

Report
on
Phase I Pilot Study on
Universal Care Need Assessment Tool

Sub-Group on Pilot Study

Task Group on Universal Care Need Assessment Tool

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Contents

| | |
|---|------------|
| List of Tables | iii |
| Acknowledgements | v |
| | |
| CHAPTER 1 Background | |
| | |
| Introduction | 1 |
| Objectives of Phase I Pilot Study | 2 |
| Overview of the Report | 2 |
| | |
| CHAPTER 2 Method | |
| | |
| Development Sample of Phase I Pilot Study | 3 |
| Assessors in Phase I Pilot Study | 3 |
| Recruitment Procedures | 3 |
| Training Session and Assessment Procedures | 4 |
| Data Collection | 5 |
| Data Analysis | 7 |
| | |
| CHAPTER 3 Major Findings | |
| | |
| Findings from On-site Observations | 8 |
| Findings from Feedback Questionnaires | 9 |
| Findings from Phone Interviews with Assessors | 13 |
| | |
| CHAPTER 4 Conclusion and Recommendations | |
| | |
| Administration Procedures of Assessment Protocol | 21 |
| Training for Assessors | 22 |
| Content of Assessment Tool and Assessor Manual | 23 |
| Other Aspects of Assessment Tool | 27 |
| Conclusion | 28 |

Annexes

| | | |
|----------------|-------------------------------------|-----------|
| Annex A | Draft Assessment Tool | 30 |
| Annex B | Draft Assessor Manual | 37 |
| Annex C | Schedule of Training Session | 59 |
| Annex D | On-site Observation Form | 60 |
| Annex E | Feedback Questionnaire | 62 |
| Annex F | Phone Interview Form | 65 |

List of Tables

- Table 1** Working experience of assessors in the field of social work
- Table 2** Working experience of assessors with persons with mental/physical handicap
- Table 3** Average time required by assessors to complete one assessment session
- Table 4** Average time required by assessors to complete one assessment session, by familiarity with target persons
- Table 5** Opinion of assessors on difficulties encountered in soliciting information
- Table 6** Opinion of assessors on difficulties encountered in soliciting information, by familiarity with target persons
- Table 7** Evaluation by assessors of various aspects of the draft assessment tool and assessor manual
- Table 8** Opinion of assessors on difficulties encountered during assessment process
- Table 9** Opinion of assessors on technicality of terms/phrasing of items in the draft assessment tool
- Table 10** Opinion of assessors on duplication of content in the draft assessment tool
- Table 11** Opinion of assessors on clarity of items in *nursing care need*
- Table 12** Opinion of assessors on clarity of items in *functional impairment*
- Table 13** Opinion of assessors on clarity of items in *challenging behavior*
- Table 14** Opinion of assessors on clarity of items in *family coping*
- Table 15** Opinion of assessors on clarity of items in *assessment summary and conclusion*
- Table 16** Opinion of assessors on clarity of items in other sections
- Table 17** Opinion of assessors on ease of comprehension of scoring system of *nursing care need*
- Table 18** Opinion of assessors on ease of comprehension of scoring system of *functional impairment*
- Table 19** Opinion of assessors on ease of comprehension of scoring system of *challenging behavior*
- Table 20** Opinion of assessors on ease of comprehension of scoring system of *family coping*

- Table 21** Opinion of assessors on ease of comprehension of scoring systems of other sections
- Table 22** Opinion of assessors on appropriateness of duration of preceding time periods used for assessment for various aspects of different domains
- Table 23** Opinion of assessors on compatibility of assessment results with their expected results
- Table 24** Opinion of assessors on usefulness of draft assessor manual
- Table 25** Opinion of assessors on usefulness of training session

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CHAPTER 1 Background

Introduction

1.1 The Task Group on Universal Care Need Assessment Tool, which was set up in September 2002 under the Steering Group on Admission Procedures for Residential Care Homes for People with Disabilities, was formed to develop a standardized assessment tool for persons with mental/physical handicap applying for rehabilitation services. With input from parents of persons with mental handicap, as well as from rehabilitation professionals from various disciplines (including clinical psychologist, nurses, occupational therapists, physiotherapist, psychiatrist, rehabilitation physician, social workers), a draft assessment tool and assessor manual was developed by the Task Group in September 2003. During the development process, views of various stakeholders such as parent associations, rehabilitation agencies and referrers (eg special school social workers) were taken into account through extensive consultation.

1.2 The standardized assessment tool is devised to identify the residential care need of persons with mental/physical handicap applying for rehabilitation services, and to match them to appropriate services. It focuses on the current needs and identified risk factors of the disabled person/applicant at the time of assessment. It is to be used for the purpose of streaming and is not meant to replace in-depth assessments conducted by professionals for the purpose of rehabilitation training and treatment. The structured multidimensional assessment instrument is designed to focus on key domains and indicators that have particular bearings on service streaming.

1.3 The Sub-group on Pilot Study¹ under the auspices of the Task Group was formed in June 2003 to plan for and coordinate the pilot study on the draft assessment tool. A detailed proposal on the pilot study was initially put forward to and discussed in the Task Group, and it was later endorsed by the Steering Group in September 2003. It was decided that the pilot study would comprise two phases. Phase I would mainly aim at refining the draft assessment tool and the assessor manual and testing out the administration process, while Phase II would collect validity and reliability data of the

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draft assessment tool.

Objectives of Phase I Pilot Study

1.4. The specific objectives of Phase I pilot study are to use empirical data:

- (a) to improve the practicality and utility of the draft assessment tool;
- (b) to test out the administration process of the draft assessment tool;
- (c) to suggest ways to enhance the user-friendliness of the draft assessor manual; and
- (d) to identify core components for the training session for assessors.

Overview of the Report

1.5 This report was prepared by the Convenor of the Sub-group on Pilot Study, and it summarizes the data collected and the suggestions agreed by all members of the Sub-group. Chapter 2 briefly describes the methods and procedures used in generating the results of Phase I pilot study. Chapter 3 covers the major findings from various data collection components of the study. Finally, conclusion and specific recommendations based on the findings reported are made in Chapter 4.

CHAPTER 2 Method

Development Sample of Phase I Pilot Study

2.1 The selection of target persons in the pilot or development sample followed the principle that they are as similar to the eventual target population of the standardized assessment tool as possible (eg in terms of range and level of disabilities).

2.2 A total of 39 target persons (and their family/primary carers) already waitlisted for residential services were invited to participate in Phase I pilot study. Their proportion in the sample was commensurate with the actual number of referrals for various types of residential services in the central waiting list as at June 2003. Of the 39 target persons, 15 (38.5%) were referred from integrated/ family services centres, 12 (30.8%) were referred from special schools, 6 (15.4%) were referred from adult rehabilitation units, and 6 (15.4%) were referred from medical social services units. Of the 39 target persons, 3 (7.7%) were on the waiting list for Supported Hostel (SHOS), 12 (30.8%) were on the waiting list for Hostel for Moderately Mentally Handicapped Persons (HMMH), 17 (43.6%) were on the waiting list for Hostel for Severely Mentally Handicapped Persons (HSMH), 3 (7.7%) were on the waiting list for Hostel for Severely Physically Handicapped Persons (HSPH), and 4 (10.3%) were on the waiting list for Care and Attention Home for Severely Disabled Persons (C&A/SD).

