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建構跨專業之都會型社區安寧療護模式

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目的：本計畫主要目的在於探討慢性病末期病人透過社區安寧照護模式之建構-從專業人員，病人及家屬角度多元層面探討，藉此提昇慢性疾病末期個案與家屬生活品質的全人照顧。**方法：**計畫實施之初，因社區安寧跨專業團隊的缺乏、院內行政作業流程繁複、未能整合社區安寧照護與急性醫療之間缺乏連結機制等因素，本院未提供社區安寧照護服務。經由文獻查證與安寧小組成立的規劃，研擬社區安寧照護計畫記錄表單共13項、擬定品質改善計畫及獎勵措施、醫師出診服務、協助社區安寧服務建立照顧品質指標監測、設計社區安寧專用「安您卡」及單一窗口服務等方案，以提供便捷快速的全方位照護服務。**結果：**在服務面成功建立社區安寧跨專業團隊提供全方位醫療服務，社區安寧個案總計190人（癌症個案90人、八大非癌症個案100人）。品質面建立定期監測指標，簽署DNR人數由原不及100人增加至627人，而監測安寧緩和需求評估大於等於6分人數為183人，佔29.19%，照護品質逐漸提升，而滿意度高達98%。**結論：**透過多元的社區安寧服務模式，由接受嚴格專業訓練的醫療跨專業照護團隊提供慢性疾病生命末期病人完整的照護服務及提供個別性的照顧計畫，滿足病人和家屬身、心、靈的需要。在整個照顧過程中，病人有最大的自主權，家屬為全程參與，提昇慢性疾病末期病人與家屬生活品質的全人照顧。透過全心、全人、全家、全隊、全程五全的照護服務，使個案能依照其意願在地老化及善終，達到以病人為中心，協助家屬安然陪伴親人度過餘生，避免兩相遺憾。如此不僅可減少醫療資源耗用，更可協助個案依個別性快樂渡過人生最後路程，也提升了醫院的照護品質，實在值得推動。

關鍵詞：社區安寧，跨專業團隊，安您卡
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前　言

社區安寧照護服務在生命末期病人回歸社區善終，提供在地且延續性的照護體系佔有重要的角色，然都會型的社區安寧照護服務發展及品質常爲民衆與學者專家所疑慮。本院基於致力都會型社區安寧特色醫療發展，特成立“社區安寧跨專業團隊”，針對轄區需要接受安寧緩和醫療照護的個案進行評估。經由訓練有素的專業團隊，提供護理師、醫師、營養師及物理治療師、心理師、社工師、宗教師及行政人員協助進行出訪評估諮詢，讓個案在安全、便捷、完整與持續性的五全照護下得以安寧。但因個案與醫療照護銜接上最大的困擾，除了後續就醫服務缺乏整合外，個案就醫後亦無共同照護目標，無法延續個案之照護需求，

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Project Report

Establishment an Interdisciplinary Community-based Palliative Care Model in Metropolitan Area

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Objective: The purpose of this study was to investigate the construction of a hospice home care model for chronic patients in the terminal stage from the aspects of professionals, patients and family members, and to enhance the quality of life and holistic care of the patients and family members accordingly. **Method:** At the beginning of this project, our hospital did not provide community hospice service because of the lack of a trans-disciplinary team, the complex hospital administrative process, and lack of communication between community hospice service unit and emergency care unit. We conducted literature review and proposed a "Trans-disciplinary Metropolitan Community Hospice Team". We designed 13 sets of community hospice record forms and "hospice card", prepared a quality improvement and incentive plan, provided physician house call service for the cases, developed a care quality monitoring system and single window service scheme for easy and efficient holistic care. **Results:** A total of 190 cases received community hospice care during the study period (90 cancer patients and 100 non-cancer patients). The patients who signed DNR increased from less than 100 cases to 627 cases. The patients who had a score ≥ 6 in palliative care needs assessment increased to 183 cases, accounting for 29.19% of 627 cases. The service quality was also improved, evident from the service satisfaction of 98%. **Conclusion:** The well trained trans-disciplinary health care team has provided the end-of-life chronic disease patients a holistic and individualized care through the pluralistic community hospice service.

Key word: Community hospice, trans-disciplinary team, self you card

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