服務目標 Program Objectives

1. 與醫院「離院長者綜合支援計劃」通力合作，提供社區支援服務予長者病人。
   To plan for the hospital discharge and to provide community care support service to elderly patients with the Integrated Discharge Support Program for Elderly Patients.

2. 爲有需要的出院長者安排出院後的過渡性家居支援及復康服務，以改善出院長者生活質素、減低再次入院風險。
   To arrange community-based rehabilitation services for newly discharged elderly, so as to maintain their quality of life and to reduce the risk of unplanned hospital re-admission.

3. 培訓及支援護老者，提升照顧質素及減輕照顧壓力。
   To enhance support and training to caregivers to increase the standard of care and to relieve stress from post-discharge care of the elderly.

收費 Fees

收費準則乃根據現行社會福利署發出的標準。
The level of service fee is set according to the standard of SWD.

辦公室開放時間 Opening Hour

星期一至五 Mon to Fri：
上午8時至下午6時　8:00am – 6:00pm
星期六 Sat：
上午9時至下午6時　9:00am – 6:00pm
星期日及公衆假期 Sun & Public holiday：
休息 Closed

聯絡方法 Enquiry

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地址 Address：新界屯門建發里4號LANE UP 9樓908室
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電郵 Email：idsp@elchk.org.hk
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基督教香港信義會社會服務部
Evangelical Lutheran Church Social Service - Hong Kong

屯門醫院、博愛醫院及天水圍醫院

長者病人出院家居支援計劃

Home Support Team of The Integrated Discharge Support Program for Elderly Patient (TMH/POH/TSWH)

服務介紹 Service Introduction

於2009年7月，基督教香港信義會社會服務部先與屯門醫院合作，成立長者病人出院綜合支援計劃，其後於2012年5月及2023年4月，計劃分別拓展至博愛醫院及天水圍醫院，爲三間醫院所轉介之出院長者病人提供平均八星期的社區支援服務。

作爲富有經驗的長者病人出院綜合支援計劃的家居支援隊，單位確立了一套周全的醫社睿智照顧模式(Medical-Social SMART Care Model)，服務內容模式主要秉持「醫社合作」、「以家爲本」、「共同照顧」及「自我管理」四大原則，從而有效地評估並支援出院長者病人及其護老者的需要，達到共同照顧的目標，達致減少長者往後不必要的入院情況，促進居家安老。

In July 2009, the Evangelical Lutheran Church Social Service - Hong Kong partnered with Tuen Mun Hospital to establish the Elderly Patient Discharge Support Program. The program expanded to Pok Oi Hospital in May 2012 and Tin Shui Wai Hospital in April 2023, providing an average of eight weeks of community support services for elderly patients discharged from the three hospitals.

As an experienced home support team for the Elderly Patient Discharge Support Program, ELCSS-HK has established a comprehensive Medical-Social SMART Care Model. The service model mainly adheres to the four principles: "medical-social cooperation," "Family-centred", "Co-care," and "self-management," thereby effectively assessing and supporting the needs of elderly patients and their caregivers after discharge, achieving the goal of shared care, reducing unnecessary hospitalizations and promoting aging at home.

服務對象 Target Group

居於屯門及元朗區達60歲以上；經由醫院離院計劃隊轉介；及有復康、個人護理及家居支援等跟進需要的長者。

Newly discharged elderly aged 60 or above (living in Tuen Mun or Yuen Long District) who are assessed and referred by the Hospital Discharge Planning Team to be in need of personal care, home care support and rehabilitation services.

服務內容 Service Contents

- 送飯服務 Meal services
- 接送/陪診 Transport and escort services
- 復康運動/訓練 Rehabilitation exercises
- 個人護理 Personal Care
- 短暫家居照顧 Elderly sitter services
- 家居清潔 Home-making services
- 購物/代辦服務 Purchasing services
- 簡單護理 Simple nursing care services
- 輔導服務 Counselling services
- 轉介其他支援服務 Referral services
- 暫住/暫託服務 Day or residential respite
- 24小時緊急支援服務 24 hours emergency support
- 護老者支援及培訓 Carer training and support

專業團隊 Professional Team