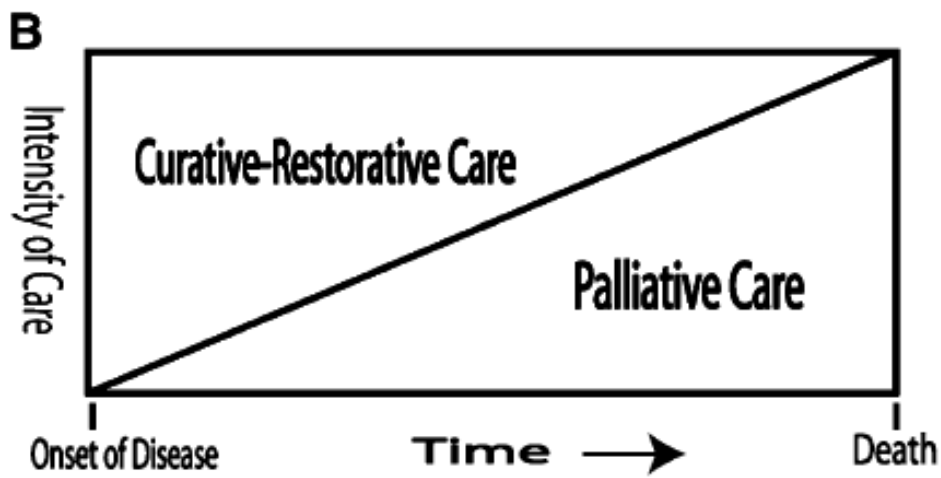
Lynn and Adamson 2003

安寧緩和照護模式

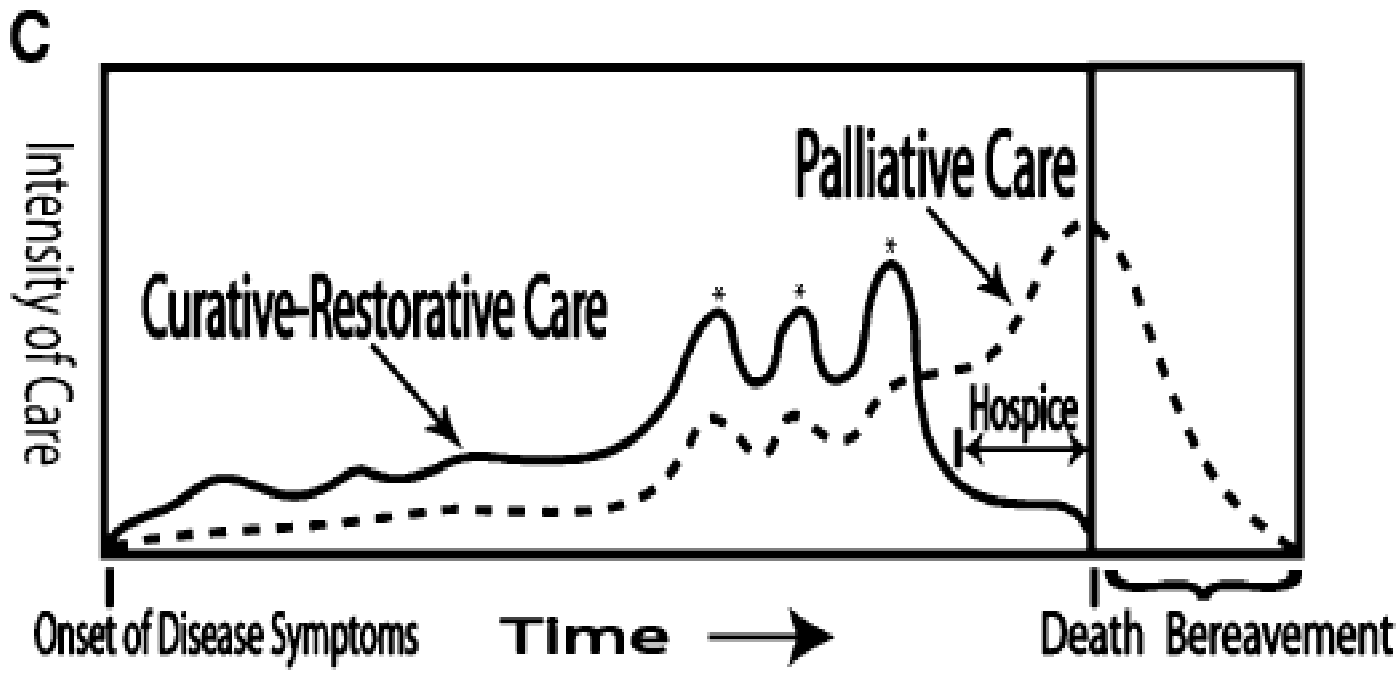
“Bad old days”



“Cancer Care model”



