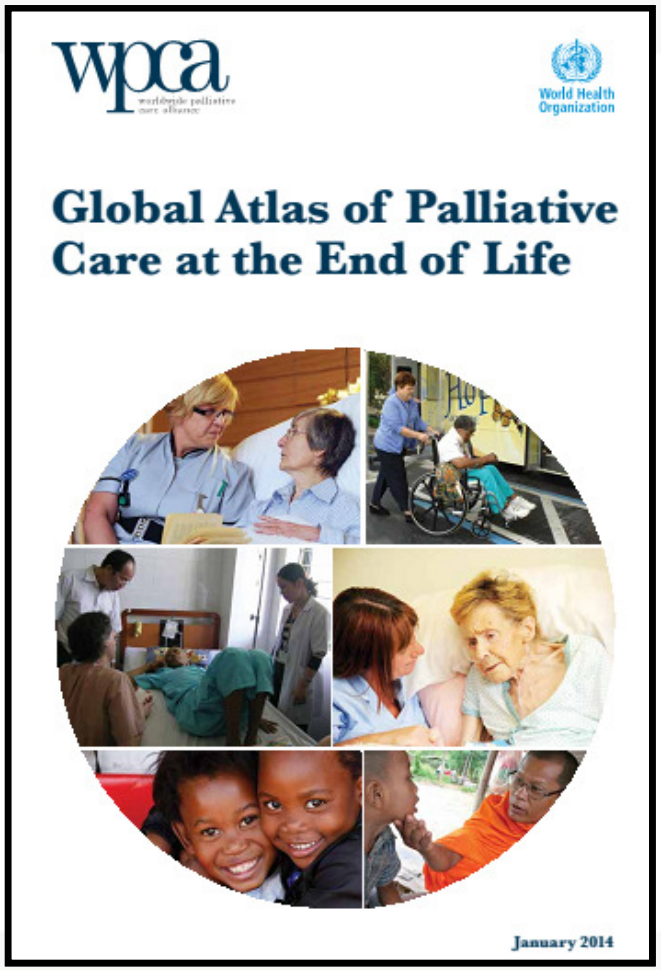
End of Life care in Taiwan
- 1st 2nd 3rd movement and National Policy-

Yingwei Wang M.D. DrPH
Director General, Health Promotion Administration
Ministry of Health and Welfare
Council member APHN
Former Director, Heart Lotus Hospice, Tzuchi General Hospital

國民健康署

Palliative Care for All



- **BY** THE PEOPLE
- **THROUGH** THE PEOPLE
- **FOR** THE PEOPLE

With the people

The goal of the care is to help people who are dying have peace, comfort and dignity.

Worldwide Hospice Palliative Care Alliance (WHPCA) 2014

Public health model for palliative care development

Policy

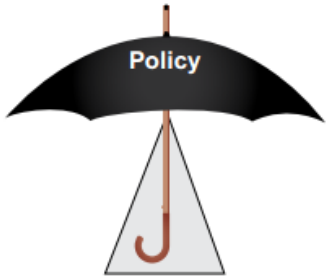
- Palliative care part of national health plan, policies, related regulations
- Funding/service delivery models support palliative care delivery
- Essential medicines

(Policy makers, regulators, WHO, NGOs)

Medicine availability

- Opioids, essential medicines
- Importation quota
- Cost
- Prescribing
- Distribution
- Dispensing
- Administration

(Pharmacists, drug regulators, law enforcement agents)



Education

- Media and public advocacy
- Curricula, courses – professionals, trainees
- Expert training
- Family caregiver training and support

(Media and public, healthcare providers and trainees, palliative care experts, family caregivers)

Implementation

- Opinion leaders
- Trainer manpower
- Strategic and business plans – resources, infrastructure
- Standards, guidelines measures

(Community and clinical leaders, administrators)

Stjernsward et al. 2007[33]. Used with permission.

Categories of palliative care services

	Palliative care			
	Palliative care approach	Specialist support for general palliative care		Specialist palliative care
Acute care	Hospital	Volunteer hospice service	Hospital palliative care support team	Palliative care unit
Long-term care	Nursing home, residential home		Home palliative care teams	Inpatient hospice
Home care	General practitioners, community nursing teams			Home palliative care teams, day-care centre

Planning and implementing palliative care services: a guide for programme managers. WHO 2016

Building Integrated Palliative Care Programs and Services

The Worldwide Hospice Palliative Care Alliance

CÀTEDRA DE CURES PAL·LIATIVES

wpca

"la Caixa" Banking Foundation

國民健康署

Conceptual transitions in palliative care in the 21st Century

	Change FROM	Change TO
CONCEPTS	Terminal disease	Advanced progressive chronic disease
	Prognosis of weeks or months	Limited life prognosis
	Cancer	All chronic progressive illnesses and conditions
	Progressive course	Progressive course with frequent crises of needs and demands
	Mortality	Prevalence

Building Integrated Palliative Care Programs and Services WHPCA 2017
http://www.thewhpca.org/resources/category/building-integrated-palliative-care-programs-and-services

Conceptual transitions in palliative care in the 21st Century

	Change FROM	Change TO
MODEL OF CARE AND ORGANISATION	Dichotomy curative or palliative	Synchronised, shared, combined care
	Specific OR palliative treatment	Specific AND palliative treatment as needed
	Prognosis as criteria for intervention of specialist services	Complexity/severity as criteria
	Late identification in specialist services	Early identification in community and all settings
	Rigid one-directional intervention	Flexible intervention
	Passive role of patients	Advance care planning
	Fragmented care	Integrated care

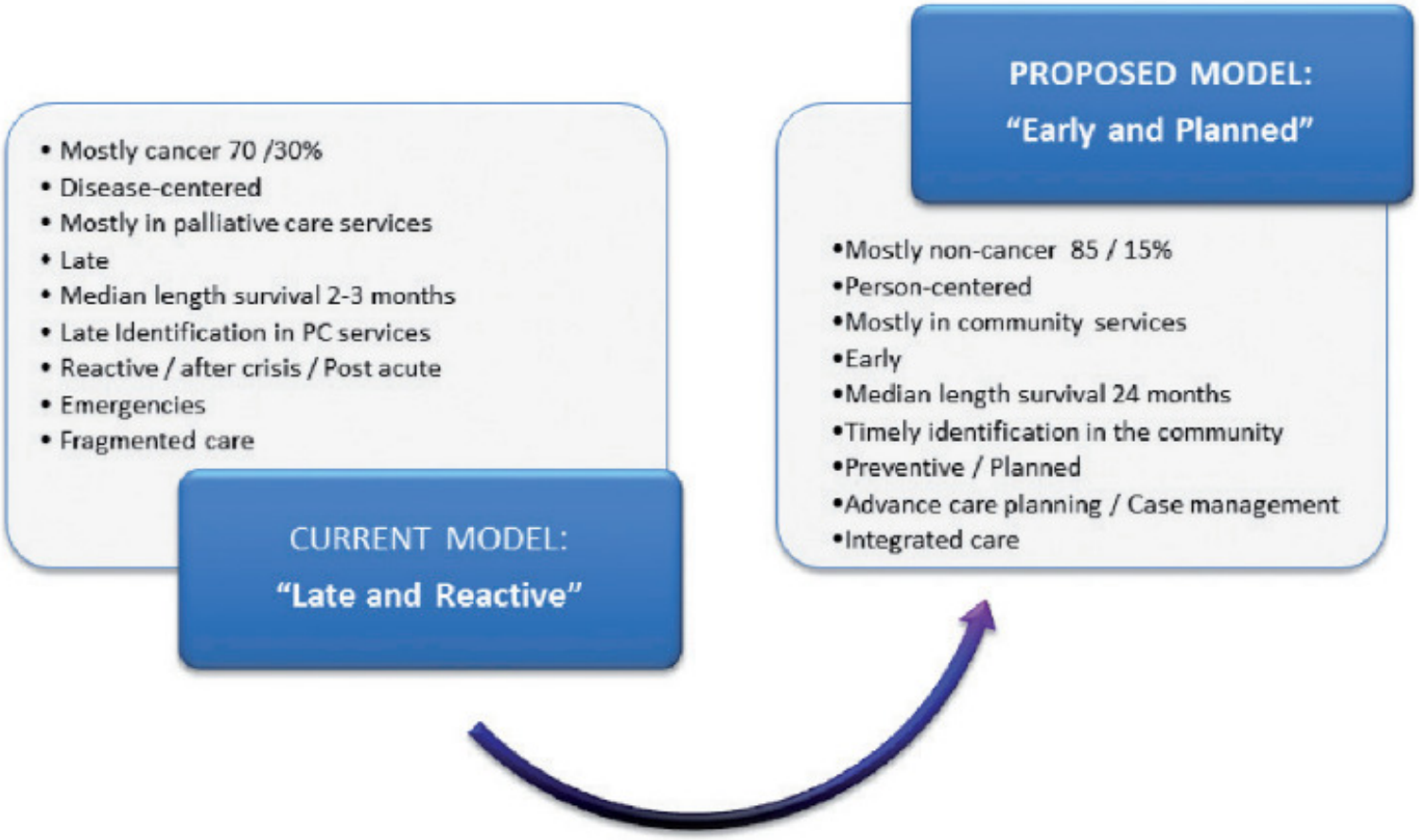
Building Integrated Palliative Care Programs and Services WHPCA 2017

Conceptual transitions in palliative care in the 21st Century

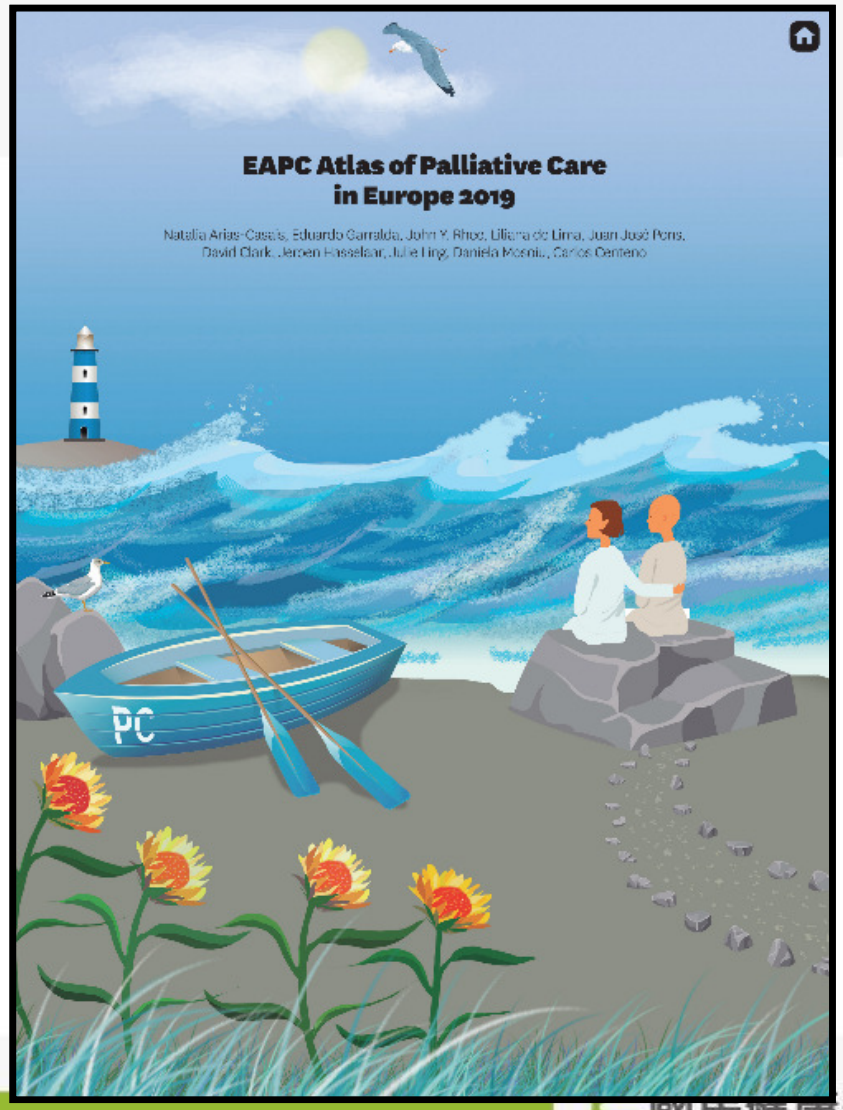
	Change FROM	Change TO
PERSPECTIVE FOR PLANNING	Palliative care services	Palliative care approach everywhere
	Specialist services	Actions in all settings of health care
	Institutional approach	Community approach
	Services approach	Population approach
	Individual service	Systems approach

Building Integrated Palliative Care Programs and Services WHPCA 2017
http://www.thewhpca.org/resources/category/building-integrated-palliative-care-programs-and-services