Assessors in Phase I Pilot Study

2.3 13 assessors were recruited from existing referrers who are registered social workers at the rank of Social Work Assistant or above. Of the 13 assessors, 7 (53.8%) are from Social Welfare Department and 6 (46.2%) are from NGOs. 5 (38.5%) are working in integrated/ family services centres, 4 (30.8%) are working in special schools, 2 (15.4%) are working in adult rehabilitation units, and 2 (15.4%) are working in medical social services units. It was designed that the proportion of assessors from each setting invited to participate in the pilot study was commensurate with the actual number of referrals in the central waiting list received from each of these settings as at June 2003.

Recruitment Procedures

2.4 Target persons and their family/primary carers constituting the pilot sample were

recruited through the assessors or their colleagues working in the same unit. Verbal consent to participate in the pilot study was obtained from the concerned persons before their information was sent to the Sub-group. Invitation letters spelling out the purpose of the pilot study, as well as the assessment focus, arrangement and procedures involved were then individually mailed to the target persons (and their family/primary carers) in October 2003. Written consent was sought from them, and they were reassured that the results of these field trial assessments would be treated confidentially and anonymously. Moreover, they were notified that their assessment outcomes would not affect their original status on the central waiting list in any way. Relevant identifying information about the concerned assessor was also included in each invitation letter so that the target persons and their family/primary carers could verify the identification of the assessors if needed.

2.5 Recruitment of assessors was not as smooth as originally hoped, but eventually 13 assessors were recruited. Each assessor who agreed to participate in this pilot study was individually informed of the details of the study in late September 2003. The draft assessment tool ([Annex A](#)) and assessor manual ([Annex B](#)) used in this study were sent to them, and other required materials (eg assessment forms, consent forms, return envelopes) were also included. The present draft of the assessment tool consists of seven sections, namely, (a) *personal information*, (b) *information on disability and health conditions*, (c) *nursing care need*, (d) *functional impairment*, (e) *challenging behavior*, (f) *family coping*, and (g) *assessment summary and conclusion*. The purpose and procedures of each assessment area, definitions of terms, scoring systems of various domains and illustrative examples can be found in the draft assessor manual. All assessors were requested to familiarize themselves with the draft assessment tool and the instructions of the draft assessor manual, and they were given the details (eg topics to be covered, trainers) of the half-day training session ([Annex C](#)) arranged for them.

Training Session and Assessment Procedures

2.6 All assessors attended the training session scheduled on 11 October 2003, and it lasted for more than four hours. Members of the Task Group and Steering Group with professional expertise in various domains of the draft assessment tool were invited as trainers of this session. The training session aimed at facilitating all assessors to better understand the areas/domains included in the assessment tool and its administration procedures, as well as their involvement in the pilot study. The assessors were also provided with the necessary information as regards the cases on which they would conduct the assessments. Their initial comments on and concerns about the assessment

tool, its administration and the assessor manual were noted.

2.7 Each assessor was requested to conduct three assessment sessions at field trial sites after the training session within a period of about four to six weeks. The administration process of the assessment tool during field trials closely resembled the conditions of eventual use, and the procedures were detailed in the assessor manual and elaborated during the training session so that all assessors could administer the instrument in the same way.

Data Collection

2.8 In order to evaluate the field trials from different perspectives, a multi-component data collection protocol was used. Data in Phase I pilot study were collected through various means, namely, (a) on-site observation at eight assessment sessions by members of the Sub-group, (b) assessment forms and feedback questionnaires completed by the assessors on each assessment situation, and (c) phone interviews with all assessors by members of the Sub-group according to a questioning route. All questionnaires and forms of the data collection protocol were endorsed by the Task Group during its meeting on 10 September 2003.

Ethical Considerations

2.9 Informed consent was obtained from all participants of the pilot study. Besides, anonymity of the participants was preserved through the use of a coding system. Each assessor and each target person could only be identified by their allocated codes.

On-site Observations

2.10 A total of eight cases, with two from each of the settings (ie integrated/ family services centres, special schools, adult rehabilitation units, and medical social services units), were selected for on-site observation, each by one designated member of the Sub-group. All concerned target persons (and their family/primary carers) and assessors were informed of and agreed to this arrangement beforehand. To ascertain standardization, all observers noted and recorded their observations on a structured form (Annex D) which covers areas including appropriateness of the assessment situation, assessment skills of the assessor, responses of the informant(s) to the assessment situation, concerns of family/primary carer(s) of the target person, and difficulties experienced by the assessor during the assessment process.

Feedback Questionnaires

2.11 After each assessment session, the assessor was required to fill in the assessment form and a feedback questionnaire (Annex E) for that particular assessment situation. Each assessment form had a code and personal particulars were not put down to ensure anonymity. In the feedback questionnaire, apart from a section on background information of the assessor, one set of questions was designed to tap familiarity of the assessor with the draft assessment tool and the target person, the time required to complete one assessment session and difficulties encountered in soliciting the needed information. Another set of statements generated responses on a 4-point Likert scale about evaluation of various aspects of the assessment tool and assessor manual by the assessor. Degree of agreement with the listed statements was indicated by categories of strongly agree, agree, disagree and strongly disagree. Seven open-ended questions were included to gather comments pertaining to areas for improvement (eg meanings of words/terms, duration of preceding time periods used for assessment for various aspects of different domains, scoring systems) on all sections of the assessment tool. The questionnaire also asked for suggestions on aspects not covered by the tool and deemed useful for service streaming, as well as comments on the draft assessor manual.

2.12 The assessor returned both the assessment form and feedback questionnaire together with the consent form to the Sub-group using the return envelope as soon as she finished completing them for each assessment situation. All completed feedback questionnaires were returned in mid December 2003.

Phone Interviews with Assessors

2.13 A phone interview with each assessor by one designated member of the Sub-group was conducted within one week after all the assessment forms and feedback questionnaires of that particular assessor were received. The assessor was informed of the particulars of (and in fact they met with) the interviewer in the training session, and the interview session took no more than an hour.

2.14 To ascertain comparability of responses and that complete data are gathered from each assessor on all relevant questions, all interviewers asked questions according to, and recorded the responses of the assessors on, a structured phone interview form (Annex F). However, a certain degree of flexibility was maintained with the use of a phone interview format so that the assessors could be facilitated to share more openly. The phone interview covers areas including sources of assessment information, assessment difficulties, technicality of terms/phrasing of the items, duplication of content, clarity of items (eg wordings and definitions adopted) in the main sections of

the draft assessment tool, user-friendliness of the scoring systems of various sections, appropriateness of the duration of preceding time periods used for assessment for various aspects of different domains, compatibility of the assessment results with the expected results of the assessors, and usefulness the draft assessor manual and the training session.

Data Analysis

2.15 All data gathered from on-site observations, assessment forms and feedback questionnaires, and phone interviews with assessors based on pilot administrations of the instrument were collated and analyzed in December 2003. All recommendations made were discussed by members of the Sub-group in two meetings held in January 2004.