慢性病照護模式

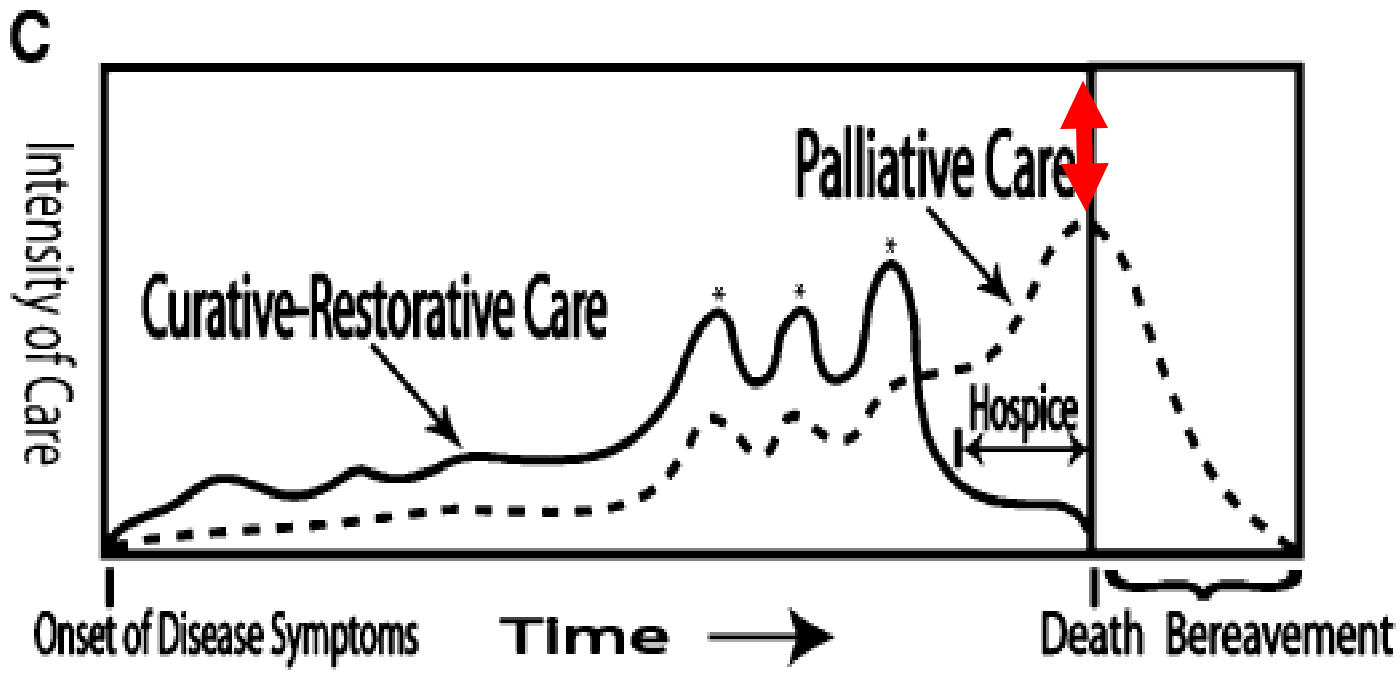

C
Intensity of Care
Palliative Care
Curative-Restorative Care
Hospice
Onset of Disease Symptoms
Time
Death
Bereavement

ATS正式宣言

- 不論病人病程處於哪個時期病人應該都能夠接受安寧緩和照護，且應該滿足個別病人與家屬的需求與喜好.

- 凡是負責照顧慢性、末期或是重症病患的臨床醫師都應該接受安寧緩和照護的基本訓練.

- 臨床上，如醫師碰到超越其安寧緩和照護能力所能應付的狀況時，應會診安寧緩和照護專科團隊


C
Intensity of Care
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Curative-Restorative Care
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Onset of Disease Symptoms
Time
Death
Bereavement

不是“慢性病照護”或“安寧緩和照護”

Heart Failure	COPD	ESRF
Ace-inhibitors Beta-blockers Loop diuretics Spironolactone Anti-platelet agents Statins	Steriods Bronchodilators Anticholinergics	Phosphate binders Calcium replacement Antihypertensive Diuretics

不是“慢性病照護”或“安寧緩和照護”

慢性病照護模式在下列狀況依然適用:

疾病全程:

- 體液平衡

病人自理功能尚可之時:

- 抗生素
- 貧血處理

將安寧緩和照護納入慢性病照護

- 討論疾病對病人自理功能影響與預後
- 評估病人生理、社會心理與靈性層面, 家庭與社區支持
- 設定目標, 隨病情調整照護目標, 納入預立醫療照護計劃
- 喪親家屬悲傷輔導