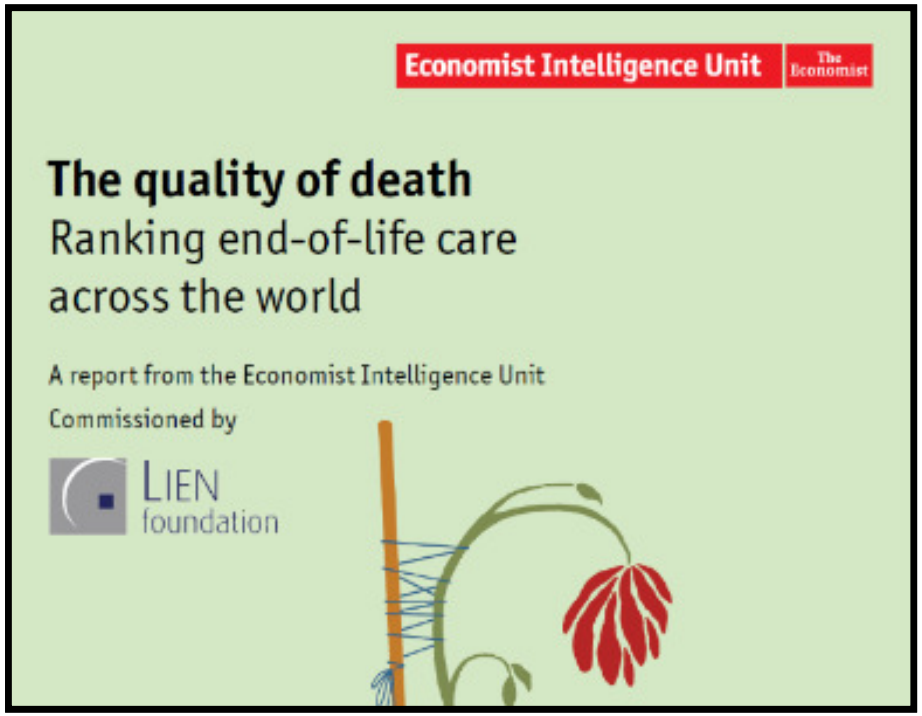
Models of palliative interventions in chronic advanced palliative care

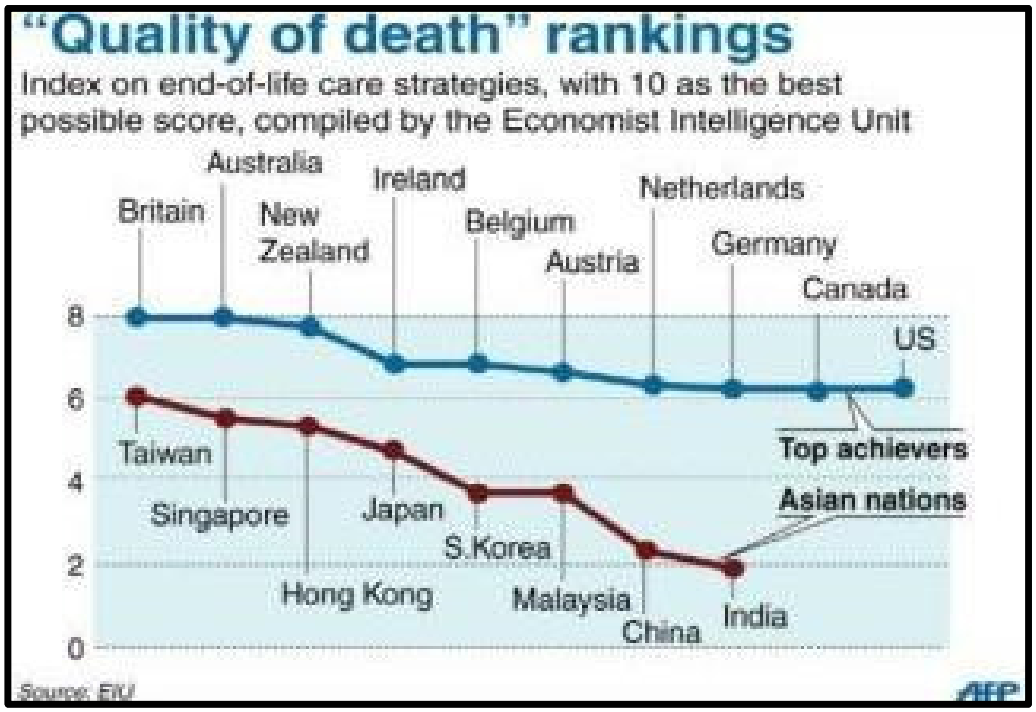



Brief Manual on Health Indicators Monitoring Global Palliative Care Development
Natalia Arias-Casais
Eduardo Garralda
Jesús López Fidalgo
Liliana de Lima
John Y. Rhee
Juan José Pons
Carlos Centeno
May 2019
ics
Universidad de Navarra
Institute for Culture and Society
ATLANTES
Palliative Care Research Group


EAPC Atlas of Palliative Care in Europe 2019
PC

Ranking End of Life Care across the world 2010





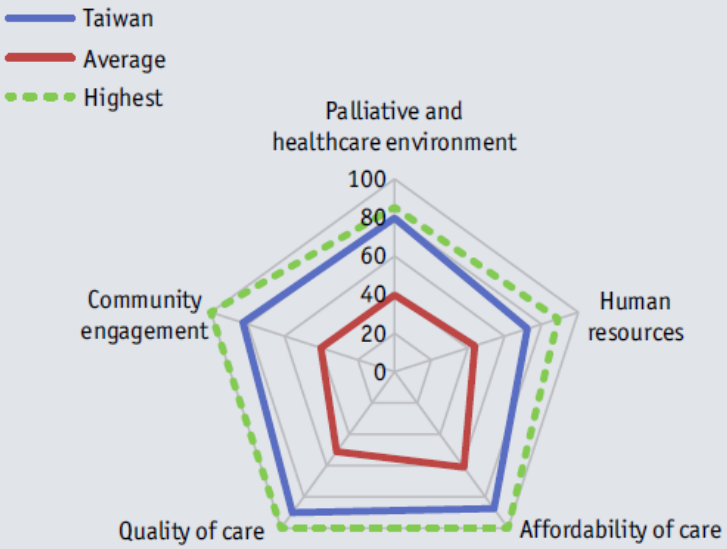

ET REPORT
QUALITY OF DEATH
An EIU report commissioned by Lien Foundation
PRESS ROOM
CONVERSATIONS
10 /40
Cost of
End-Of-Life care
15 /40
Basic End-Of-Life
Healthcare Enviroment
10/40
Quality of
End-Of-Life care
19/40
Availability of
End-Of-Life care

2015 Quality of Death Index—Overall scores

Rank	Country	
1	UK	93.9
2	Australia	91.6
3	New Zealand	87.6
4	Ireland	85.8
5	Belgium	84.5
6	Taiwan	83.1
7	Germany	82.0
8	Netherlands	80.9
9	US	80.8
10	France	79.4
11	Canada	77.8
12	Singapore	77.6
13	Norway	77.4
14	Japan	76.3
15	Switzerland	76.1
16	Sweden	75.4
17	Austria	74.8
18	South Korea	73.7
19	Denmark	73.5
20	Finland	73.3
21	Italy	71.1
22	Hong Kong	66.6

Case study: Taiwan—Leading the way

	Rank/80	Score/100
Quality of Death overall score (supply)	**6**	**83.1**
Palliative and healthcare environment	5	79.6
Human resources	9	72.2
Affordability of care	=6	87.5
Quality of care	=8	90.0
Community engagement	=5	82.5



The quality of palliative care in Taiwan is high (it is tied for eighth place in this category), with a focus on improving the quality of a patient's last days. Major steps have been made in recent years: Dr Siew Tzuh Tang, a professor at Chang Gung University School of Nursing, reports substantial improvement in several end-of-life indicators between her team's national surveys in 2003/4 and 2011/12. For example, while less than half of terminally ill cancer patients were aware of their prognosis in the first survey, this number increased to 74% by 2012. Use of aggressive medical treatments for cancer patients in the last month of life, such as CPR and intubation, also declined over this period.

Community engagement, in particular to break down cultural taboos against discussing death, has also been a focus. Such taboos are still widespread, but proponents of palliative care are attempting to change that by introducing discussions of life and death into the education system from primary school through university, and by changing the mindset of patients.

"Family members feel that for the patient to die without CPR is not filial," says Dr Rongchi Chen, chairman of the Lotus Hospice Care Foundation. "But we are trying to teach people that filial duty and love should find its expression in being with the family member at the end of his or her life, and in

Indicator scores

	Rank / 80	Score / 100	Data	Unit
SUPPLY ENVIRONMENT	**6**	**82.1**		**0 - 100 where 100= best and 0=worst**
1) PALLIATIVE AND HEALTHCARE ENVIRONMENT	**7**	**74.5**		**0 - 100 where 100= best and 0=worst**
1.1) Healthcare spending	46	36.9	6.6	% of GDP
1.2) Presence and effectiveness of government-led national palliative	=1	100.0	5	EIU rating
1.3) Availability of research-based policy evaluation	=1	100.0	5	EIU rating
1.4) Capacity to deliver palliative care	12	61.3	39.0	%
2) HUMAN RESOURCES	**10**	**69.4**		**0 - 100 where 100= best and 0=worst**
2.1) Availability of specialised palliative care workers	=4	75.0	4	EIU rating
2.2) General medical knowledge of palliative care	=7	75.0	4	EIU rating
2.3) Certification for palliative care workers	=1	100.0	1	EIU rating
2.4) Number of doctors per 1,000 PC-related deaths	24	49.2	588.8	Doctors per 1,000 non-accidental deaths
2.5) Number of nurses per 1,000 PC-related deaths	=11	47.7	1731.9	Nurses per 1,000 non-accidental deaths
3) AFFORDABILITY OF CARE	**=6**	**91.7**		**0 - 100 where 100= best and 0=worst**
3.1) Availability of public funding for palliative care	=7	75.0	4	EIU rating
3.2) Financial burden to patients for available palliative care	=1	100.0	5	EIU rating
3.3) National pension scheme coverage of palliative care services	=1	100.0	3	EIU rating
4) QUALITY OF CARE	**=7**	**87.5**		**0 - 100 where 100= best and 0=worst**
4.1) Presence of monitoring standards for organisations	=1	100.0	1	EIU rating
4.2) Availability of painkillers	=1	100.0	5	EIU rating
4.3) Availability of psycho-socio support for patient and families	=1	100.0	3	EIU rating
4.4) Presence of Do not resuscitate (DNR) policy	=1	100.0	1	EIU rating
4.5) Shared decisionmaking	=25	50.0	3	EIU rating
4.6) Use of patient satisfaction surveys	=4	75.0	4	EIU rating
5) COMMUNITY ENGAGEMENT	**=3**	**87.5**		**0 - 100 where 100= best and 0=worst**
5.1) Public awareness of palliative care	=5	75.0	4	EIU rating
5.2) Availability of volunteer workers for palliative care	=1	100.0	5	EIU rating

New Movements in Hospice and Palliative Care

The Ministry of Health and Welfare organized a taskforce to develop hospice and palliative care in 1995

First

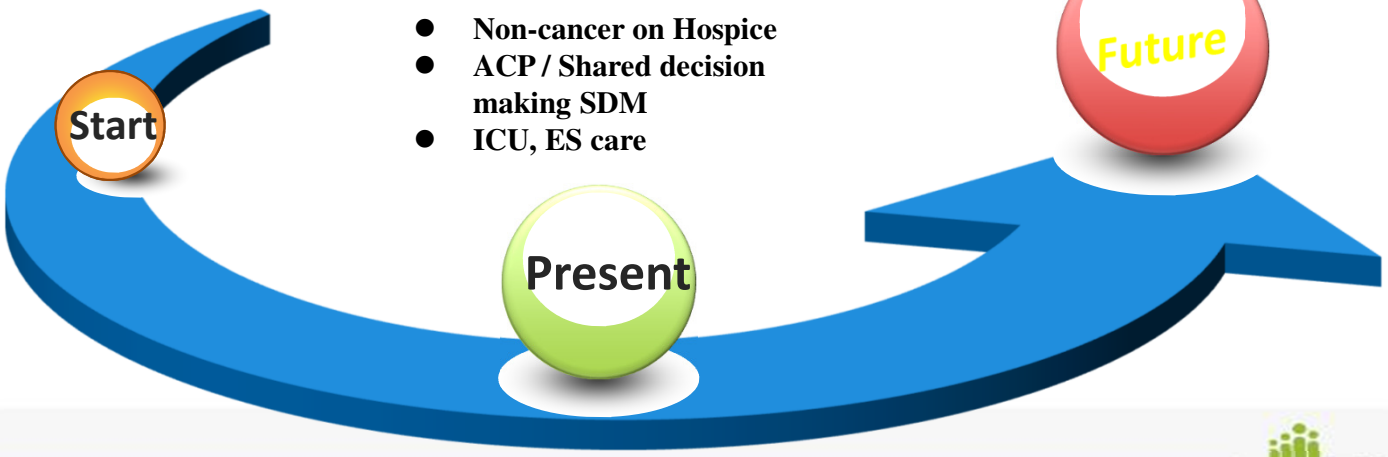
- Development of Hospice concept
- Focus on cancer
- Development of hospital care, shared care and home care