CHAPTER 3 Major Findings

3.1 A total of eight on-site observations were made, and 39 assessment forms and 39 feedback questionnaires were returned. 13 phone interviews with assessors were completed. Of the 39 assessment forms received, 25.6% of them have errors in the scoring or completion of the form (eg low level of functional impairment was scored as no functional impairment), which may have significant effect on the conclusion and recommendation made by the assessors. Nonetheless, all adhered to the agreed method, and all major data sets including the returned on-site observation forms, feedback questionnaires, and phone interview forms are valid. The ensuing sections highlight the major findings from these data collection components of the pilot study.

Findings from On-site Observations

Appropriateness of the Assessment Situations

3.2 Most of the observers (75%) indicated that the assessments were conducted under appropriate assessment situations, ie an undisturbed, quiet and natural environment, and the assessment sessions could be smoothly conducted. There were remarks that observations of the target person could be made by the assessor when s/he was present with the informant.

Assessment Skills of the Assessors

3.3 Almost all observers (88%) commented that the assessors could convey a warm and friendly attitude during the assessment sessions. A few observations pointed out that important aspects of some items (eg duration of preceding time periods used for assessment for various aspects of the *nursing care need* domain) were sometimes left out when the items were administered, while one assessor was observed to be reading the items of the instrument in a verbatim manner.

Responses of the Informants to the Assessment Situations

3.4 Many of the observations (63%) showed that the informants could respond to the assessment situations in a natural and relaxed way. One informant was noted to be apprehensive that the results of the assessment might affect the waiting time for residential services, while another one voiced out preference for the use of community support services. One observation noted some vocabulary used in the instrument was not readily understood (ie 弱視 (*information on disability and health conditions*), 癲癇

(nursing care need), 喧鬧 (challenging behavior)).

Concerns of Family/Primary Carers of the Target Persons

3.5 A few observations recorded difficulties in coping with the caring responsibilities as the main concerns of family/primary carers of the target persons. A few carers expressed the need for emergency placement and respite services.

Difficulties experienced by the Assessors

3.6 The most frequent observations (38%) made as regards difficulties experienced by the assessors were that the assessors appeared to be unfamiliar with some of the items of the instrument (eg the epileptic condition of the target person (nursing care need), caregiving hours (family coping)).

Findings from Feedback Questionnaires

Working Experience of the Assessors

3.7 Of the 13 assessors who returned the feedback questionnaires, only 7.7% of them had less than five years of working experience in the field of social work, while the majority (77%) had five to fifteen years of such experience (Table 1). 38.5% of the assessors had less than five years of working experience with persons with

Table 1: Working experience of assessors in the field of social work (n=13)

| Years of working experience | Number | Percent |
|-----------------------------|--------|---------|
| Less than five years | 1 | 7.7% |
| Five to nine years | 5 | 38.5% |
| Ten to fifteen years | 5 | 38.5% |
| Over fifteen years | 2 | 15.4% |

Note: The percentages may not total 100 percent because of rounding.

Table 2: Working experience of assessors with persons with mental/physical handicap (n=13)

| Years of working experience | Number | Percent |
|-----------------------------|--------|---------|
| Less than five years | 5 | 38.5% |
| Five to nine years | 5 | 38.5% |
| Ten to fifteen years | 3 | 23% |
| Over fifteen years | 0 | 0% |

Note: The percentages may not total 100 percent because of rounding.

mental/physical handicap, while many of them (61.5%) had five to fifteen years of such experience (Table 2).

Average Time for One Assessment Session

3.8 As shown in Table 3, on average the assessors used about 50 minutes to complete one assessment session. When the assessors used the assessment tool for the first time, on average they required about 46 minutes to complete the session, ranging from 30 to 60 minutes. 46% of them used 45 minutes. When they used it for the second time, on average they required about 60 minutes to complete the session, ranging from 20 to 110 minutes. About 70% of them used 60 minutes or less. When they used it for the third time, on average they required about 44 minutes to complete the session, ranging from 20 to 90 minutes. About 92% of them used 60 minutes or less.

Table 3: Average time required by assessors to complete one assessment session

| Time of use | Average time (minutes) |
|--------------------|-------------------------------|
| First (n=13) | 46.2 |
| Second (n=13) | 59.6 |
| Third (n=13) | 43.5 |
| All (n=39) | 49.7 |

3.9 The average time used by the assessors to complete one assessment session was about 43 minutes if the target persons were known to the assessors, while it was about 61 minutes if the target persons were not known to the assessors (Table 4).

Table 4: Average time required by assessors to complete one assessment session, by familiarity with target persons

| Time of use | Average time (minutes), if known | Average time (minutes), if not known |
|--------------------|---|---|
| First | 46 (n=10) | 46.7 (n=3) |
| Second | 40.8 (n=6) | 75.7 (n=7) |
| Third | 40.6 (n=8) | 48 (n=5) |
| All | 42.9 (n=24) | 60.7 (n=15) |

Difficulties in Soliciting Information

3.10 Most of the assessors (81.6%) reported that they did not encounter difficulties in soliciting the needed information to complete the assessment (Table 5). It is noted that

assessors were more prone to encounter difficulties if the target persons were not known to them (Table 6).

Table 5: Opinion of assessors on difficulties encountered in soliciting information (n=38)

| Difficulties encountered | Number | Percent |
|--------------------------|--------|---------|
| Yes | 7 | 18.4% |
| No | 31 | 81.6% |

Note: The percentages may not total 100 percent because of rounding.

Table 6: Opinion of assessors on difficulties encountered in soliciting information, by familiarity with target persons (n=38)

| Difficulties encountered | Known | Not known |
|--------------------------|------------|-----------|
| Yes | 1 (2.6%) | 6 (15.8%) |
| No | 22 (57.9%) | 9 (23.7%) |

Note: The percentages may not total 100 percent because of rounding.

3.11 Of the seven comments on difficulties encountered in soliciting information to complete the assessment, five stated that the informants (mostly family/primary carers of the target persons) were unclear about the conditions (eg level of mental handicap, information on physical handicap, date of report) of the target persons. Subsequent clarification with concerned parties (eg staff of sheltered workshop and C&A/SD) was needed. One comment stated that there was information discrepancy between self-report (of the target person) and proxy (ie mother of the target person) responses on specific items related to the use of medical equipment.

Evaluation of the Draft Assessment Tool and Assessor Manual

3.12 As presented in Table 7, on a 4-point Likert scale about evaluation of various aspects of the draft assessment tool and assessor manual by the assessors, almost all assessors (97.4%) agreed or strongly agreed that the content of the draft assessment tool is understandable, and most of them (76.9%) agreed that it is easy to apply the tool. All assessors indicated that the draft assessor manual is useful in assisting them to conduct the assessment sessions, but about 39% of the assessors stated that it is not easy to comprehend the scoring systems of the instrument.