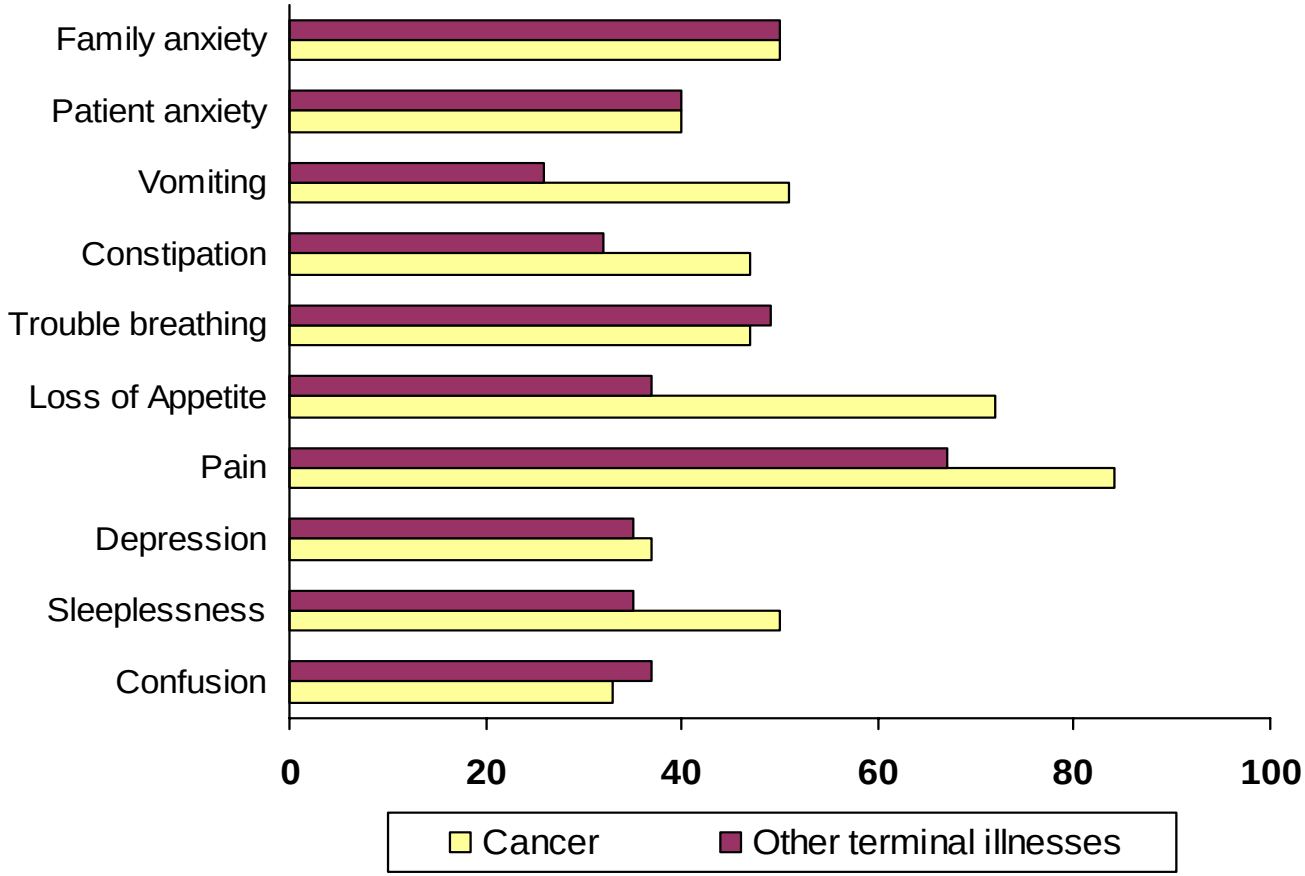
死於慢性病:症狀有何不同?

病人出現下列症狀的比例:

	Non-malignant disease	Cancer
Pain	67%	84%
Trouble breathing	49%	47%
Vomiting/nausea	27%	51%
Sleeplessness	36%	51%
Mental confusion	38%	33%
Depression	36%	38%
Loss of appetite	38%	71%
Constipation	32%	47%
Bedsores	14%	28%