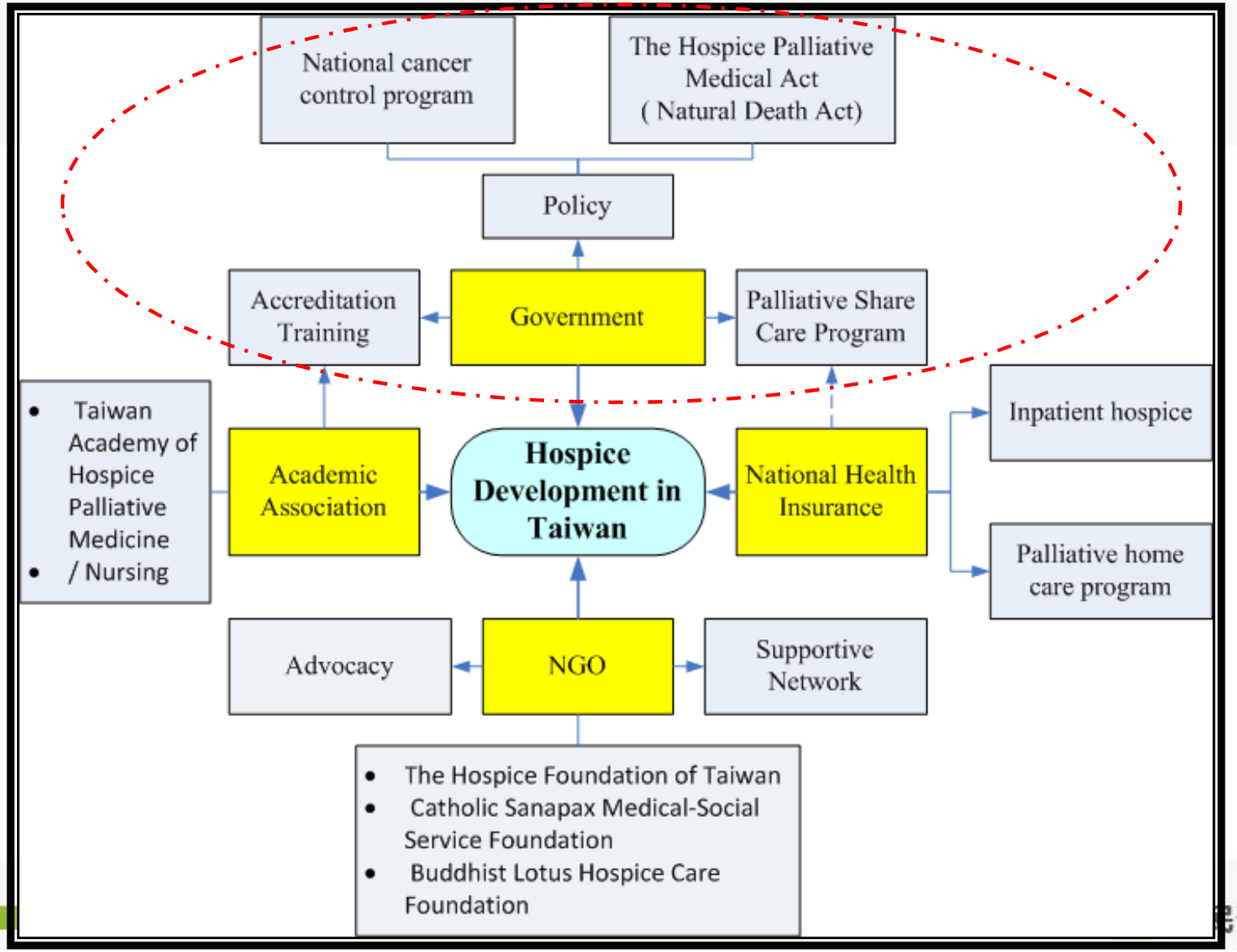
Second

- Non-cancer on Hospice
- ACP / Shared decision making SDM
- ICU, ES care

Third

- The elderly and children Hospice Care
- Early palliative Care
- Hospice of Long-Term Care and community
- New Technology in community Palliative care
- Patient Right to Autonomy Act
- **Compassionate cities/compassionate community**




National cancer control program
The Hospice Palliative Medical Act (Natural Death Act)
Policy
Accreditation Training
Government
Palliative Share Care Program
Taiwan Academy of Hospice Palliative Medicine / Nursing
Academic Association
Hospice Development in Taiwan
National Health Insurance
Inpatient hospice
Palliative home care program
Advocacy
NGO
Supportive Network
The Hospice Foundation of Taiwan
Catholic Sanapax Medical-Social Service Foundation
Buddhist Lotus Hospice Care Foundation

Government department responsible for hospice palliative care

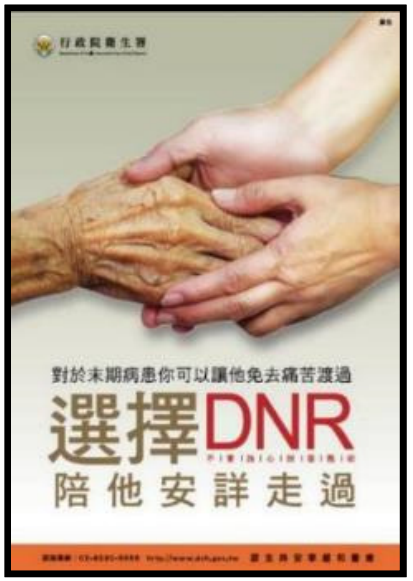
Policy for palliative care

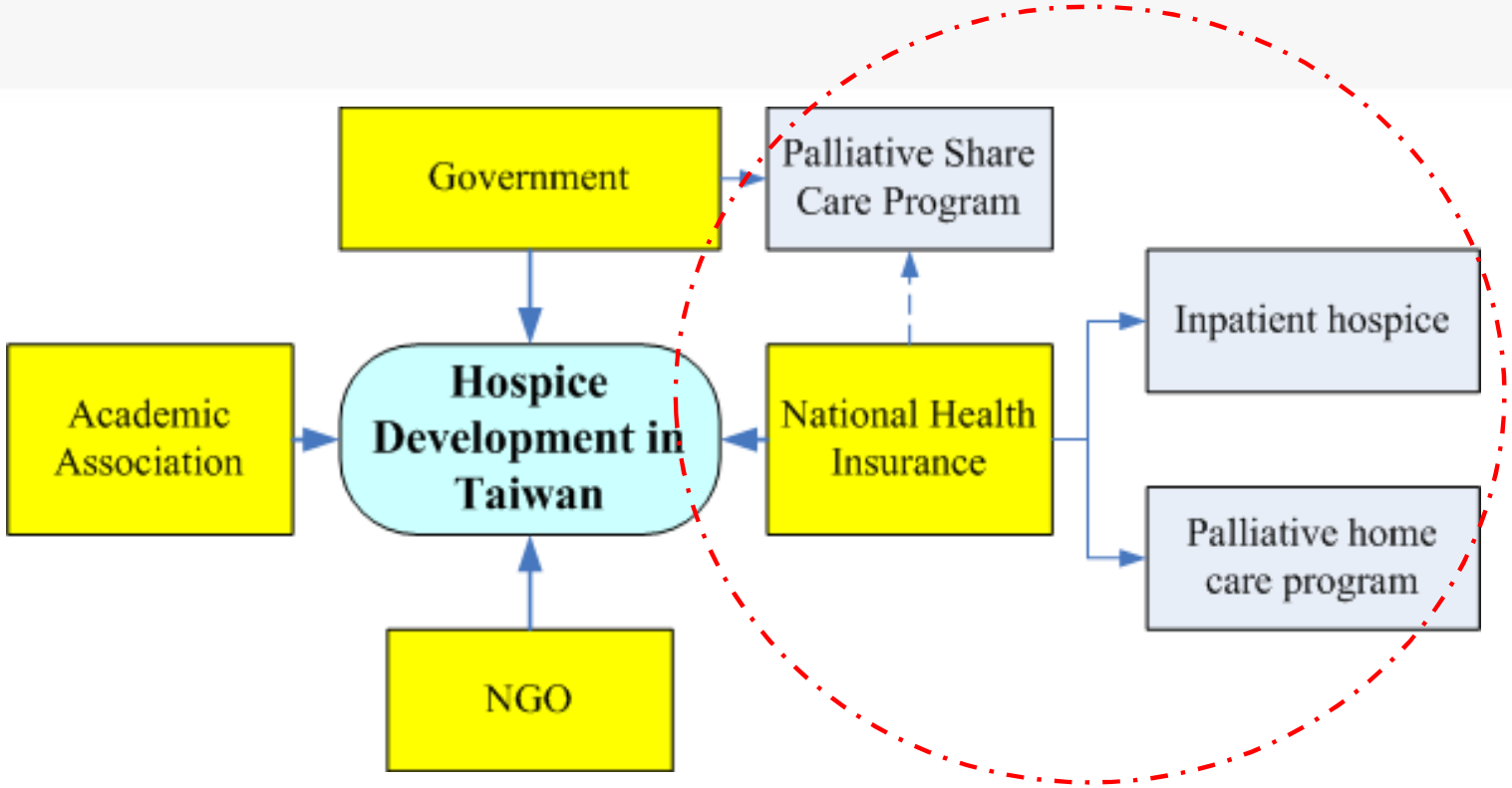
- Nature Death Act 2000 (Hospice Palliative Medical Act)
- Patient Self Determinant Act 2015
- National Cancer Control Program: at least 50% terminal cancer patient should receive palliative care service
- National health insurance subsidize hospice home-care and in-patient-care system (for cancer1996, 2000, motor neuron disease 2003)
- Department of Health set up the standard of hospice home care, the standard of in-patient hospice care, guidelines for pain control in terminal cancer patients
- Taiwan Academy of Hospice Palliative Medicine began a nationwide and official accreditation for hospice service 2000

Hospice Palliative Medical Act

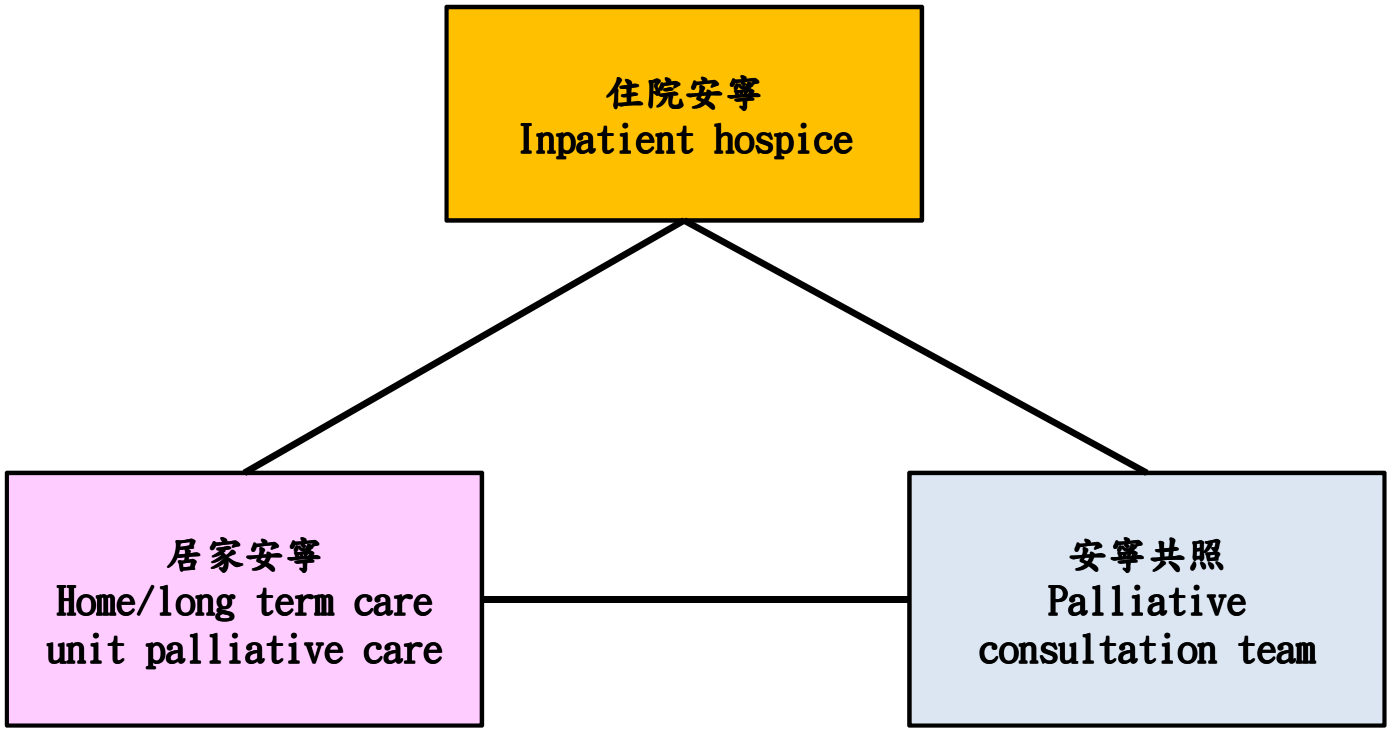
- The patient's right to sign a 'do not resuscitate' order 2000
- The Act was first amended in 2002 to allow for the withdrawal of life-sustaining devices for terminally ill patients if pre-determined by oneself.
- The Act was second amended in 2011 to allow withdrawal of life-sustaining devices for terminally ill if all family members agree and approved by ethical committee.
- The Act was **third amended in 2013 to allow withdrawal of life-sustaining devices for terminally** ill if at least one family members agree.