Areas for Improvement

3.13 Comments pertaining to areas for improvement for the draft assessment tool and its

administration procedures were gathered from seven open-ended questions. The major qualitative responses are described below:

Table 7: Evaluation by assessors of various aspects of the draft assessment tool and assessor manual (n=39)

| Assessment tool and assessor manual | Strongly disagree | Disagree | Agree | Strongly agree |
|--|--------------------------|-----------------|--------------|-----------------------|
| Content of the tool is understandable | 0 (0%) | 1 (2.6%) | 35 (89.7%) | 3 (7.7%) |
| It is easy to apply the tool | 0 (0%) | 9 (23.1%) | 30 (76.9%) | 0 (0%) |
| It is easy to comprehend the scoring systems | 0 (0%) | 15 (38.5%) | 24 (61.5%) | 0 (0%) |
| The assessor manual is useful | 0 (0%) | 0 (0%) | 39 (100%) | 0 (0%) |

Note: The percentages may not total 100 percent because of rounding.

(a) Section on *personal information*: add “hospital services” and “home-based training and support service” to item 6; add the procedure to get required information from other sources such as school social workers when appropriate.

(b) Section on *information on disability and health conditions*: add “no other disabilities” to item 3; need clarification on difference between receiving psychiatric service (eg for challenging behaviors) and having psychiatric illness.

(c) Section on *nursing care need*: for item 3, separate “oral intake of drugs” from “drug injection”; add a box/choice to indicate “no nursing care need”.

(d) Section on *functional impairment*: use “self-care abilities” instead of “functional impairment”; for item B2.2, add the choices on different types of drinking aids; for item B3, need clarification when the target person uses both walking aids and wheelchair; for item B3.1, add the choices on different types of walking aids; no place to indicate and score points on further deterioration of health of the target person; need clarification on how the level of performance of the target person is to be assessed when the level of performance of the same functional skill is not the same at different settings (eg home and rehabilitation unit).

(e) Section on *challenging behavior*: need clarification on whether absconding from facility is included as challenging behavior; impact and disturbance of less serious challenging behaviors (eg obnoxious behaviors) of the target person on family/primary

carers is not indicated; for item C2, need explicit definition of “serious object damage”.

(f) Section on *family coping*: for item A1, modify “daily caregiving hours” as “weekly caregiving hours”; judgement of referrer (轉介者認為) for items A2 and C is required and this brings in subjective element; for items B2 and B3, need explicit definition of “serious conflict”; add “relationship among family members” since this may affect the coping ability of the primary carer; add whether family members are willing to shoulder caring responsibilities; there are problems in filling in some of the items when the target person is living in private residential/long stay care settings and has no home leave/is not visited by family members.

(g) Section on *assessment summary and conclusion*: judgement of referrer (轉介者認為) is required and this brings in subjective element; for item 5, modify wording of 無法能夠 to 不能; for item 5, separate items for “causes” and “long term arrangement”; for item 5, add the choice of “community residential services” to “suggested residential services”; this tool no longer relies solely on IQ scores to assess the needs of target persons and this is a great improvement; this tool has comprehensive content as compared to the existing application form.

3.14 Suggestions on aspects not covered by the draft assessment tool and deemed useful for service streaming are: include “supported hostel”; include “home-based training and support service”; add personality characteristics of the primary carers; add number of persons living together with the target person to item A of the section *family coping*.

3.15 Most comments (9 out of 11) on the draft assessor manual stated that (a) the manual is detailed and clear, and has useful illustrative examples, and (b) it would be better to include pictures/photos and more illustrative examples for different case scenarios.

Findings from Phone Interviews with Assessors

Sources of Information

3.16 Apart from interviews with informants, many assessors (61.5%) gathered required information from caseworkers and school social workers, and referred to school records and reports of clinical psychologist, nurse and occupational therapist, in order to complete the assessment.

Difficulties Encountered

3.17 As shown in Table 8, 84.6% of the assessors reported some form of difficulties

when conducting the assessments. Of these difficulties included in the responses, 45.5% were due to the fact that the assessors were either not familiar with the draft assessment tool and assessor manual, or not familiar with the target persons concerned. 27.3% of them were related to discrepancy between different sources of information (eg family members and school social workers), or the need to solicit information from other sources (eg nurses). The rest of the responses were comments rather than difficulties, and they include: (a) the items of the instrument do not address the conditions of “mild cases”, and (b) the use of judgement of referrer (轉介者認為) brings in subjective element.

Table 8: Opinion of assessors on difficulties encountered during assessment process (n=13)

| Difficulties encountered | Number | Percent |
|--------------------------|--------|---------|
| Yes | 11 | 84.6% |
| No | 2 | 15.4% |

Note: The percentages may not total 100 percent because of rounding.

Technicality of Terms/Phrasing of Items

3.18 61.5% of the assessors were of the opinion that the terms used, and the phrasing of the items, in the draft assessment tool are on the whole not too technical (Table 9). The terms which the assessors found technical are those in sections *nursing care need* (eg 無菌換症, 褥瘡, 凝固粉) and *functional impairment*. Some assessors observed that there was some difficulty for the informants to understand these terms without explanation from the assessors during the assessment sessions.

Table 9: Opinion of assessors on technicality of terms/phrasing of items in the draft assessment tool (n=13)

| Too technical | Number | Percent |
|---------------|--------|---------|
| Yes | 5 | 38.5% |
| No | 8 | 61.5% |

Note: The percentages may not total 100 percent because of rounding.

Duplication of Content

3.19 Most assessors (76.9%) indicated that there is no content overlap or duplication as regards the items included in the draft assessment tool (Table 10). One assessor commented, but without giving specific details, that there was some duplication

between item A and item D in the section *family coping*, while another assessor opined that there might be confusion between item 2 進食問題 of *nursing care need* and item B2.1 進食情況 of *functional impairment*.

Table 10: Opinion of assessors on duplication of content in the draft assessment tool (n=13)

| Duplication found | Number | Percent |
|-------------------|--------|---------|
| Yes | 3 | 23.1% |
| No | 10 | 76.9% |

Note: The percentages may not total 100 percent because of rounding.

Clarity of Items

3.20 The majority of the assessors were of the opinion that the phrasing of, and definitions used in, the items for sections *nursing care need* (76.9%), *functional impairment* (76.9%), and *challenging behavior* (92.3%) is clear and comprehensible (Tables 11 to 13).

Table 11: Opinion of assessors on clarity of items in *nursing care need* (n=13)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 10 | 76.9% |
| No | 3 | 23.1% |

Note: The percentages may not total 100 percent because of rounding.

Table 12: Opinion of assessors on clarity of items in *functional impairment* (n=13)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 10 | 76.9% |
| No | 3 | 23.1% |

Note: The percentages may not total 100 percent because of rounding.

Table 13: Opinion of assessors on clarity of items in *challenging behavior* (n=13)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 12 | 92.3% |
| No | 1 | 7.7% |

Note: The percentages may not total 100 percent because of rounding.

3.21 For the section *nursing care need*, some assessors commented that “partial incontinence” (item 4) was not well defined, and “no epilepsy” (item 5) and “no nursing care need” should be added. For the section *functional impairment*, one comment stated that item B1 could be split into two items for awareness to go toileting (便意) and cleanliness (清潔情況) after toileting. For the section *challenging behavior*, one assessor asked for clarification of the definition of “serious object damage” (item C2).