Cartwright & Seale Study, 1991

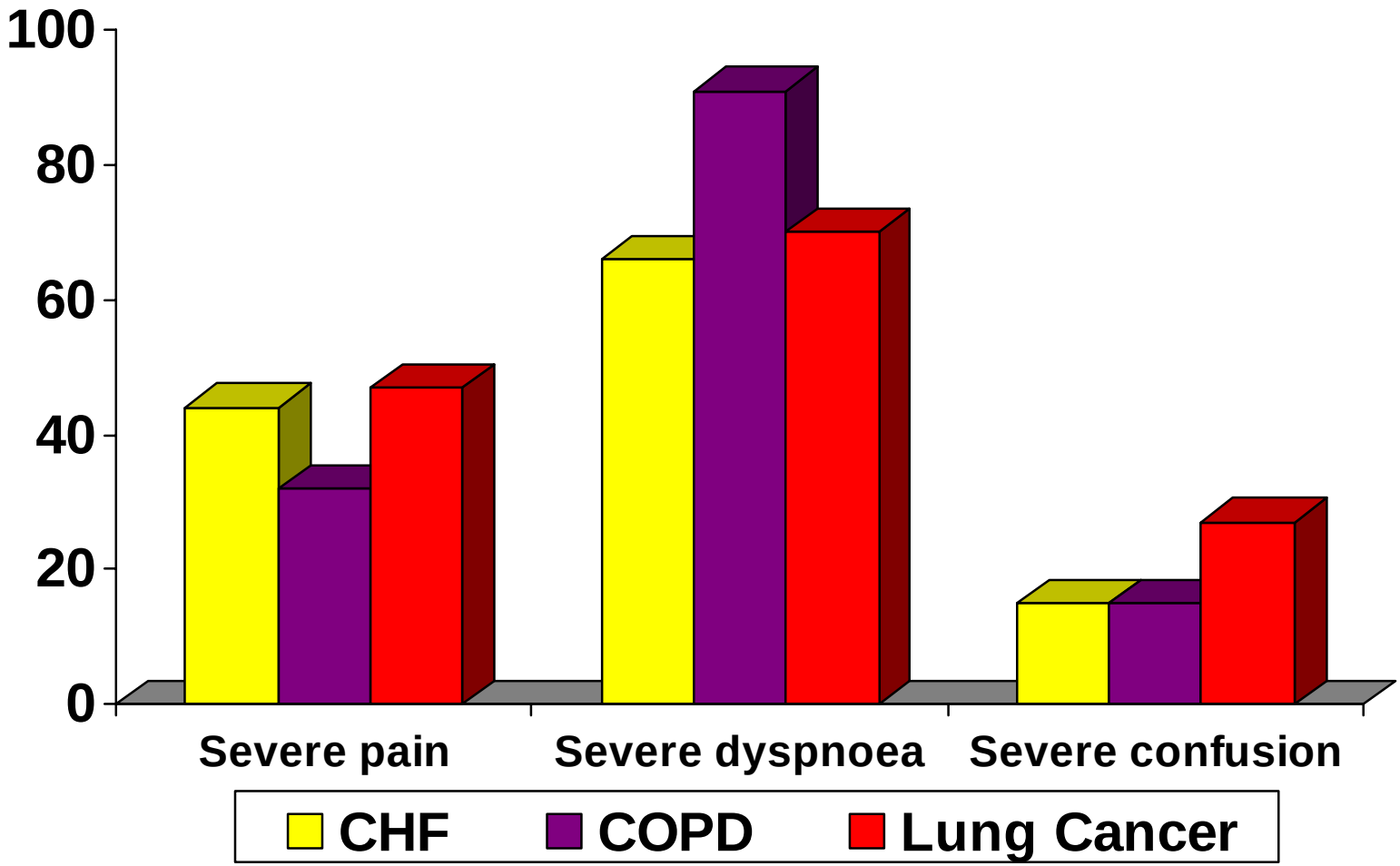
生命末年的症狀比率



Higginson I. Epidemiologically based needs assessment for palliative and terminal care. Radcliffe Medical Press 1997

英國一項大型回溯性人口調查 (Addington-Hall et al. 1995. 瀕死病人照護) 顯示充血性心衰竭, 慢性阻塞性肺疾病, 或是中風末期患者，到了生命末年在健康照護與社會照護上有許多需求沒有獲得解決.

SUPPORT Study: 往生前三日出現的嚴重症狀 (調查對象：親戚)