Willingness to accept Natural Death Act recorded in the NHI card




Government
Palliative Share Care Program
Academic Association
Hospice Development in Taiwan
National Health Insurance
Inpatient hospice
Palliative home care program
NGO

全民健保給付三種安寧緩和醫療照護方式
National Health Insurance - 3 types service program



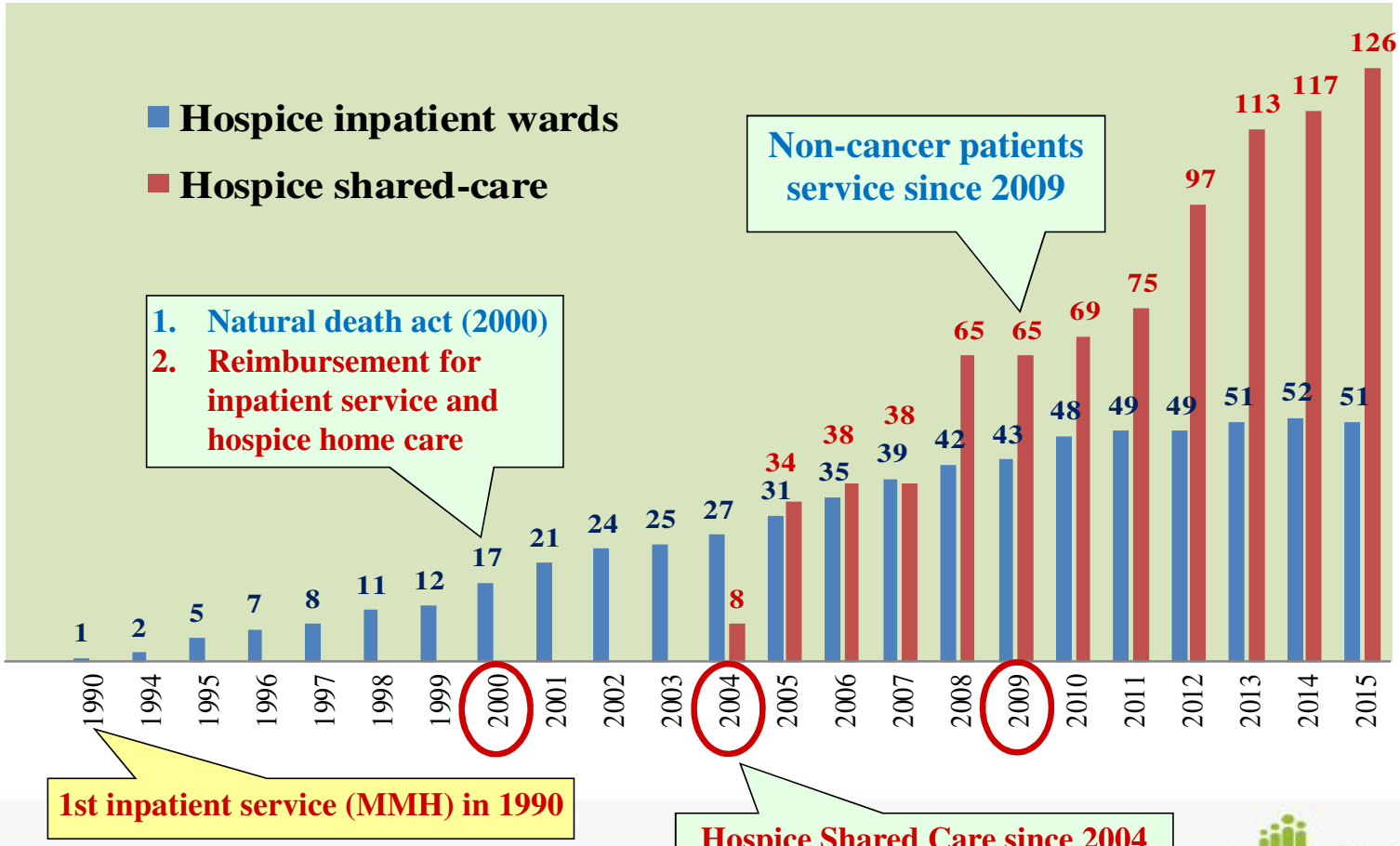
Increase reimbursement for Hospice and Palliative care

Since Feb. 1, 2015, rising the payment point of hospice service:

	iterm	Before adjustment (point)	After adjustment (point)	Adjustment range	Financial impact assessment (hundred million point)
Hospice inpatient service	1	4,390	6,409	30%	2.073
Hospice home care services	29	700~2,750	840~5,500	50~100%	0.256
Hospice shared-care	3	850~1,350	1,275~2,025	50%	0.288
Hospice Consult fees	1	1500	2250	50%	0.272

Note：
Financial impact assessment: estimated the increase level of medical cost, by 2013 and 2014 data and other data of Adjustment range.

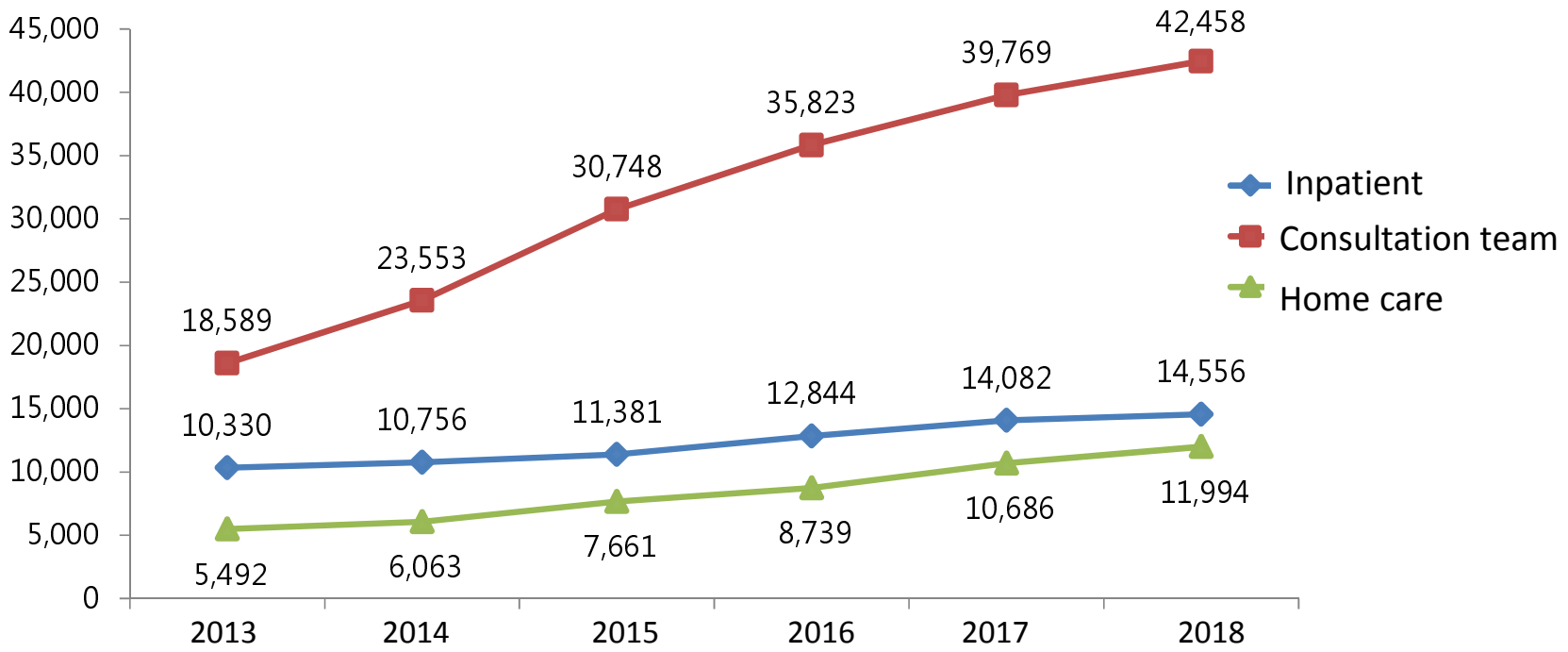
The numbers and the growth of units of Hospice in-patient wards and shared care teams