3.22 Only 54.5% of assessors opined that the phrasing of, and definitions used in, the items for the section *family coping* is clear (Table 14). Comments in relation to the clarity of items for this section include: for item A, clarification on whether “caregiving” (照顧) also means “supervision” (看住) and “visit” (探望) is needed; for item A1, modify “daily caregiving hours” as “weekly caregiving hours”; for items B1 and B2, clarification on the meaning of 同居者 and 同住人士 is required; for items B2 and B3, examples of “serious conflict” should be stated in the assessment tool.

Table 14: Opinion of assessors on clarity of items in *family coping* (n=11)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 6 | 54.5% |
| No | 5 | 45.5% |

Note: The percentages may not total 100 percent because of rounding.

3.23 Many assessors indicated that the phrasing of, and definitions used in, the items for the section *assessment summary and conclusion* (69.2%) and other sections (72.7%) is clear and comprehensible (Tables 15 and 16). For the section *assessment summary and conclusion*, comments include: for item 4, need clarification on when “not applicable” will be used; for item 5, separate items for “causes” and “long term arrangement”; the relationship between items 1 to 4 and item 5 is not clear; more elaboration of the terms used in this section is needed; there might be difficulties filling in this section if the assessor was not familiar with community support services.

Table 15: Opinion of assessors on clarity of items in *assessment summary and conclusion* (n=13)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 9 | 69.2% |
| No | 4 | 30.8% |

Note: The percentages may not total 100 percent because of rounding.

Table 16: Opinion of assessors on clarity of items in other sections (n=11)

| Items are clear | Number | Percent |
|-----------------|--------|---------|
| Yes | 8 | 72.7% |
| No | 3 | 27.3% |

Note: The percentages may not total 100 percent because of rounding.

Comprehension of Scoring Systems

3.24 About 69% of the assessors stated that it is easy to comprehend the scoring system of the section *nursing care need* (Table 17). There were comments that the format of the scoring system of this section is different from that of other sections, and “no nursing care need” should be added.

Table 17: Opinion of assessors on ease of comprehension of scoring system of *nursing care need* (n=13)

| Easy to comprehend | Number | Percent |
|--------------------|--------|---------|
| Yes | 9 | 69.2% |
| No | 4 | 30.8% |

Note: The percentages may not total 100 percent because of rounding.

3.25 Only 61.5% of the assessors indicated that it is easy to comprehend the scoring system of the section *functional impairment* (Table 18). The main difficulties of the assessors resided in not knowing how the level of performance of the target person is to be assessed (a) when the level of performance of the same functional skill is not the same at different settings (eg home and rehabilitation unit), and (b) when the level of performance is affected by lack of volition and not by lack of functional skills. Request for more guidance on when to score 0 and 1 was also made.

Table 18: Opinion of assessors on ease of comprehension of scoring system of *functional impairment* (n=13)

| Easy to comprehend | Number | Percent |
|--------------------|--------|---------|
| Yes | 8 | 61.5% |
| No | 5 | 38.5% |

Note: The percentages may not total 100 percent because of rounding.

3.26 Most assessors (84.6%) opined that it is easy to comprehend the scoring system of

the section *challenging behavior* (Table 19). There were comments that it is not clear why item D does not score points.

Table 19: Opinion of assessors on ease of comprehension of scoring system of *challenging behavior* (n=13)

| Easy to comprehend | Number | Percent |
|--------------------|--------|---------|
| Yes | 11 | 84.6% |
| No | 2 | 15.4% |

Note: The percentages may not total 100 percent because of rounding.

3.27 Most assessors (81.8%) stated that it is easy to comprehend the scoring system of the section *family coping* (Table 20). There were comments that this section could not be scored when the target person is living in a private residential setting.

Table 20: Opinion of assessors on ease of comprehension of scoring system of *family coping* (n=11)

| Easy to comprehend | Number | Percent |
|--------------------|--------|---------|
| Yes | 9 | 81.8% |
| No | 2 | 18.2% |

Note: The percentages may not total 100 percent because of rounding.

3.28 Most assessors (92.3%) stated that it is easy to comprehend the scoring systems of other sections (Table 21). There were comments that in the section *assessment summary and conclusion* it is difficult to understand the situations when the target person has challenging behaviors and is in need of rehabilitation service staffed with more manpower.

Table 21: Opinion of assessors on ease of comprehension of scoring systems of other sections (n=13)

| Easy to comprehend | Number | Percent |
|--------------------|--------|---------|
| Yes | 12 | 92.3% |
| No | 1 | 7.7% |

Note: The percentages may not total 100 percent because of rounding.

Appropriateness of Preceding Time Periods used for Assessment

3.29 75% of the assessors opined that the preceding time periods used for assessment (eg one month for item 2 in *nursing care need*, one year for items A1 and A2 in *challenging behavior*) for various aspects of different domains are appropriate (Table 22). One comment indicated it is more appropriate to use two to three years as preceding time period used for assessment of *challenging behavior*.

Table 22: Opinion of assessors on appropriateness of duration of preceding time periods used for assessment for various aspects of different domains (n=12)

| Appropriate | Number | Percent |
|-------------|--------|---------|
| Yes | 9 | 75% |
| No | 3 | 25% |

Note: The percentages may not total 100 percent because of rounding.

Compatibility of Assessment Results with Expected Results of Assessors

3.30 Many assessors (66.7%) opined that the results obtained from the draft assessment tool are compatible with their expected results (Table 23). A few assessors pointed out that the assessed residential care need of the target persons was not as great as they had expected.

Table 23: Opinion of assessors on compatibility of assessment results with their expected results (n=12)

| Results compatible | Number | Percent |
|--------------------|--------|---------|
| Yes | 8 | 66.7% |
| No | 4 | 33.3% |

Note: The percentages may not total 100 percent because of rounding.

Usefulness of Draft Assessor Manual

3.31 Over nine-tenths (91.7%) of the assessors indicated that the draft assessor manual is useful in assisting them to understand the content and the administration procedures of the assessment (Table 24). Some commented that the manual was detailed and the examples used (eg in *nursing care need*) were clear and useful, while one comment asked for more examples on “general cases”.

Usefulness of Training Session

3.32 As displayed in Table 25, all assessors were of the opinion that the training session

is useful in assisting them to understand the content and the administration procedures of the assessment. Many showed appreciation that the session was clearly presented and the examples used could clarify their queries (eg on scoring system). Some suggested that it would be better to extend the session to one whole day, and practice sessions of the assessment tool could be included.

Table 24: Opinion of assessors on usefulness of draft assessor manual (n=12)

| Useful | Number | Percent |
|--------|--------|---------|
| Yes | 11 | 91.7% |
| No | 1 | 8.3% |

Note: The percentages may not total 100 percent because of rounding.

Table 25: Opinion of assessors on usefulness of training session (n=12)

| Useful | Number | Percent |
|--------|--------|---------|
| Yes | 12 | 100% |
| No | 0 | 0% |

Note: The percentages may not total 100 percent because of rounding.