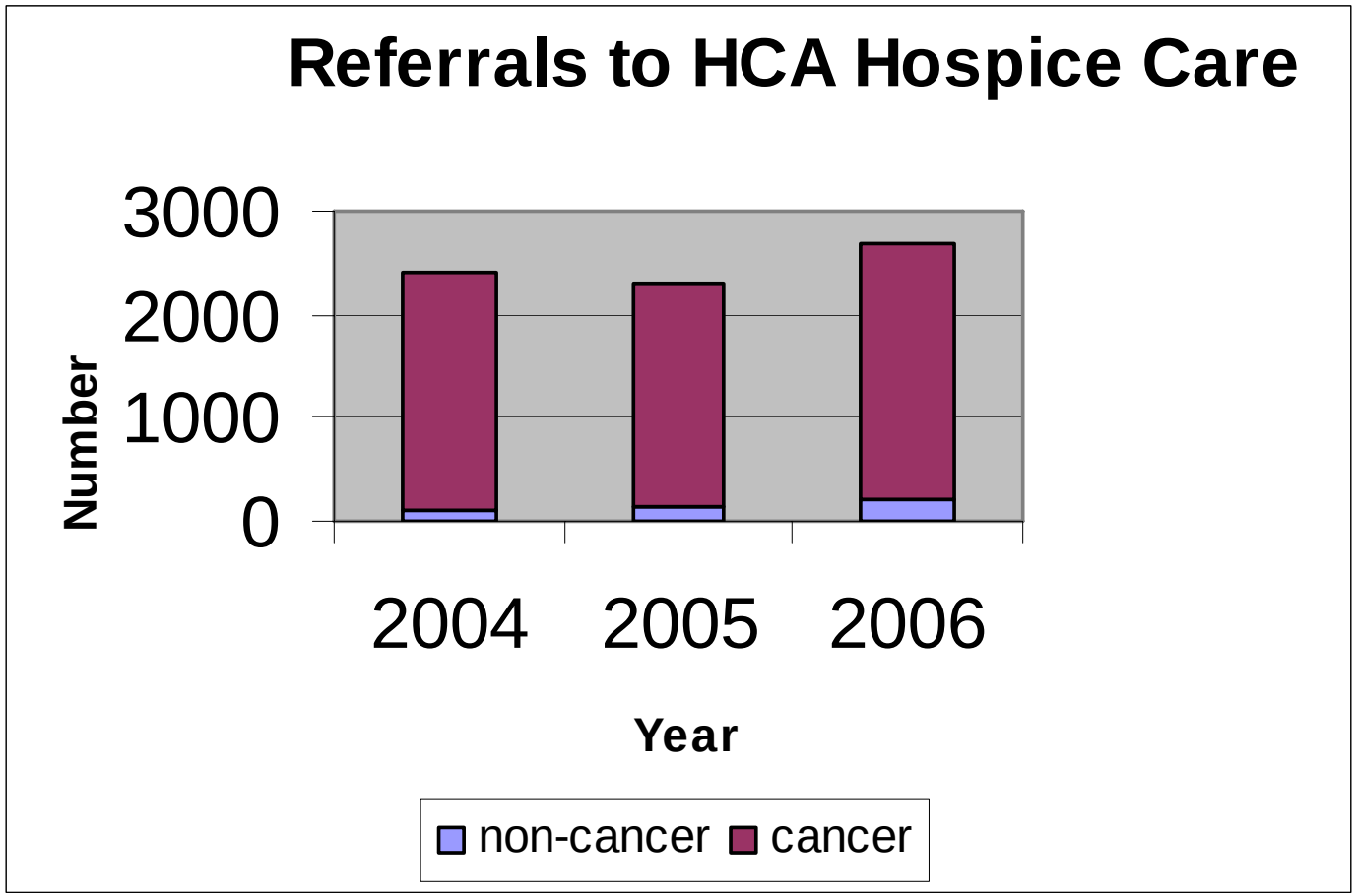
慢性病安寧緩和照護所面臨的挑戰

- 預後的不確定性 (對於安寧緩和療護經費的影響)
- 安寧療護資源有限之下, 何時為適當的介入時機
- 教育其他領域的醫事人員

照顧慢性病末期病患的議題

- 許多病人在反覆出入院中度過最後一年
- 醫師無法預估患者已屆生命盡頭
- 未來的醫療計劃沒有事先討論並記錄
- 長期照護機構(如護理之家)沒有適當的設備,也沒有準備好照顧瀕臨死亡的院民
- 安寧院對於非癌症病患會比較揀選挑剔
    i. 預後不定
    ii. 經費哪裡來

轉介安寧緩和照護



HCA	4.6%	7.2%	8.6%
TTSH	9.6%	15.0%	20.3%

轉介非癌症病患

2008年:

- 安寧住院服務 (陳篤生醫院, TTSH):

  非癌症佔22.6%, 癌症佔77.4%

- 安寧居家 (居家安寧協會, HCA):

  非癌症佔9.1%, 癌症佔90.9%

轉介至主要安寧緩和照護機構 (2008八月~2009七月)

	HCA (home care and day care)	Dover Park Hospice (inpatient)	Assisi Hospice (home care, day care and inpatient)
Non-cancer	453	29	154
Cancer	2967	444	1029
Total	3420	473	1183
% of non-cancer	13.2%	6.1%	13.0%

改進癌症患者與非癌症患者的臨終照護

- 教育醫護人員, 知道哪些病人有安寧療護的需求, 改進照護以符合病人所需 (陳篤生醫院, TTSH)
- 改進長期照護機構的臨終照護品質並預立醫療計劃, 以減少不必要入院 (CARE專案)
- 提出非癌症安寧居家計劃 (國立醫療群-預立醫療計劃NHG ACP)
- 運用威斯康辛-尊重病人選擇專案教材(Respecting Choices®), 介紹並協助病人進行預立醫療計劃

陳篤生醫院(TTSH)- 改進臨終照護行動

- 2006年成立了臨終照護專業團隊, 調查如何改進臨終照護品質

- 行動: Omega專案

‘Omega’專案

- 執行臨終照護模組(EOL bundle), 改進陳篤生醫院院內臨終照護品質

- 2007年3月1日 – 2009年6月31日

目標

1. 多方進行改進 (開始 50%到後來的70%):
   a. 評估瀕死病患心理社會與靈性需求
   b. 評估影響存活的危險因子
   c. 評估照顧者的喘息需求

2. 提高喪親家屬對臨終照護滿意度達25%

問問自己是否會“surprise”…

‘如果眼前這個病人在12個月內離開人世, 我們是否會驚訝意外?’

Joanne Lynn

Murray S, Boyd K, Sheikh A. Palliative care in chronic illness. BMJ 2005 ; 330: 611-612

臨終照護模組

- 利用Extent of Care/DNR表單來決定照護內容與緊急狀況處理的內容
- 舒適護理照顧組套(Comfort care order set)
- 護理照顧重點記錄 (改編自Liverpool 臨終照顧臨床路徑)

輔以系列教學訓練活動

Tan Tock Seng HOSPITAL

Extent of Care and Resuscitation Status Form

Affix Patient Label Here

Ward/ Bed:	Date/Time:	Doctor recording:	*Initial against all alterations. Subsequent updates will supersede orders recorded here. Draw line across current form with date/time/signature if a new form is used.*

(A) CLINICAL STATUS

Is this patient currently on the 'Dangerously Ill List' (DIL)[§]? **Yes / No**

(B) RESUSCITATION AND EXTENT OF CARE STATUS

Is this patient for cardiopulmonary resuscitation (CPR) in event of deterioration[†]?