Number of person received hospice care

2013

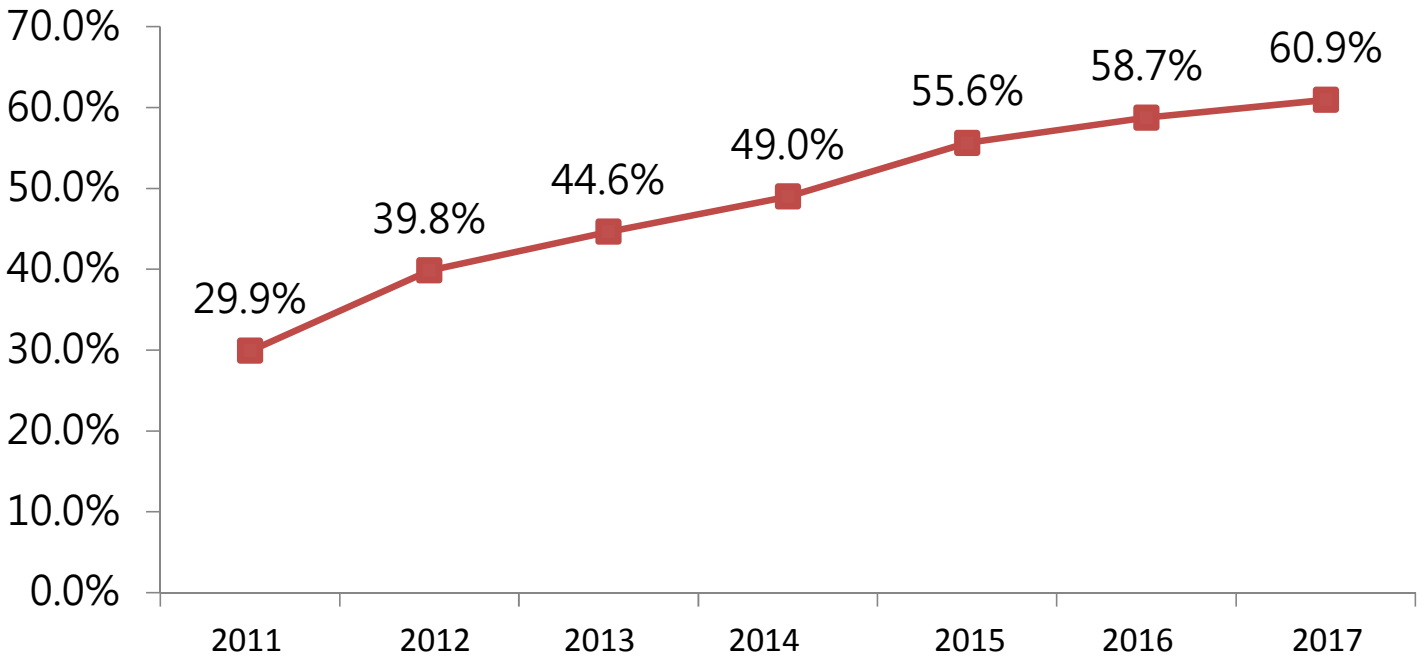
Unit : people



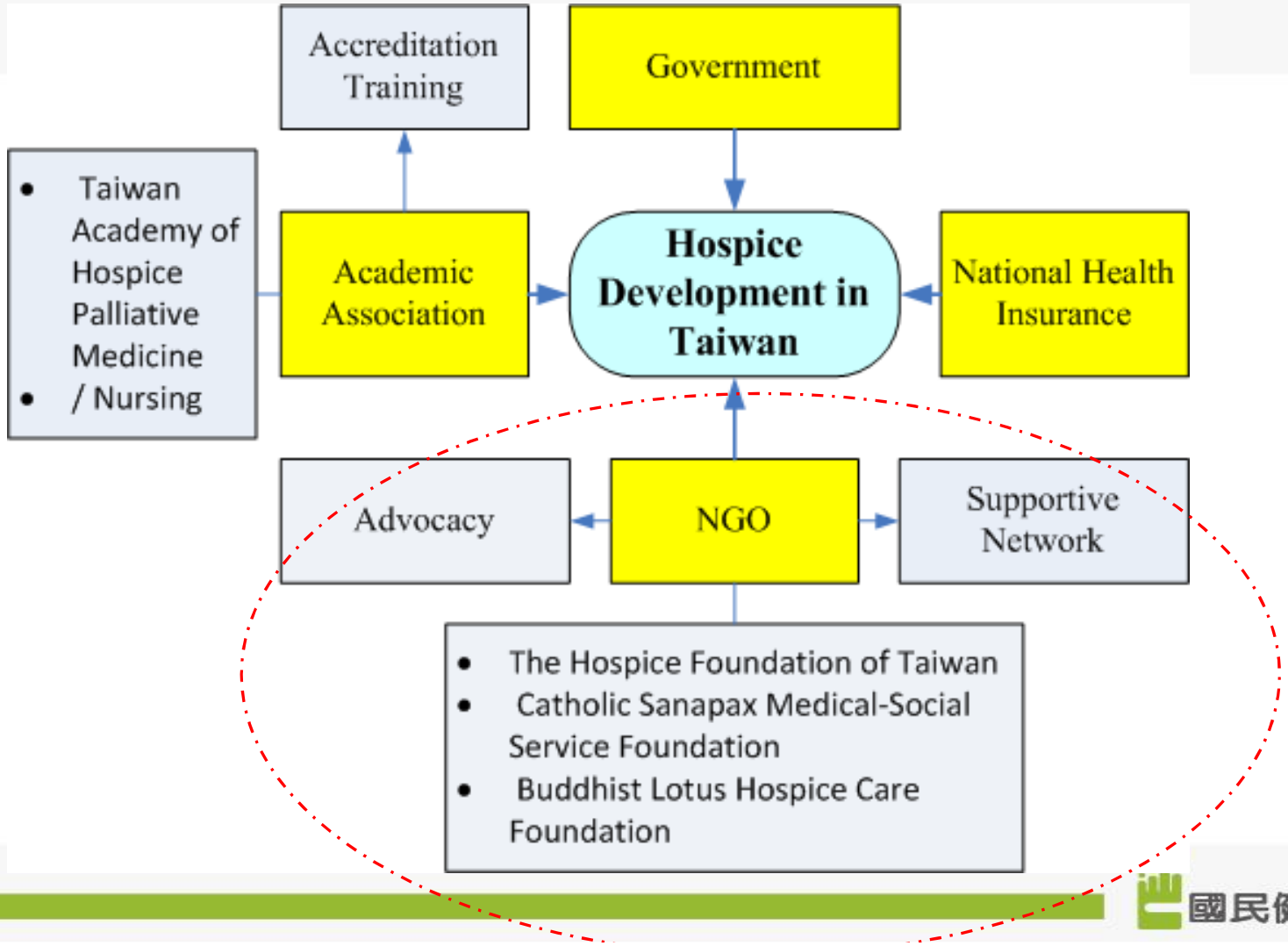
註：

1. 資料來源：健保署三代倉儲門診、住院明細醫令檔(擷取日期： 108年1月31日)
2. 103年安寧居家申報資料包含社區安寧之申報資料。

Cancer patients received hospice care within one year before death

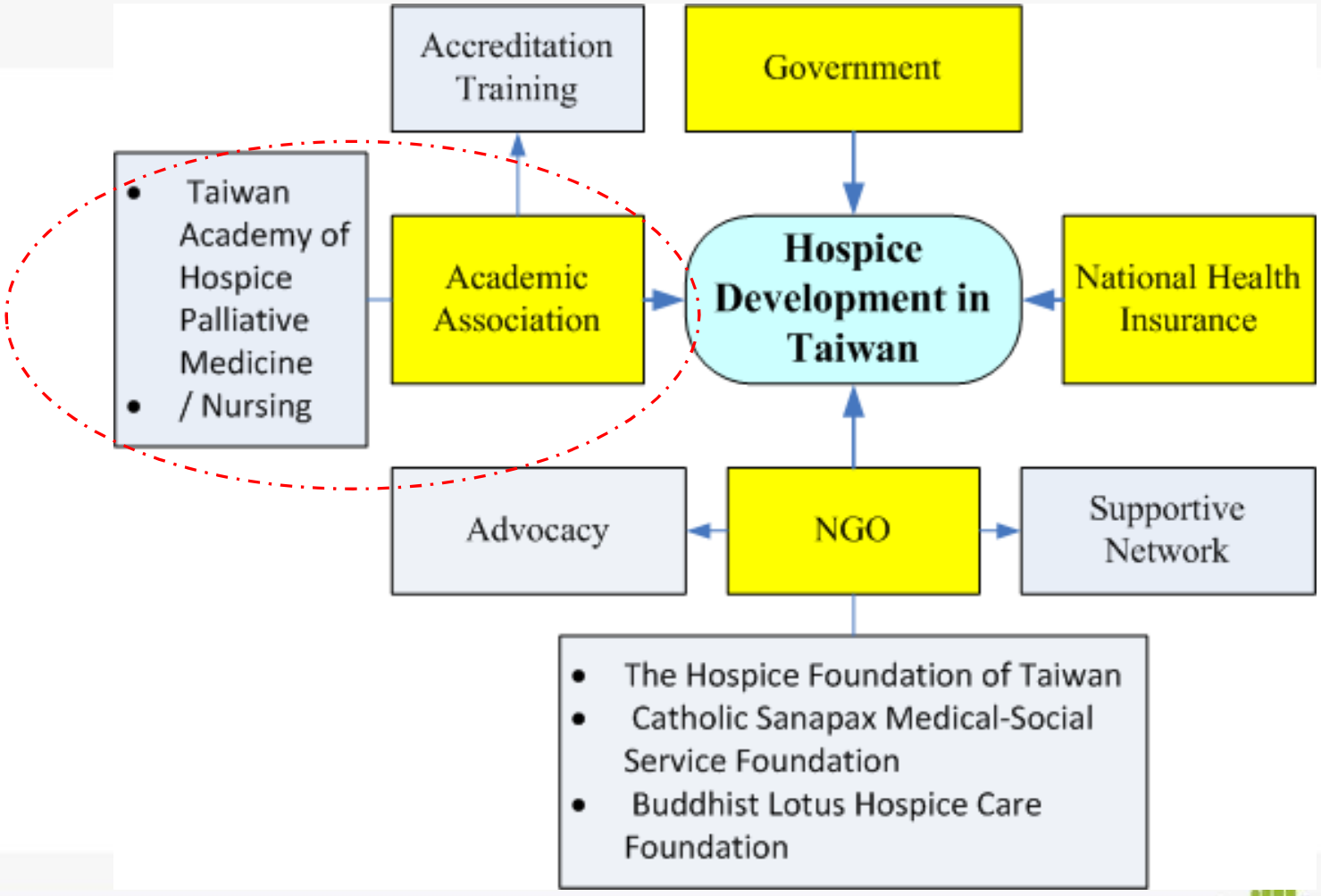


註：
1. 資料來源:健保署三代倉儲門診、住院明細醫令檔、衛生福利部全國死因檔(擷取日期: 107年8月22日）。
2. 使用安寧療護係指接受安寧住院、安寧居家及安寧共照任一項。
3. 本資料以死亡前一年內曾接受安寧療護之人數統計。


Accreditation Training
Government
Taiwan Academy of Hospice Palliative Medicine / Nursing
Academic Association
Hospice Development in Taiwan
National Health Insurance
Advocacy
NGO
Supportive Network
The Hospice Foundation of Taiwan
Catholic Sanapax Medical-Social Service Foundation
Buddhist Lotus Hospice Care Foundation

Community Action - NGO

- Foundation
  - The Hospice Foundation of Taiwan (**Christian**)
  - The **Catholic** Sanipax Socio-Medical Service and Education Foundation
  - The **Buddhist** Lotus Hospice Care Foundation
- Academic association
  - Taiwan Hospice Organization 1995
  - Taiwan Academy of Hospice Palliative Medicine 1999
  - Taiwan Association of Hospice Palliative Nursing in 2005
  - Taiwan society of cancer palliative care 2004
- Advocacy for palliative care in the community yearly


Accreditation Training
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Hospice Development in Taiwan
National Health Insurance
Advocacy
NGO
Supportive Network
The Hospice Foundation of Taiwan
Catholic Sanapax Medical-Social Service Foundation
Buddhist Lotus Hospice Care Foundation

Accreditation for palliative care service

- Taiwan Academy of Hospice Palliative Medicine began a nationwide and official accreditation for hospice service 2000
- Integrate into the national hospital accreditation program since 2008
- New criteria implemented since 2015

106年度醫院評鑑基準(醫學中心適用)

2017 Accreditation criteria (medical center)

條號	條文	評量項目(草案)
可 2.3.18	有適當安寧緩和醫療團隊提供安寧照護服務	目的： 安寧緩和醫療有適當之專業團隊，提供多元化、高品質的安寧照護服務。 符合項目： 1-a.安寧病房： (1)應有受過安寧緩和醫學訓練之專責主治醫師1人負責安寧緩和醫療團隊相關業務。 (2)每床應有護理人員1人以上。 1-b.安寧居家療護： (1)應有專責主治醫師1名以上。 (2)應有專責護理師至少1人，且每月每45訪視人次應有專任安寧居家療護護理師1人以上。 (3)應提供安寧療護護理專業人員24小時電話諮詢服務。 (4)有專責之醫護主管負責管理相關事務，並訂有居家訪視醫療人員的安全保障措施。 1-c.安寧共同照護： (1)應有專責主治醫師1名以上。 (2)應有專責護理師至少1人，且每月每30新收案人數應有專任安寧共同照護護理師1人以上。 2.應有1名專責社工人員。 3.安寧居家療護及安寧共同照護護理師需具備至少2年之內外科(或安寧病房)相關臨床經驗。 4.上述人員均需受過安寧療護教育訓練80小時以上。 5.安寧緩和醫療團隊組織架構明確，定期召開跨專業團隊會議，整合團隊共識，並擬定跨專業的處置計畫 優良項目：(下述項目1(1-a至1-c)依提供之服務，為可選項目，且1至4項僅限一項未達成) 1-a.安寧病房： (1)50%以上護理人員具1年以上臨床安寧療護護理經驗。 (2)夜間及假日能有主治醫師待命，且其需受過安寧療護教育訓練80小時以上。 1-b.安寧居家療護：專任安寧居家護理師休假時，有明確職務代理制度提供出勤服務。 1-c.安寧共同照護：每月每25新收案人數應有專任安寧共同照護護理師1人以上。 2.安寧緩和醫療團隊之醫師、護理人員及社工人員每3年應接受安寧相關繼續教育訓練至少60小時並有紀錄。 3.有專責心理師、志工或靈性關懷人員提供服務，且需受過安寧療護教育訓練並有紀錄。 4.有為各專業新進醫療團隊人員設計完整標準作業手冊、自學教材(書面或視聽)、輔導計畫及輔導機制。

National EoL Caring Guideline

End stage neurological disease

End stage dementia

End stage renal disease

Indicator scores

2015 Quality of Death Index

	Rank / 80	Score / 100	Data	Unit
SUPPLY ENVIRONMENT	**6**	**82.1**		**0 - 100 where 100= best and 0=worst**
1) PALLIATIVE AND HEALTHCARE ENVIRONMENT	**7**	**74.5**		**0 - 100 where 100= best and 0=worst**
1.1) Healthcare spending	46	36.9	6.6	% of GDP
1.2) Presence and effectiveness of government-led national palliative	=1	100.0	5	EIU rating
1.3) Availability of research-based policy evaluation	=1	100.0	5	EIU rating
1.4) Capacity to deliver palliative care	12	61.3	39.0	%
2) HUMAN RESOURCES	**10**	**69.4**		**0 - 100 where 100= best and 0=worst**
2.1) Availability of specialised palliative care workers	=4	75.0	4	EIU rating
2.2) General medical knowledge of palliative care	=7	75.0	4	EIU rating
2.3) Certification for palliative care workers	=1	100.0	1	EIU rating
2.4) Number of doctors per 1,000 PC-related deaths	24	49.2	588.8	Doctors per 1,000 non-accidental deaths
2.5) Number of nurses per 1,000 PC-related deaths	=11	47.7	1731.9	Nurses per 1,000 non-accidental deaths
3) AFFORDABILITY OF CARE	**=6**	**91.7**		**0 - 100 where 100= best and 0=worst**
3.1) Availability of public funding for palliative care	=7	75.0	4	EIU rating
3.2) Financial burden to patients for available palliative care	=1	100.0	5	EIU rating
3.3) National pension scheme coverage of palliative care services	=1	100.0	3	EIU rating
4) QUALITY OF CARE	**=7**	**87.5**		**0 - 100 where 100= best and 0=worst**
4.1) Presence of monitoring standards for organisations	=1	100.0	1	EIU rating
4.2) Availability of painkillers	=1	100.0	5	EIU rating
4.3) Availability of psycho-socio support for patient and families	=1	100.0	3	EIU rating
4.4) Presence of Do not resuscitate (DNR) policy	=1	100.0	1	EIU rating
4.5) Shared decisionmaking	=25	50.0	3	EIU rating
4.6) Use of patient satisfaction surveys	=4	75.0	4	EIU rating
5) COMMUNITY ENGAGEMENT	**=3**	**87.5**		**0 - 100 where 100= best and 0=worst**
5.1) Public awareness of palliative care	=5	75.0	4	EIU rating
5.2) Availability of volunteer workers for palliative care	=1	100.0	5	EIU rating