Other Comments

3.33 Other comments by the assessors include: “mild” problems are not captured by the assessment tool; there are problems in applying the tool to cases when the target person is living in private residential/long stay care settings and has no home leave/is not visited by family members; the instrument will be more user-friendly if the items are of alternate-choice format rather than free response format; impact of disturbing behaviors of target persons on family is not included in this tool; the instrument gives a fair and objective evaluation of the service needs of applicants; the objective of the assessment tool for streaming is appropriate as this can enable welfare resources to be used more effectively.

CHAPTER 4 Conclusion and Recommendations

4.1 In this Phase I pilot study, the present draft of the assessment protocol has been piloted on 39 target persons (and their family/primary carers) waitlisted on rehabilitation residential services, with the assistance of 13 assessors recruited from existing referrers, with a view to fine-tune the instrument and its administration procedures. In order to maximize the applicability of the results of this study, it has been designed that the characteristics of the development sample (eg range and level of disabilities) and the participating assessors (eg variety of work settings, professional training and experience) are similar to that of the target population and assessors in eventual implementation of the standardized assessment tool for persons with mental/physical handicap applying for rehabilitation services. In addition, a multiple-component data collection protocol was used in this pilot study to yield a comprehensive and rich set of data. In this chapter, the significant findings and conclusion of this pilot study are summarized and specific recommendations are made.

Administration Procedures of Assessment Protocol

4.2 It is noted that the present assessment, with its current content, structure and procedures, can on the whole be conducted smoothly under appropriate situations by registered social workers at the rank of Social Work Assistant or above (see 3.2 and 3.3). Moreover, it is expected that most informants (both the target persons and their family/primary carers) will respond to the assessment situations in a natural and relaxed way without unease (see 3.4).

4.3 It is demonstrated empirically that on average one assessment session is normally completable within 60 minutes (see 3.8). Influence of practice effect on time required for the assessment session is not apparent, but expectedly the assessment will take significantly shorter time if the target person is already known to the assessor before the assessment (see 3.9).

4.4 It is shown that most assessors found it easy to apply the instrument (see 3.12) and they did not encounter much difficulty in soliciting the needed information to complete the present assessment (see 3.10), pointing to clinical applicability of the assessment procedures. However, clarification and liaison with other concerned parties (eg school social workers, nurses) was sometimes necessary in order to gather information the

informants themselves could not provide or to verify information provided by the informants (see 3.11 and 3.16). Information discrepancy between self-report and proxy responses or between different sources of information sometimes occurred (see 3.11 and 3.17), and professional judgement is called for in these situations.

4.5 In sum, the findings of this pilot study lend support to the assertion that on the whole **the present design of administration procedures of the assessment protocol including the qualification of the assessor, its administration format, the time range for completion of each assessment, and the assessment procedures as detailed in the draft assessor manual, is viable and practicable.**

Recommendation One:

Adopt the present design of administration procedures of the assessment protocol since it is empirically established to be practicable.

Recommendation Two:

Elaborate on information gathering procedures of the assessment (eg sources of information) and strategies to handle information discrepancy (eg lack of concordance between self-report and proxy responses) in the assessor manual as well as in the training to be provided to the assessors.

Training for Assessors

4.6 As alluded to earlier, one prominent difficulty encountered by the assessors in administration of the assessment tool is lack of familiarity with (a) the items of the instrument, (b) the definitions of the terms used, and (c) the instructions given in the assessor manual (see 3.3, 3.6 and 3.17). As a result, important aspects of some items might be left out, or adequate explanation of the meanings of the terms used (sometimes in a colloquial way) cannot be provided to the informants at the time of the assessment. These may render the informants misunderstanding the items and the information collected incomplete or inaccurate. One implication of this finding is that **the need of training for assessors, and practice of the use of the assessment instrument, is essential for successful application of the tool.**

4.7 The findings confirm that all assessors in this pilot study found the training session provided to them in October 2003 useful in assisting them to apply the assessment

instrument and procedures, and they also appreciated the expert input of rehabilitation professionals from various disciplines (see 3.32). Training emphasis on (a) detailed elaboration of the definitions of various terms/conditions used in the items with a real-life and case-focused context, (b) means to assist the informants to understand the items when administering the instrument, (c) the meaning of different scores, and (d) relevant specific assessment skills (eg observation of functional skills), is beneficial to the assessors. Some suggested that a one-day training session could give more time for case discussion and clarification of issues and areas of uncertainty. Besides, practice sessions with role-playing exercises which can enable the assessors to rehearse their assessment skills (eg how to rephrase the items or technical terms, say, in the sections *nursing care need* and *functional impairment*, in a colloquial way so that the vocabulary can be better understood by the informants, ways to attend sensitively to the informants during assessment) can then be incorporated. Updates on community support services (eg types, eligibility criteria, accessibility on a district level) also constitute an important element of the training session (see 3.5 and 3.23).

Recommendation Three:

Build upon the existing training program for assessors and extend the session to a one-day workshop on the assessment protocol for assessors so that practice sessions can be included. Updates on community support services are important.

Content of Assessment Tool and Assessor Manual

4.8 It is affirmed that almost all assessors in the pilot study indicated that **the content of the draft assessment tool is comprehensible and the instruction points of the draft assessor manual are useful** (see 3.12, 3.15 and 3.31). The terms used, and the phrasing of the items, in the draft assessment tool are on the whole not too technical (see 3.18) and can be understood by the informants, and most assessors did not find any content duplication (see 3.19). Likewise, the majority of the assessors stated that the phrasing of, and definitions used in, the items for sections *nursing care need*, *functional impairment* and *challenging behavior* is clear, unambiguous and comprehensible (see 3.20). Comments and suggested modifications on the content of the instrument as well as the assessor manual were considered by all members of the Sub-group, and the following **specific changes are recommended** (it should be underscored that all changes made to the assessment tool will necessitate corresponding changes in the assessor manual):

(a) Section on *personal information*:

- for item 6, expand on “community support services” to include “home-based training and support service” and “other community support services, please specify:”;
- add “hospital services (both general and psychiatric)” to item 6 so that information on services received by target persons who have stroke or long term illness can be included.

(b) Section on *information on disability and health conditions*:

- for item 3, add “can check more than one choice” (可選擇多項);
- for item 3, “others, please specify:”, add in relevant section of the manual that this may include those target persons who acquire cognitive impairment after 18 years of age (and therefore cannot be diagnosed to have mental retardation according to the *DSM*² system) owing to stroke, drug abuse, car accident etc;
- elaborate in training the difference between receiving psychiatric service (eg for challenging behaviors) and having psychiatric illness.

(c) Section on *nursing care need*:

- modify the presentation layout of this section so that (i) the assessor can record on the assessment form the absence of the conditions listed in the concerned items and (ii) the layout is more consistent with that of other sections. One cannot distinguish between whether the assessor has forgotten to fill in the items or the assessor means to indicate there is absence of such conditions for the target person when none of the boxes/choices are marked for the items of this section in its present layout;
- for item 4, elaborate on the meaning of “partial incontinence” in relevant section of the manual;
- for item 5, add examples on different degree of severity of epilepsy in relevant section of the manual;
- reiterate in relevant section of the manual (and in training) that only nursing needs relevant to consideration for residential services are included in the instrument.