[ ] **Yes, patient is for aggressive management including ICU.** (skip section C)
[ ] **No, patient is not for cardiopulmonary resuscitation (DNR).** Indicate extent of care below:
- [ ] For High Dependency Unit support
- [ ] For General Ward management including the following as appropriate:
  - Fluid resuscitation Yes / No*
  - Inotropic support Yes / No*

  *If not for fluid resuscitation and inotropic support, patient is for comfort care only.
- [ ] For comfort care only* (including withdrawal of life support)

*If patient is for comfort care only (not for resuscitation) and is DIL:
Review current medications and discontinue non-essential medications.
Review appropriateness of investigations and monitoring.
Review ability to consume oral medications and convert to non-oral means, if appropriate.
Consider standing orders for terminal symptoms.

DIL and DNR patients will be put on NURSING PCR-COMFORT CARE (if in general ward and are not for transfer to HD) or CareVue-Comfort Care (if already in ICU) unless otherwise specified.

(C) IF NOT FOR CPR, REASONS FOR INITIATING THE DNR ORDER

對醫院員工的教育

1. 症狀控制
2. 當病人病危/已簽署DNR, 給予社會心理支持
3. 狀況不好時辦理出院
4. 壞消息告知/討論醫療處置要做到什麼程度

症狀控制

- 重點放在4個常見症狀.
  - 審慎而主動地評估症狀 (不要等病人主訴抱怨時才進行評估).

Assessment/Interventions				
Neurosensory : (N ot A gitated)(A gitated *)				
Check for possible source of agitation e.g. *P* ain/*B* owel/*B*				
Review use of				
Inform doctor if patient remains agitated despite interventions for ≥ 1 hr				
Respiratory: (*E* asy)(*D* yspnoea*)(*R* attling*)(*O* thers*)				
N asal/*F* ace/*V* enti/High Concentration/*N* on-*R* ebreathing/*T* rachy				
Litre / 02%				
Prop up in bed if				
Secretions:*N il/*				
Suction if copious or purulent secretions:*T rachy/ O ropharyngeal*				
SpO2 if patient is dyspnoeic				
Inform doctor is dyspnoea remains unrelieved despite interventions ≥ 1 hr				
Pain :(*A* bsent)(*N ot in obvious D* istress)(*P* resent*) (*E* vidence of Distress*)				
Site : _____ *(please specify)*				
Score: _____				
Character*: S* h				
Serve breakthrough analgesia if pain score is ≥ 6 or at patient's request				
Inform doctor if no breakthrough analgesia is ordered or when pain score is ≥ 6 despite breakthrough analgesia				
Nutrition: (NBM)(*A* dequate)(*I* nadequate*)(*R* isk*)				
(*O* ral)(*NG* tub				
NG Suction: *I* n				
Implement enteral tube care				
Presence of *N* ausea/*V* omiting				

病人沒有躁動的情形

病人沒有呼吸困難或出現嘎嘎的呼吸聲

疼痛已完全控制住

噁心與嘔吐已完全控制住

症狀控制

- 如果出現症狀, 立刻擬定治療計劃.
  - 如果有需要，開立prn藥物應付不時之需 (在ExOC表單第2頁有解釋)

Tan Tock Seng
HOSPITAL

xtent of Care and
esuscitation Status Form

Affix Patient Label Here

ard/ Bed:	Date/Time:	Doctor recording:

Initial against all alterations.

(A) CLINICAL

this patient currently on the 'Dangerously Ill Li

(B) RESUSCITATION AND EX

this patient for cardiopulmonary resuscitation (C

] Yes, patient is for aggressive management incl
] No, patient is not for cardiopulmonary resuscita
[ ] For High Dependency Unit support
[ ] For General Ward management including the
Fluid resuscitation Yes / No*
Inotropic support Yes / No*
[ ] For comfort care only* (including withdrawal c

*If patient is for comfort care only (not for resuscitati
Review current medications and discontinue non-e
Review appropriateness of investigations and mon
Review ability to consume oral medications and co
Consider standing orders for terminal symptoms.
DIL and DNR patients will be put on NURSING PCR-C
transfer to HD) or CareVue-Comfort Care (if already i

(C) IF NOT FOR CPR, REASONS FO

Management of terminal symptoms

Check for easily correctable causes of distress e.g. distended bladder for agitation in drowsy patient. Consider standing orders for symptom control.

Pain	Opioid-naïve	S/C Morphine 1.0 – 3.0 mg prn for breakthrough pain followed by S/C Morphine 0.5 – 2.0 mg / hr via syringe pump and titrate (normal liver and renal function). 1/6 of total daily dose as breakthrough dose.
	Opioid non-naïve	Convert to S/C morphine (1/3 of total oral morphine equivalent) if unable to take orally.
Dyspnea	Opioid-naïve	Mist morphine 2.5 – 10 mg q4H + Mist morphine 2.5 – 10 mg prn for breakthrough dyspnea OR S/C morphine 1.0 – 5.0 mg q4H + S/C morphine 1.0 – 5.0 mg prn for breakthrough dyspnea (normal liver and renal function).
	Opioid non-naïve	Increase dose by 50% if still dyspnoiec.
Nausea and vomiting		S/C Metoclopramide 10 mg prn up to q4-8H (if no intestinal obstruction) S/C Haloperidol 0.5 – 1.0 mg prn up to q8H (if centrally-mediated cause)
Terminal agitation		S/C Midazolam 1.0 – 3.0 mg bolus followed by 10 – 30 mg / 24H and titrate. S/C Haloperidol 1.0 – 2.5 mg bolus followed by 5 – 10 mg / 24H.
Terminal rattling		S/C hyoscine butylbromide 20 mg stat followed by 40 – 80 mg / 24H.