全球一等(第一): 政府支持、有實證研究的政策、安寧人員的認證制度、病人經濟的負擔、機構的管理與評估、完整止痛的藥物、對病人與家屬的心理靈性支持、DNR的政策(緩和安寧條例、參與安寧療護的志工)


送你一份愛的禮物
Love Gift
預立醫療自主計畫
Advance Care Planning
手冊
王英偉


送你一份愛的禮物
Love Gift
送你一份愛的禮物
Love Gift


醫病共享決策介紹
決策輔助工具
教育資源
相關網站
常見問題
聯絡我們
衛生福利部
醫病共享決策平台
Ministry of Health and Welfare,
Platform for Shared Decision Making
請輸入關鍵字
搜尋
熱門關鍵字: 輔助工具 SDM 人工膝關節 呼吸 醫病
醫病共享決策介紹
醫病共享決策（SDM）緣起
醫病共享決策輔助工具介紹
醫病共享決策響應活動
醫病共享決策輔助工具競賽
您現在的位置 › 首頁 › 醫病共享決策介紹 › 醫病共享決策輔助工具競賽
醫病共享決策輔助工具競賽
Shared decision making tools
請輸入您要查詢的關鍵字
搜尋
標題
日期
競賽說明
2016.06.02
報名資訊
2016.06.02

New Movements in Hospice and Palliative Care

The Ministry of Health and Welfare organized a taskforce to develop hospice and palliative care in 1995

First

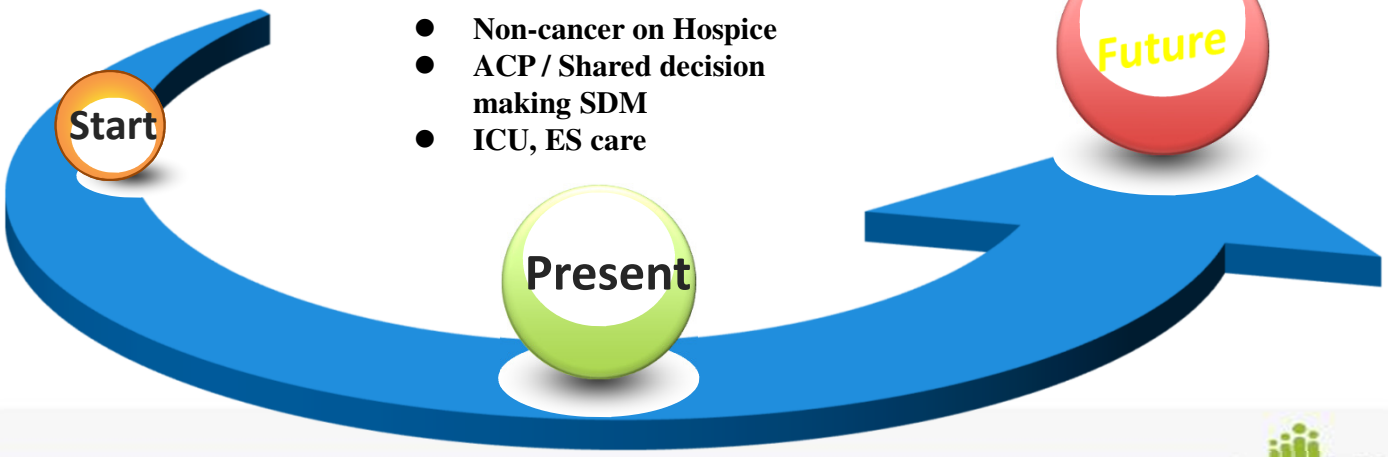
- Development of Hospice concept
- Focus on cancer
- Development of hospital care, shared care and home care

Second

- Non-cancer on Hospice
- ACP / Shared decision making SDM
- ICU, ES care

Third

- The elderly and children Hospice Care
- Early palliative Care
- Hospice of Long-Term Care and community
- New Technology in community Palliative care
- Patient Right to Autonomy Act
- **Compassionate cities/compassionate community**



Patient Right to Autonomy Act in Taiwan
Implement in Jan 2019

- By the end of 2015, Taiwan has become the first Asian country which has the Patient Right to Autonomy Act legislation.

- The right of refusal of Life- Sustaining Treatment: Patient can use Advance decision (AD)to express their wish to accept or refuse certain kind of medical treatments when diagnosed with the specific clinical condition.

Patient Self-Determination Act Passes Third Reading

by HFT secretariat

The Legislature Yuan of Taiwan has passed the Patient Self-Determination Act (PSDA) on December 18, 2015. This act allows patients to have a say in their medical care at the end of life. The Ministry of Health and Welfare indicates that the act is the first patient self-determination act published in statutory form and will begin to take effect three years later.

The purpose of PSDA is to re-emphasize the importance of patients' rights when it comes to medical decision making, especially when it is a matter of life or death. Patients can make their own Advance Directive via Advance Care Planning by stating whether they wish to accept or refuse any kind of medical treatments when diagnosed with the following conditions: being terminally-ill, in a coma or persistent vegetative state, or with advanced dementia or incurable diseases that include unbearable pain.

The highlight of PSDA is it gives Advance Directive a legally binding nature, which occurs when patients receive Advance Care Planning consultation provided by approved medical institutions. The result is the patients' own Advance Directive, which then needs to be notarized or witnessed by two fully capable adults, stamped by the institution, and be registered in the National Health Insurance system. Additionally, two specialist physicians are required to confirm if patients meet the five definitions stated in the act.

In order to minimize the skepticism of the medical staff, immunity is introduced to this act. That means medical institutions and physicians are freed from criminal liability when they do not completely fulfill the patients' Advance Directive based on the staff's own judgment or willingness; or when they perform according to the patients' Advance Directive to suspend, remove or refuse life sustaining treatments. When it comes to the

(News picture)

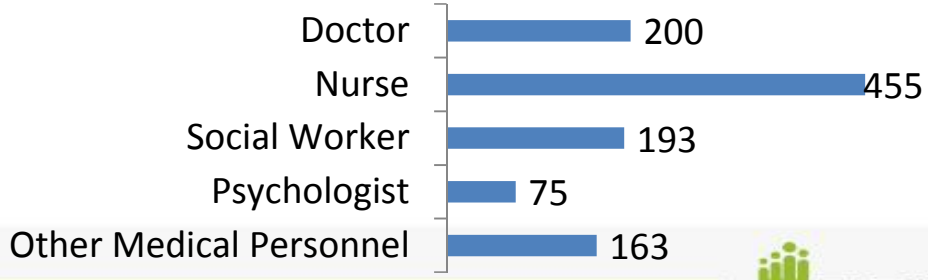
Training

Training workshop for Teachers of Patient Right to Autonomy Act

Teach method : Cooperative Learning/ Flipped Classroom

(Jun. 2017-Nov.2018)
The total of class opened: 19 times
Numbers of Participant:1086

The participation of Prefossionals



VOLUME 35 · NUMBER 1 · JANUARY 1, 2017

JOURNAL OF CLINICAL ONCOLOGY

ASCO SPECIAL ARTICLE

Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update

Betty R. Ferrell, Jennifer S. Temel, Sarah Temin, Erin R. Alesi, Tracy A. Balboni, Ethan M. Basch, Janice I. Firn, Judith A. Paice, Jeffrey M. Peppercorn, Tanyanika Phillips, Ellen L. Stovall,† Camilla Zimmermann, and Thomas J. Smith

Early palliative Care in cancer

New Quality Assurance Program for Cancer Care 2017

【加分項目】基準3.3	
評分說明	符合項目： 1. 已建立晚期癌症病人接受緩和醫療之照護標準與流程。 2. 在兩種癌別或兩個腫瘤相關病房（安寧病房除外）開始實行。
準備文件	1. 晚期癌症病人接受緩和醫療之照護標準與流程。 2. 緩和照護團隊之成員名單。 3. 緩和照護之執行紀錄（例如：照護服務單紀錄或病歷紀錄）。 4. 緩和照護團隊教育訓練課程大綱。
重點	1. 晚期癌症定義：癌症出現遠處轉移或復發，但透過治療仍可延長病人生命（生命預期存活期 > 6個月）。 2. 照護標準與流程應包含啟動轉介緩和醫療之條件、轉介流程與照護服務內容等。 3. 緩和照護團隊除需包含醫師（安寧專科醫師或腫瘤治療專科醫師）、護理師、社工師、心理師外；亦可自行增加其他相關人員（如靈性關懷人員等）。可由現有安寧緩和照護團隊或多專科團隊中成立功能小組負責辦理。 4. 緩和照護團隊成員應接受相關教育訓練，課程內容至少應涵蓋身心症狀處理、共同醫療決策及照護者支持等面向。

REVIEW

CME CREDIT ***EDUCATIONAL OBJECTIVE:*** Readers will consider frailty as a factor when helping patients make decisions about end-of-life care

KATALIN KOLLER, MD, FRCPC
Assistant Professor, Division of Geriatric Medicine, Dalhousie University, Halifax, Nova Scotia, Canada

KENNETH ROCKWOOD, MD, FRCPC, FRCP
Professor of Medicine, Division of Geriatric Medicine and Division of Neurology, Kathryn Allen Weldon Professor of Alzheimer Research, Dalhousie University, Halifax, Nova Scotia, Canada

Frailty in older adults: Implications for end-of-life care

Age and Ageing 2016; **45:** 863–873
doi: 10.1093/ageing/afw124
Published electronically 1 September 2016

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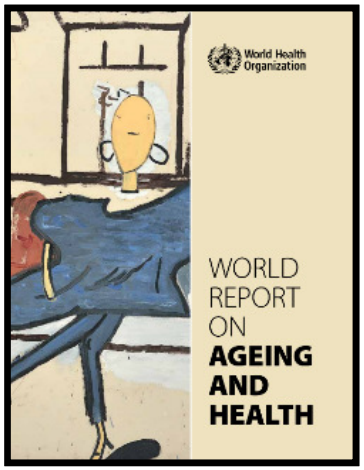
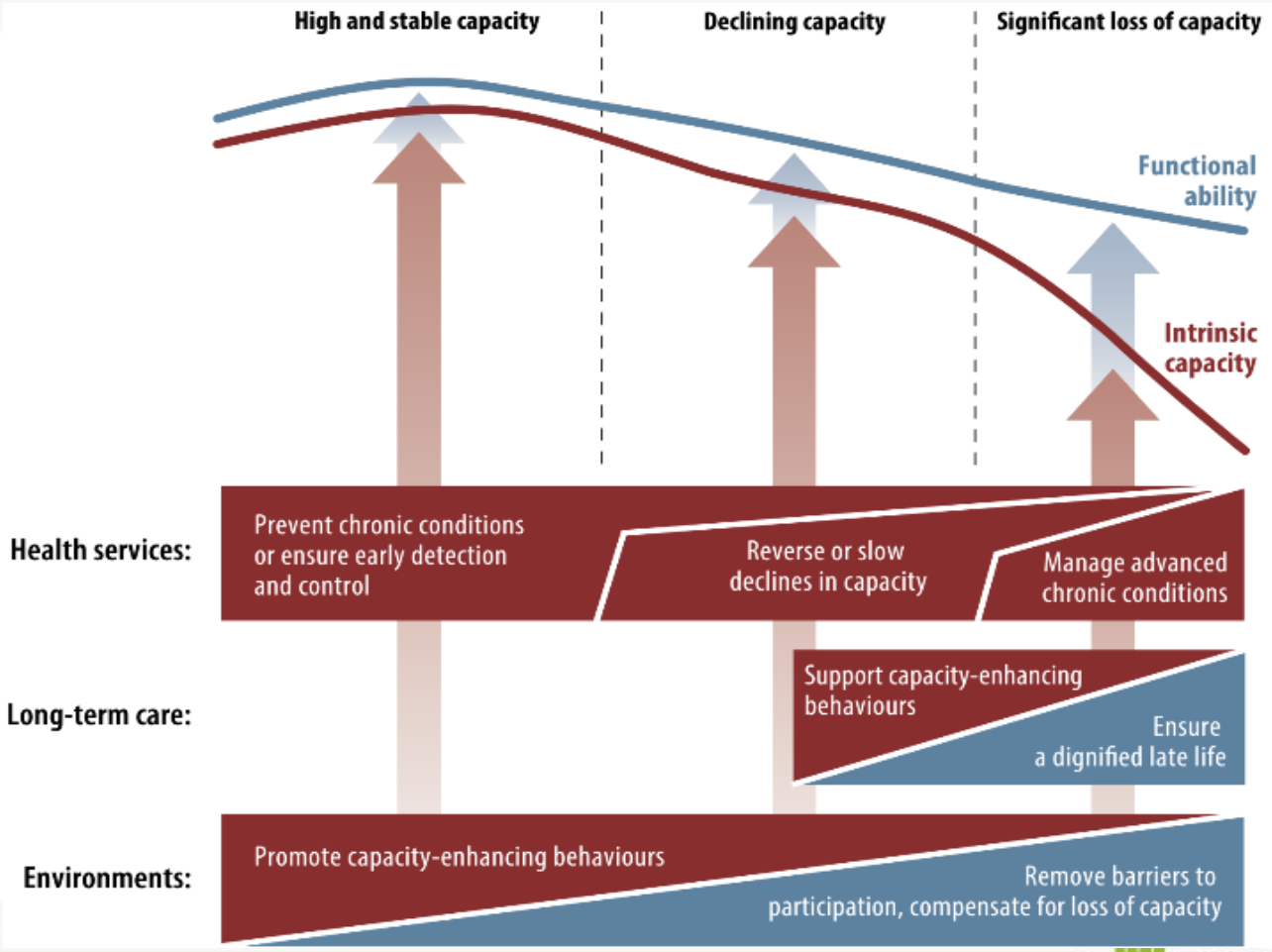
Developing a model of short-term integrated palliative and supportive care for frail older people in community settings: perspectives of older people, carers and other key stakeholders