² *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association. The current version is *DSM-IV-TR* (2000).

(d) Section on *functional impairment*:

- reiterate in relevant section of the manual (and in training) that assessment of the level of performance of functional skills of the target person should be based on interview with the target person (and her/his family/primary carer as appropriate) given that s/he is stable both physically and emotionally;
- reiterate in relevant section of the manual (and in training) that the reported performance at current natural living environment (eg home or long stay care settings) is used as the primary basis for assessment of the level of performance of functional skills of the target person. If in doubt, the assessor should arrange to observe the actual performance of the target person at such natural settings;
- for item A2.2, add in the choice on body position of the target person when s/he carries out the activity (進行活動時的姿勢:*坐/站);
- for item B1, in order to avoid confusion, delete the part on awareness to go toileting as the assessment is focused on the skill to achieve cleanliness after toileting;
- for item B2.2, in order to facilitate the assessor to fill in this item more easily, add the choices on different types of drinking aids and add pictures/photos of such aids to relevant section of the manual;
- for item B3.1, in order to facilitate the assessor to fill in this item more easily, add the choices on different types of walking aids and add pictures/photos of such aids to relevant section of the manual;
- add an item so that conditions of the physical environment that significantly compromise the level of performance of functional skills of the target person can be remarked.

(e) Section on *challenging behavior*:

- reiterate in relevant section of the manual (and in training) that absconding from facility is already included as item C(d) in the section *family coping* and therefore it is not included in the section *challenging behavior*;
- for item B2, modify “medical practitioner” as “medical/nursing staff”;
- for item C2, elaborate in relevant section of the manual the definition of “serious object damage”;
- reiterate in training that impact and disturbance of less serious challenging behaviors (eg obnoxious behaviors) of the target person on family/primary carers can be reflected in items A2 and B of the section *family coping*;
- note that less serious challenging behaviors do not score points as the design of the items is to attain one of the principal objectives of the instrument which is to identify

target persons with serious challenging behaviors.

(f) Section on *family coping*:

- for item A, elaborate on the meaning of “caregiving” (照顧) (which does not include supervising the target person and visits to the target person) in relevant section of the manual;
- for item A1, modify “daily caregiving hours” as “weekly caregiving hours” since variation of the former is great and the latter can give a better and more accurate picture;
- add instructions to relevant items to indicate that some of the items are only applicable to those target persons who live or have contacts with her/his family since it is repeatedly pointed out that there are problems in filling in some of the items of this section when the target person is living in private residential/long stay care settings and has no home leave/is not visited by family members. Also add elaboration and examples of such situations to relevant section of the manual;
- for item B1, add to relevant section of the manual examples of 其他人士;
- for item B2, modify 同居者 as 同住者 for consistency;
- for items B2 and B3, add to relevant section of the manual examples of “serious conflict” (ie assistance of police is required, some party is injured) so that its definition is clearer;
- consider putting item D into a new section as *community support services*, or reformat it so that its relationship to the section *assessment summary and conclusion* is clearer;
- reiterate in training that relationship problems among family members can be handled by assistance of family counseling service.

(g) Section on *assessment summary and conclusion*:

- modify the presentation layout of this section so that the relationship between the assessment summary (items 1 to 4) and the conclusion (item 5) can more easily be understood by the assessors;
- for item 5, modify wording of 無法能夠 to 不能;
- for item 5, delete “long term arrangement” since the instrument is meant to focus on the current needs and identified risk factors of the target person at the time of assessment;
- for item 5, add in relevant section of the manual examples of special consideration (eg deterioration of health of the target person, family members are not willing to

shoulder caring responsibilities);

- for item 5, add the choice of “community residential services” to “suggested residential services” to make it more inclusive.

(h) Others:

- modify the layout of the instrument to reformat the items as alternate-choice items rather than free response items as far as possible to make it more user-friendly. However, essential open-ended questions that can yield useful qualitative responses should be kept;
- consider adding items to tap special conditions of the physical environment;
- reiterate in relevant section of the manual (and in training) that dependability of the sources of information should be critically examined by the assessors so as to assure that the information collected by the instrument is accurate at the time of assessment;
- include pictures/photos and more illustrative examples for different case scenarios for all sections in the manual as far as possible to make it more user-friendly.

Recommendation Four:

Accept the content of the present draft assessment tool and assessor manual as the blueprint of the assessment protocol of the standardized assessment tool for persons with mental/physical handicap applying for rehabilitation services since its clinical utility is empirically demonstrated. However, further technical evaluation of the instrument is required.

Recommendation Five:

Consider refining the present draft assessment tool and assessor manual by incorporating the specific recommended changes above into the assessment protocol.

Other Aspects of Assessment Tool

4.9 A special note is warranted on the observation that about 39% of the assessors stated that it is not easy to comprehend the scoring systems of the instrument as a whole (see 3.12), and further analysis shows that over 80% of the assessors indicated that the scoring systems of all sections in the instrument, save the sections *nursing care need* and *functional impairment*, are user friendly (see 3.24 to 3.28). In this connection, it is also

observed that about 25.6% of the returned assessment forms contain errors in scoring or completion that may have significant effect on the conclusion and recommendation made by the assessors (see 3.1). In view of the above, it is recommended that the presentation layout of the scoring system of *nursing care need* be modified to make it more consistent with that of other sections, and the training session for assessors be given more emphasis on the scoring system of *functional impairment* (eg differentiation of scoring rules of 0 and 1). Practice of the use of the assessment tool can be scheduled in the training session, and more illustrative examples to shed light on the scoring of items, especially in sections *nursing care need* and *functional impairment* can be added to the assessor manual so that the scoring systems can be applied more consistently.

4.10 It is of interest to note that most assessors found the preceding time periods used for assessment for various aspects of different domains are appropriate (see 3.29), and about two-thirds of the assessors opined that the results obtained from the draft assessment tool are compatible with their expected results (see 3.30). A few pointed out that the assessed residential care need of the target persons was not as great as what they had expected after systematic review of the needs of the target persons on various domains listed in the assessment tool.

Recommendation Six:

Consider implementing the recommendations made pertaining to the scoring systems of the assessment protocol.

Recommendation Seven:

Take note of the observations made in this pilot study about (a) the preceding time periods used for assessment for various aspects of different domains, and (b) the degree of compatibility between results of the assessment tool and expected results of the assessors.

Conclusion

4.11 The findings of this Phase I pilot study on the Universal Care Need Assessment Tool provide useful empirical data on the practicality and utility of the present draft assessment tool, together with its assessor manual and administration procedures. They can be used as a provisional blueprint for further development as the assessment protocol of the standardized assessment tool for persons with mental/physical handicap

applying for rehabilitation services. Recommendations on re-calibration of various aspects of the instrument, the assessor manual and the training workshop for assessors, have been made. Although the findings provide evidence for the applicability and feasibility of the assessment protocol, they should be seen in the light of the fact that the development sample for the study was relatively small. The next necessary step is to commence a Phase II pilot study to collect more data to examine the technical aspects (eg reliability) of the revised version of the assessment tool.