症狀控制

- 定期檢討討論.

- 如果控制的不好及早尋求協助
  - 使用更進階的藥物
  - 轉介專科團隊

如果病人已經病
且已經簽署DNR

Tan Tock Seng HOSPITAL

Name :
NRIC :
DOB :
Race :
Sex :
Case No :

PATIENT CARE RECORD - COMFORT MEASURES

For DIL and DNR Patients

Class	Discipline	Ward	Bed

"自動啟動

Date / Time					Evaluation/Remarks
Specific Care					
Assessment/Interventions					
Neurosensory : (Not Agitated)(Agitated*)					
Check for possible source of agitation e.g. *P*ain/*B*owel/*B*ladder/*F*ever/*I*nvasive *D*evices					
Respiratory: *(E*asy)(*D*yspnoea*)(*R*attling*)(*O*thers*)					
*N*asal/*F*ace/*V*enti/*N*on-*R*ebreathing/*T*rachy					
Litre / 02%					
Prop up in bed if dyspnoeic					
Secretions:*N il/C opious*/P urulent*.					
Suction if copious or purulent secretions:*T rachy/ O ropharyngeal*					
Pain *:(A*bsent)(*N ot in obvious D*istress)(*P*resent*) (*E*vidence of Distress*)					
Site : _____ *(please specify)*					
Score: _____ *(please specify)*					
Character: *S*harp/*D*ull/*O*thers					
Serve breakthrough analgesia if pain score is ≥ 6 or at patient's request					

DOCTOR

目標:

- 臨終照護重點在處理常見症狀
- 社會心理靈性照顧
  - 針對病人
  - 針對家庭

精神狀態

The 4 Cs of "psycho" status

Psycho Status: (***A***nxious")(***D***epressed")(***O***thers")				
Patient - Identify information deficits e.g. condition and management plan				
NOK - Identify information deficits e.g. patient's condition and management plan				
Update NOK on patient's condition and management plan (*State name and relationship of NOK in Remarks*)				
Allow family/caregiver to keep patient company				
Identify need for religious/spiritual support				
Refer MSW for: ***F***inancial / ***E***motional or Grief / Care issues				

Communication

Company

Clergy (religious/spiritual) **suppo**

Counseling

“為什麼現代醫療體系無法符合瀕死病人的希望與需求? 如果臨終病人希望在家往生我們應該協助達成他們的願望.” – 健康局局長 Khaw Boon Wan

296 PAGES IN ELEVEN PARTS » MICA (P) 198/12/2006 SATURDAY, SEPTEMBER 8

Dying at home: Ministry to look into changing rules

Health-care system 'should facilitate those who have a preference to do so'

BY JUDITH TAN

THE Health Ministry is moving into new territory – death.

It will study what it will take for more people to die a dignified death at home, instead of in a hospital or hospice, said Health Minister Khaw Boon Wan yesterday.

Right now, just under three deaths in every 10 take place at home. Most people die in hospitals.

"Why is the modern health-care system failing in meeting the preference of the dying? I believe we should try to facilitate dying at home for the terminally ill if this is their preference," said Mr Khaw.

An ageing population and all its related concerns – staying healthy and active, and having enough savings – have become key concerns of the Government.

Yesterday, Mr Khaw added one more – dealing with death.

End-of-life issues are deeply emotional, but talking about them helps, he said, recalling his recent visit to the Ogimi village in Okinawa, Japan, which has a population with one of the highest percentage of centenarians in the world.

"They realise that treating death as taboo does a disservice to both the dying and the living, adding to loneliness, anxiety and stress for all," he said.

For a start, his ministry will identify the obstacles, such as the reluctance of some doctors to certify a death at home and the extra costs involved.

For instance, while subsidies help cover medical costs for those dying in hospitals, these subsidies stop once they go into home hospice care, he said. It is a similar case for insurance coverage.

If need be, rules and processes that hinder dying at home will be changed.

Recounting his grandmother's death of old age at home, Mr Khaw said that there was a time when death was an integral part of family life.

"She had never been hospitalised, and the hospital was the last place she would want to draw her last breath," he said.

In a way, modern health care has made dying a lonelier process, he told reporters after he opened the Children Hospice International 18th World Congress yesterday,

The three-day congress, attended by 150 participants from 25 countries, deals with treating terminally-ill children and hospice care.

Mr Khaw said he wants to make hospice and home palliative care – specialised care of people who are dying – part of the health care delivery system.

The first step is to make palliative medicine an attractive sub-specialty – something many doctors had been lobbying for for many years.

"This way, we can start thinking about the needs and demands of this sub-specialty, such as how many more people we need to train," he said.

As of last year, there we five doctors in Singapore wi in-depth training in this field.

Palliative care will also be e tended beyond cancer to oth terminal stage chronic cond tions.

Taking care of the dying is labour- and skill-intensive ser ice, so manpower needs w have to be planned for and c reer prospects improved make it attractive.

Singapore is not alone in co fronting these issues. La month, a report by the Nation Health Service for London d voted a section to end-of-li care and lamented the lack discussion in society abo "what constitutes a goo death", noted Mr Khaw.