A public-health framework for *Healthy Ageing:* opportunities for public-health action across the life course



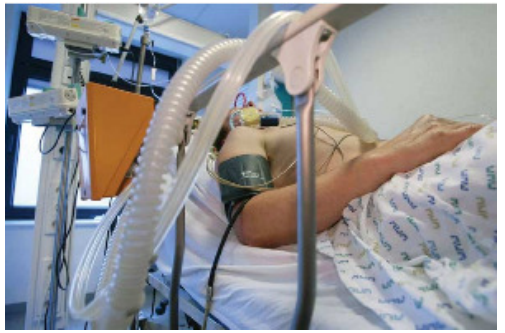


Inpatient hospice

Home hospice care

Long term care institution

General ward

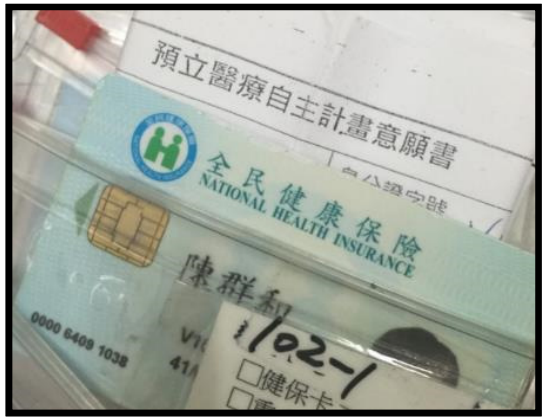


ICU

End of Life care in long term care institution

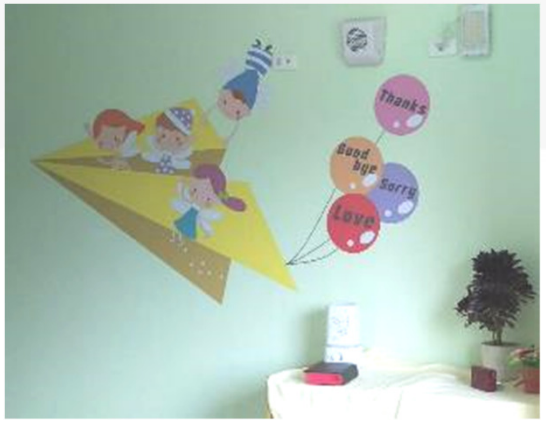
Advanced care planning

預立醫療自主計劃

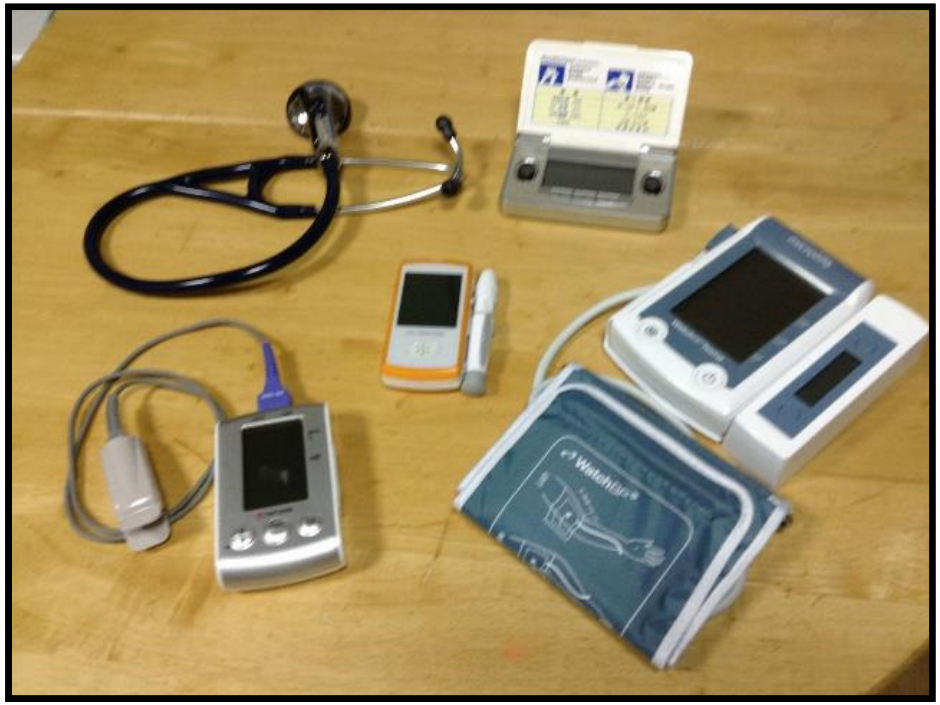


Room for dying patient in long term care institution

臨終照護—候機室



New Technology in Community Palliative Care



Remote monitor of vital sign of the patient (BP, HR, blood oxygen, heart/breathing sound)

Palliative home care monitoring

Instruction for foreign health helper by using their own language

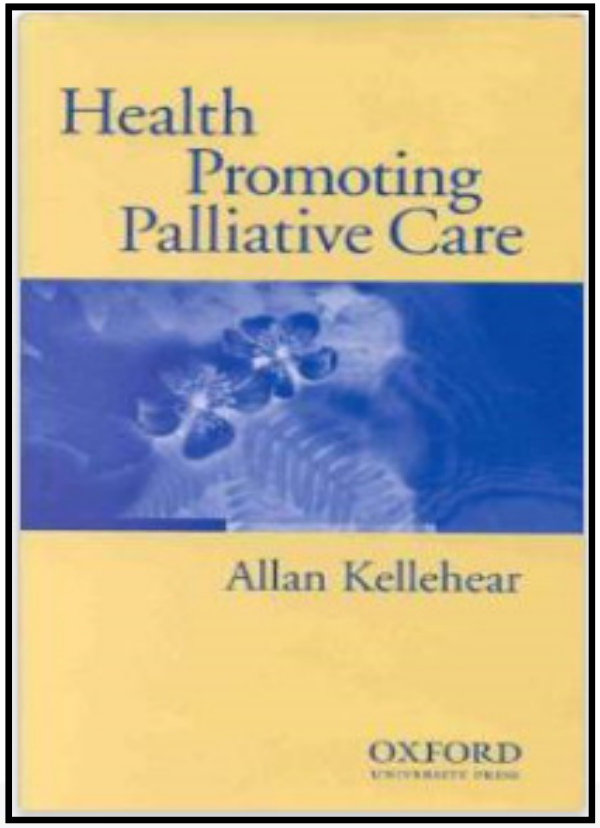
居家護理師透過衛教影片(印尼語)指導外藉看護如何為病人病人作舒適護理。

Web based translator

病人：原住民長者、或外籍看護：印尼語

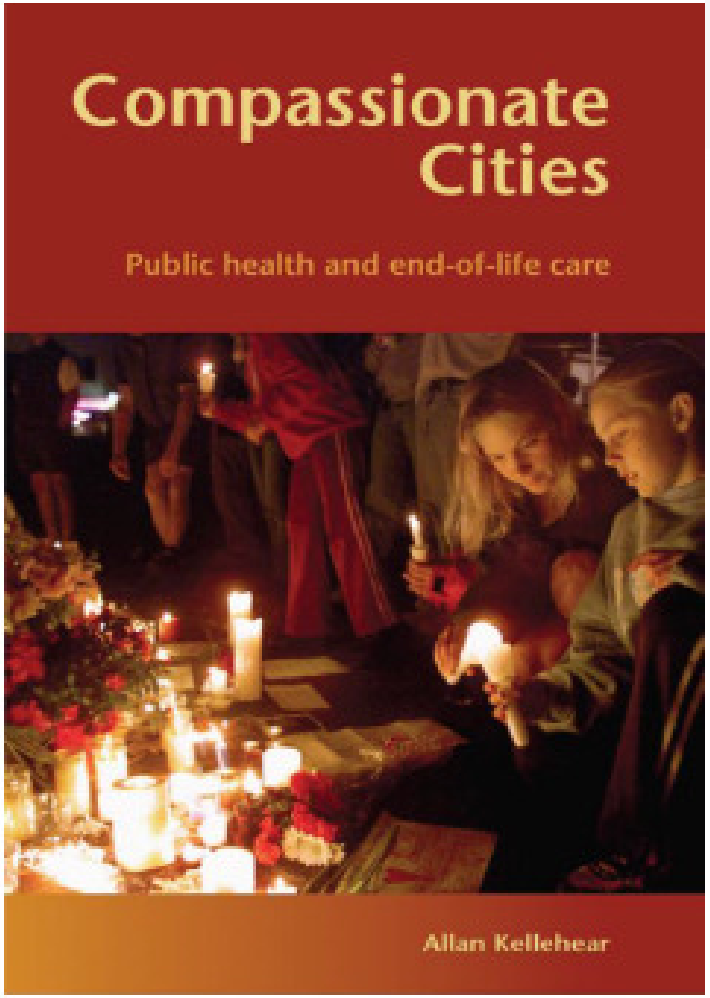
1. 醫護人員
2. 在家的翻譯志工

Empowerment for patient and family in the community



Ottawa Charta(1986)

- Healthy public policy
- Supportive environment
- Community action
- Improve personal skill
- Reorienting health services



© Allan Kellehear - From K. Wegleitner, K. Heimerl, A. Kellehear (2016)
Compassionate Communities: Case studies from Britain and Europe. Abingdon, Routledge, 2016, pp 80-82.

THE COMPASSIONATE CITY

- A CHARTER of ACTIONS -

Compassionate Cities are communities that recognize that all natural cycles of sickness and health, birth and death, and love and loss occur everyday within the orbits of its institutions and regular activities. A compassionate city is a community that recognizes that care for one another at times of crisis and loss is not simply a task solely for health and social services but is everyone's responsibility.

Compassionate Cities are communities that publicly encourage, facilitate, supports and celebrates care for one another during life's most testing moments and experiences, especially those pertaining to life-threatening and life-limiting illness, chronic disability, frail ageing and dementia, grief and bereavement, and the trials and burdens of long term care. Though local government strives to maintain and strengthen quality services for the most fragile and vulnerable in our midst, those persons are not the limits of our experience of fragility and vulnerability. Serious personal crises of illness, dying, death and loss may visit any us, at any time during the normal course our lives. A compassionate city is a community that squarely recognizes and addresses this social fact.

Through auspices of the Mayor's office a compassionate city will - by public marketing and advertising, by use of the cities network and influences, by dint of collaboration and co-operation, in partnership with social media and its own offices – develop and support the following 12 social changes to the cities key institutions and activities.

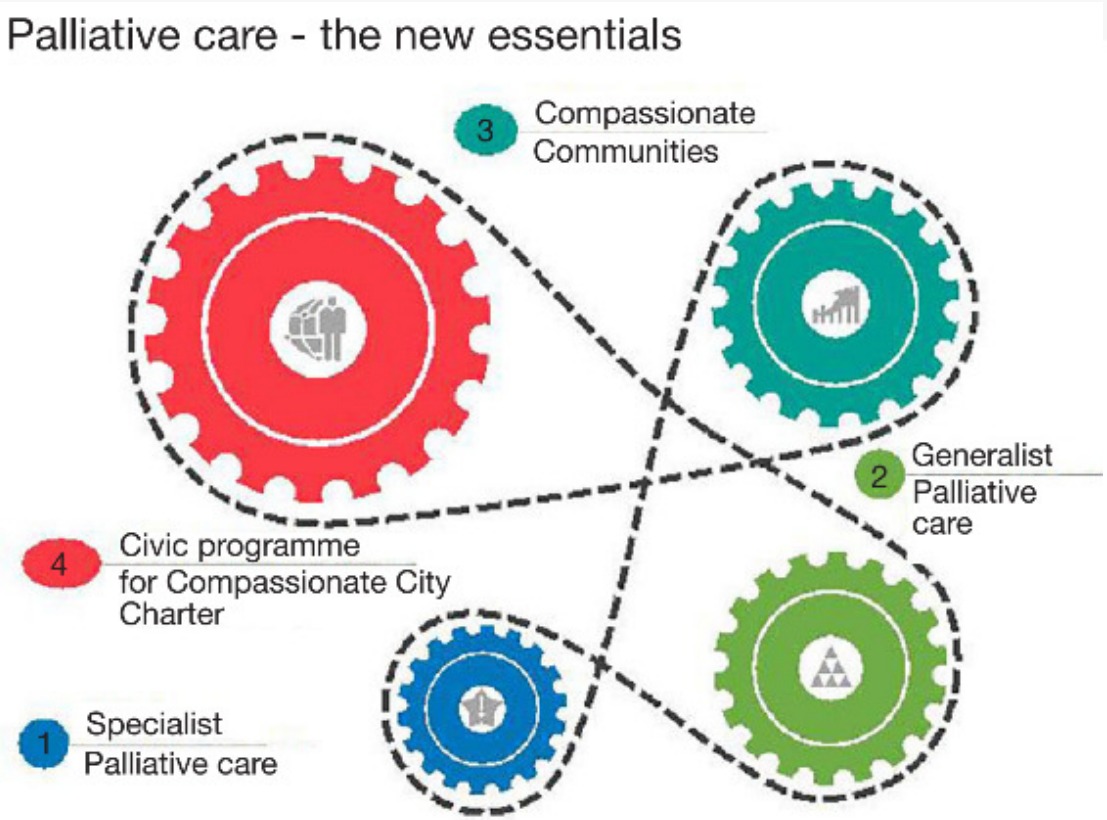
- Our schools will have annually reviewed policies or guidance documents for dying, death, loss and care
- Our workplaces will have annually reviewed policies or guidance documents for dying, death, loss and care
- Our trade unions will have annually reviewed policies or guidance documents for dying, death, loss and care
- Our churches and temples will have at least one dedicated group for end of life care support
- Our city's hospices and nursing homes will have a community development program involving local area citizens in end of life care activities and programs
- Our city's major museums and art galleries will hold annual exhibitions on the experiences of ageing, dying, death, loss or care

20 Pilot spots for compassionate communities since March 2018

Dabei Buddhist Center - Sprirtual Café

Compassionate Community
臺南市天主教守護生命關懷協會

Palliative care—the new essentials model



Ann Palliat Med 2018;7(Suppl 2):S3-S14

衛生福利部
國民健康署
Health Promotion Administration,
Ministry of Health and Welfare

Education and Training

Palliative care education in medical school

- Lecture
- Site visit
- Clinical rotation: days to weeks
- Home visit
- ….

Postgraduate Physician (PGY) training

二年期醫師畢業後一般醫學訓練計畫

PGY1-社區醫學

特殊照護

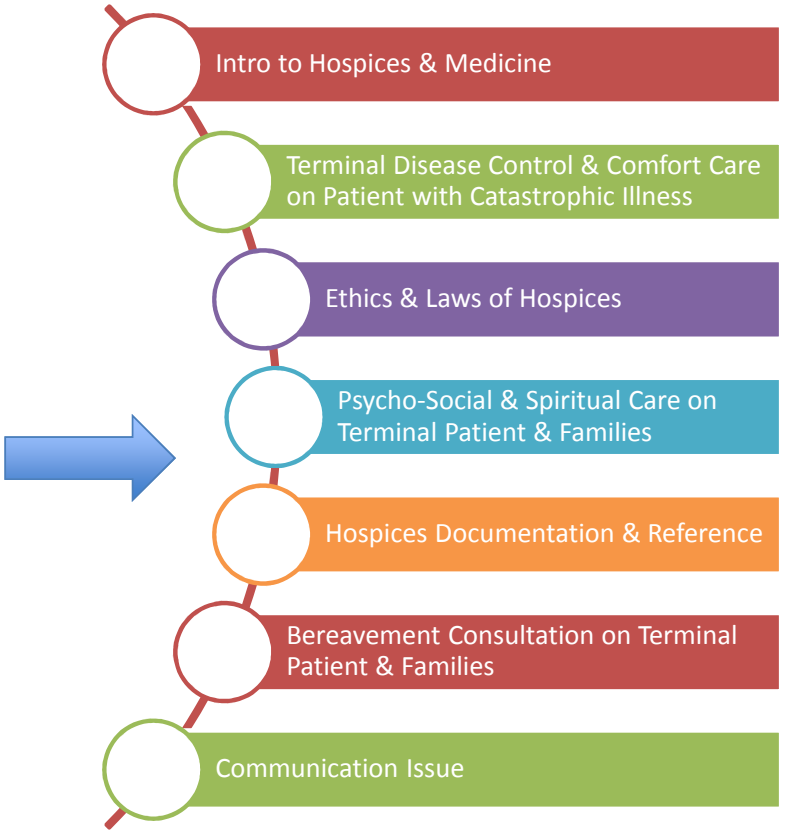
必修	中老年族群之健康照護及應用	1.能瞭解國內中老年族群前十大死因及前五大癌症名稱。 2.能夠執行至少三種中老年族群常見慢性病的診斷與治療。 3.能夠執行至少三種中老年族群常見慢性病的衛教諮詢。
必修	安寧緩和醫療照護概念及應用	1.能瞭解「安寧緩和醫療條例」及安寧照護之目標、對象及照護內容。 2.能瞭解各種安寧療護(住院、居家、共照及社區)模式，並參與病人之評估及照護。 3.能瞭解社區安寧療護與在宅善終目標及內容。

Specialist Palliative Care

Launched in 2013 by Professional societies

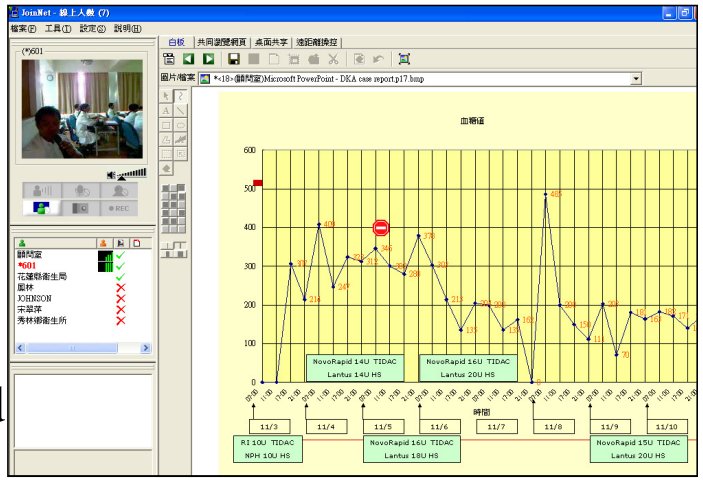
2018 年安寧緩和醫療照護之專業教育訓練營

場次	醫師	護理	居家之類	活動時數	主題	題目
通識(A)0421	必1	必1	必1	1	安寧緩和醫療的介紹	安寧緩和療護的哲理、現況與展望
	必1	必1	必1	1	安寧緩和醫療的介紹	社區安寧緩和療護
	必1	必1	必1	1	末期症狀控制與十大疾病病人之舒適照護	末期疾病症狀評估與控制總論
	必1	必1		1	末期症狀控制與十大疾病病人之舒適照護	末期疾病下同的軌線圖（disease trajectory）與存活期預估
	必2	必2	必1.5	2	安寧療護倫理與法律	安寧緩和醫療條例與相關法律之臨床運用
	必2	必2	必1.5	2	安寧療護倫理與法律	安寧療護臨床決策的倫理與困境
通識(B)0422	必2	必2	必2	2	安寧緩和醫療的介紹	老人及十大末期疾病的安寧緩和療護 (註:末期疾病涵括安寧緩和給付之疾病)
	必1	必1	必1	1	末期病人及家屬之心理社會與靈性照護	末期病人的心理社會需求
	必1	必1	必1	1	末期病人及家屬之心理社會與靈性照護	末期病人的靈性需求
	必1	必1	必1	1	安寧療護服務(含住院、居家及共照)相關表單制度與轉介	出院準備與安寧居家療護
	必1	必1	必1	1	末期病人與遺族之哀傷輔導	末期病人之家屬的照護
	必1	必2	必1	2	末期病人與遺族之哀傷輔導	悲傷輔導之臨床實務運用
通識(C)0505		必2		2	末期病人及家屬之心理社會與靈性照護	文化及宗教的生死觀與喪葬禮俗
		必1		1	末期病人及家屬之心理社會與靈性照護	專業人員之壓力與耗竭暨安寧療護專業人員之特質、自我覺知與壓力調適
		必2		2	安寧緩和醫療的介紹	兒童安寧療護概念
				1	末期症狀控制與十大疾病病人之舒適照護	中醫藥在安寧病房的運用
通識(D)0512		必1		2	安寧療護服務(含住院、居家及共照)相關表單制度與轉介	安寧療護護理紀錄之書寫—護理過程之運用
				1	安寧療護服務(含住院、居家及共照)相關表單制度與轉介	安寧療護相關表單紀錄書寫
	必1			1	安寧療護服務(含住院、居家及共照)相關表單制度與轉介	安寧緩和療護的專業照會(含初次評估)
	必1	必2		2	溝通議題	家庭動態評估、家庭會議與預立照顧計畫
通識(E)0519	必1	必1		1	末期症狀控制與十大疾病病人之舒適照護	呼吸症狀處理
	必1	必2		2	末期症狀控制與十大疾病病人之舒適照護	瀕死症狀與瀕死期的照護
	必2	必2		2	末期症狀控制與十大疾病病人之舒適照護	疼痛病理學、疼痛評估與照護；嗎啡類藥物疼痛控制、非嗎啡類止痛藥及輔助用藥、困難處理之疼痛與難題
				1	末期症狀控制與十大疾病病人之舒適照護	安寧療護的輔助療法(概論)：芳香、音樂、寵物、TENS 等
通識(F)0526	必1	必2		2	溝通議題	末期疾病的病情告知技巧與死亡準備
		必1		1	安寧療護倫理與法律	安寧緩和療護的營養與水分議題之倫理思辨
	必1	必2		2	末期症狀控制與十大疾病病人之舒適照護	非癌症病人的安寧緩和醫療(含急重症、ESRD、COPD、ALS、AIDS 及失智症)
				1	末期症狀控制與十大疾病病人之舒適照護	安寧療護的輔助療法(概論)：芳香、音樂、寵物、TENS 等
舒適護理(F)0602 0609 0623						
		必8		8	末期症狀控制與十大疾病病人之舒適照護	舒適護理(採回覆示教之教學) 北區、中區、南區



Case discussion by Videoconference in Taiwan

- Since 1997 , using telephone line (ISDN)
  - Expensive, high technology required, limited to 10 location (dial into MCU)
- Change to Web based program since 2008
  - Less expensive, free to access, quality related to band width, participants up to 50 or more, can connect around the world…
  - Every two weeks , up to 60 or more locations joint the discussion
  - More than 400 participant each time:
- Participants stay in their own unit, include physician, nurse, social worker…



Integrated Holistic Hospice and Palliative Care Training Program and Guideline development (2017-2019)

20 civil organizations involved for local service

NHS England

Safe, compassionate care for frail older people using an integrated care pathway:

Practical guidance for commissioners, providers and nursing, medical and allied health professional leaders

Our vision

High-quality care for all

What do we mean by quality?

Positive patient experience

Clinically effective

Safe

What are our goals?

Enhancing quality of life for people with long-term conditions

Ensuring people have a positive experience of treatment and care

Reducing premature mortality

Helping people to recover from episodes of ill health or following injury

Treating people in a safe environment and protecting them from avoidable harm

What will my care look and feel like?

My care and treatment will be organised around me as a person.

I will get the best possible care and treatment when I'm in hospital and I'm supported to recover when I leave.

I will feel safe but if things do go wrong people are open and honest with me.

I will feel supported to keep healthy and spot any problems at an early stage.

I will feel in control of managing my own condition(s).

I will always be treated with dignity, compassion and respect.

The feedback I provide will be acted upon.

台灣安寧緩和療護
政策白皮書
White Paper for Hospice Palliative Care in Taiwan

台灣安寧緩和療護發展願景

01 尊重個人獨特性與價值觀
所有人皆有機會善生與善終

02 提供整合性的五全療護
讓舒適與生活品質最佳化

03 確保療護團隊的專業知識、態度與技能
提供協調性療護

神給我們的天賦

接受我們不能改變的事實、

有勇氣去改變我們能改變的事情、

有智慧去分辨這兩者的差異。

God grant me the serenity

To accept the things I cannot change,

The courage to change the things I can,

And the wisdom to know the difference.

Reinhold Niebuhr

守護國民　促進健康！

促進健康 Promotion,

預防疾病 Prevention,

安全防護 Protection,

共同參與 Participation,

夥伴合作 Partnership!

民眾為中心的照顧

Person Center Care

民眾參與

Person engagement

民眾增能

Person empowerment