The report recommended ge ting patients to declare whe they prefer to die, a develo ment which Singapore ca study too, he said.

A long-time advocate for te minally ill patients to die home, HCA Hospice Care president Seet Ai Mee agreed

Citing her experience whe her father was dying from ca cer, she said he summoned a his family members and to them his last wishes. Th helped, she said.

"We didn't have to secon guess him or ourselves. It al helped keep the harmony of t children and grandchildren she said.

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PALLIATIVE CARE GIVES PEACE TO TERMINALLY ILL PATIENTS, HOME H6

Post your comments online at www.straitstimes.com
Catch our free video report at www.straitstimes.com

NHG ACP(國立醫療群-預立照護計劃)

- 國立醫療群-預立照護計劃 (NHG ACP)

- 衛生部全額補助3年的先期計劃
- 提供非癌症病患居家安寧緩和照護
- 末期心臟衰竭，末期腎臟衰竭與慢性阻塞性肺疾病的末期

NHG ACP(國立醫療群- 預立照護計劃)

- 因為像COPD與慢性心衰竭病患的需求沒有被照顧到, 而有此計劃

- 計劃強調重點:醫護居家訪視, 電訪追蹤, 預立醫療計劃, 居家臨終照護, 提供喪親悲傷家屬支持

‘CARE’專案

- 3年先期計劃, 以改善護理之家臨終照護品質
- 選出9間鄰近醫院的護理之家
- 團隊包含醫師, 護士與輔導人員

'CARE'專案

- 目的:

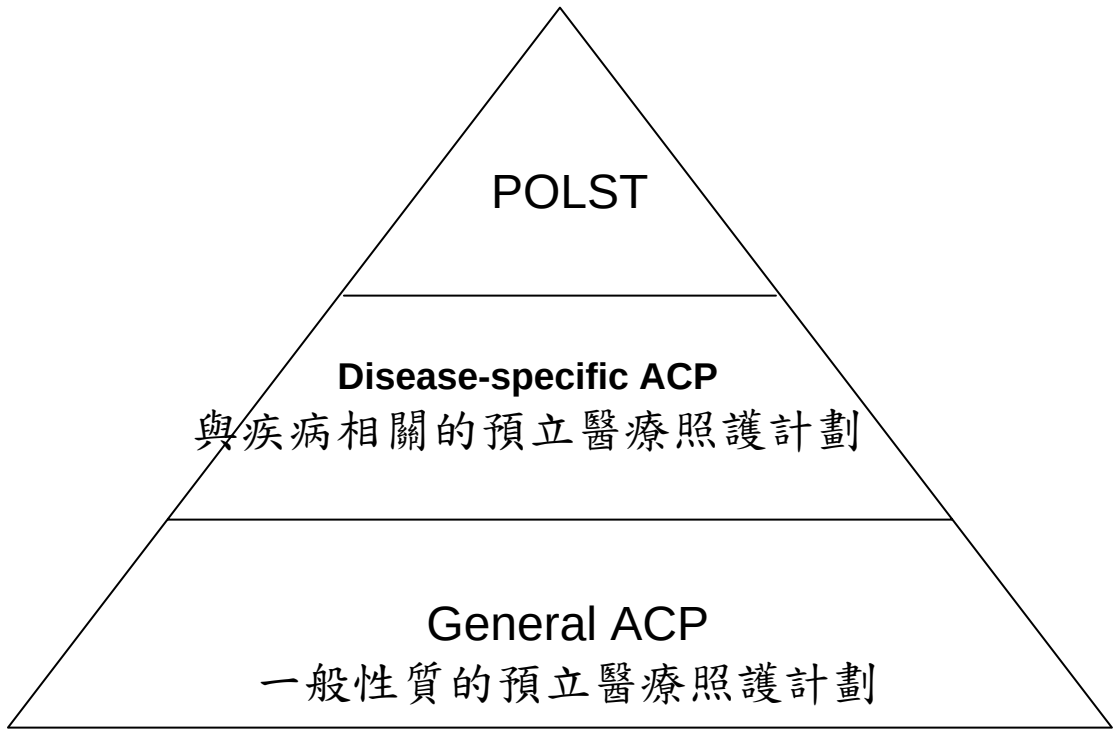
  1. 護理之家工作人員的教育訓練(改變心態)
  2. 與護理之家住民與親戚討論未來照護計劃
  3. 護理之家提供急症處置(全時全日皆然)
  4. 護理之家提供臨終病人照顧

預立照護計劃

美國威斯康辛- 尊重病人選擇專案®(Engaging Respecting Choices®)

1. 訓練協同溝通專才, 與病人/家屬討論預立醫療照護計劃
2. 研究如何改變體制，以便把預立醫療照護計劃納入醫療照護，並確保預定目標不因照護地點不同而有改變
3. 教育醫療人員與一般大眾，好的臨終照護，預立醫療照護計劃十分重要

討論預立照護計劃的內容



POLST: Physician Order for Life-Sustaining Treatment(醫師指示使用維生治療)

致謝

- Dr Angel Lee, Senior Consultant, TTSH
- HCA Hospice Care
- Singapore Hospice Council

Thank you