Annexes**Annex A Draft Assessment Tool**

社會福利署

弱智人士及肢體傷殘人士住宿服務評估 [草稿]

I. 個人資料

1. 姓名：

_____ (英文) _____ (中文)

2. 出生日期： _____ (年) _____ (月) _____ (日)

3. 性別： 男 女

4. 香港身分證號碼： _____ () 或 L/M(_____) in RP 3/3/220/(_____)

5. 居住地區：

| | | | | | | | | | | |
|--------|--------------------------|-------|--------------------------|-----|--------------------------|-----|--------------------------|-----|--------------------------|-----|
| 香港島及離島 | <input type="checkbox"/> | 中西區 | <input type="checkbox"/> | 灣仔 | <input type="checkbox"/> | 東區 | <input type="checkbox"/> | 南區 | <input type="checkbox"/> | 離島 |
| 九龍 | <input type="checkbox"/> | 觀塘 | <input type="checkbox"/> | 黃大仙 | <input type="checkbox"/> | 九龍城 | <input type="checkbox"/> | 旺角 | <input type="checkbox"/> | 油麻地 |
| | <input type="checkbox"/> | 尖沙咀 | <input type="checkbox"/> | 深水 | <input type="checkbox"/> | 將軍澳 | <input type="checkbox"/> | 西貢 | | |
| 新界 | <input type="checkbox"/> | 上水及粉嶺 | <input type="checkbox"/> | 馬鞍山 | <input type="checkbox"/> | 沙田 | <input type="checkbox"/> | 大埔 | <input type="checkbox"/> | 荃灣 |
| | <input type="checkbox"/> | 葵涌及青衣 | <input type="checkbox"/> | 屯門 | <input type="checkbox"/> | 元朗 | <input type="checkbox"/> | 天水圍 | | |

6. 現正接受的服務

| | | | |
|------------------------------------|-------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> 無 | <input type="checkbox"/> 特殊學校 | <input type="checkbox"/> 特殊學校寄宿服務 | <input type="checkbox"/> 社區支援服務 |
| <input type="checkbox"/> 日間訓練服務： | <input type="checkbox"/> 輔助就業 | <input type="checkbox"/> 庇護工場 | <input type="checkbox"/> 展能中心 |
| <input type="checkbox"/> 殘疾人士住宿服務： | <input type="checkbox"/> 中度弱智人士宿舍 | <input type="checkbox"/> 嚴重弱智人士宿舍 | |
| | <input type="checkbox"/> 嚴重肢體傷殘人士宿舍 | <input type="checkbox"/> 殘疾人士護理院 | |
| | <input type="checkbox"/> 自負盈虧殘疾人士院舍 | <input type="checkbox"/> 私營院舍 | |

II. 有關殘疾及健康問題的資料

主要殘疾

1. 肢體傷殘

| | | | |
|--|--|---|------------------------------------|
| <input type="checkbox"/> 並非肢體傷殘 (請轉答第 2 項) | | | |
| <input type="checkbox"/> 缺失上或下肢 | <input type="checkbox"/> 缺失手 / 腳掌或手 / 腳趾 | <input type="checkbox"/> 上肢或下肢癱瘓 | <input type="checkbox"/> 左 / 右半身不遂 |
| <input type="checkbox"/> 大腦癱瘓 | <input type="checkbox"/> 四肢癱瘓 | <input type="checkbox"/> 其他, 請註明: _____ | |

2. 弱智

| | |
|---|---|
| <input type="checkbox"/> 並非弱智 (倘若當事人並非肢體傷殘或弱智人士, 請終止評估程序) | |
| <input type="checkbox"/> 極度嚴重 | <input type="checkbox"/> 嚴重 <input type="checkbox"/> 中度 <input type="checkbox"/> 輕度 <input type="checkbox"/> 其他, 請註明: _____ |
| 心理評估日期: _____ 年 _____ 月 _____ 日 | |

次要殘疾

3. 其他殘疾

| | | |
|-------------------------------|------------------------------------|---|
| <input type="checkbox"/> 言語障礙 | <input type="checkbox"/> 聽覺受損 / 弱聽 | <input type="checkbox"/> 視覺受損 (<input type="checkbox"/> 失明 / <input type="checkbox"/> 弱視) |
| <input type="checkbox"/> 自閉症 | <input type="checkbox"/> 精神病 | <input type="checkbox"/> 其他, 請註明: _____ |

4. 疾病 / 健康問題 若有, 請註明: _____

III. 護理需要

| 項目 | 低度護理需要 | 中度護理需要 | 高度護理需要 | 極高護理需要 |
|------------------------------|---|--|---|---|
| 1. 皮膚問題 皮膚是否： | <input type="checkbox"/> 在過往一年內因反覆出現皮膚問題須搽醫生處方藥膏，如季節性皮膚病。 | <input type="checkbox"/> 在過往一個月內皮膚重覆損傷須觀察傷口發炎情況，並接受無菌換症清洗傷口。 | <input type="checkbox"/> 在過往一個月內皮膚出現潰瘍、褥瘡須接受無菌換症。 | <input type="checkbox"/> 在過往一個月內褥瘡有見骨情況。 |
| 2. 進食問題 在過往一個月內是否須： | | <input type="checkbox"/> 加凝固粉進行餵食。 <input type="checkbox"/> 有吞嚥問題。 | <input type="checkbox"/> 加凝固粉進行餵食，或經常出現哽塞。 <input type="checkbox"/> 須用導管餵食，當事人並非嚴重／極度嚴重弱智人士。 | <input type="checkbox"/> 須用導管餵食，當事人為嚴重／極度嚴重弱智人士。 |
| 3. 使用藥物情況 在過往一個月內當事人是否： | <input type="checkbox"/> 須每天接受藥物注射，當事人並非嚴重／極度嚴重弱智人士。 | <input type="checkbox"/> 長期使用藥物，並須跟進藥物反應 ¹ 。 <input type="checkbox"/> 須每天接受藥物注射，當事人為嚴重／極度嚴重弱智人士。 | | |
| 4. 排泄控制 在過去一個月內的排泄能力： | <input type="checkbox"/> 間中失禁。 | | <input type="checkbox"/> 大小便完全失禁 ² 。 <input type="checkbox"/> 使用導尿管。 | |
| 5. 癲癇情況 在過去三個月是否有癲癇發作： | <input type="checkbox"/> 曾有癲癇發作。 | | | <input type="checkbox"/> 癲癇情況經住院治療及調較用藥後仍不能控制（須經醫生證明）。 |
| 6. 氧氣治療 在過往一個月內是否須接受氧氣治療： | | | <input type="checkbox"/> 當事人並非弱智人士，在使用氧氣後仍能處理日常作息。 | <input type="checkbox"/> 當事人為弱智人士，在使用氧氣後仍能處理日常作息。 <input type="checkbox"/> 當事人在使用氧氣後仍無法處理日常作息 ³ 。 |
| 7. 抽吸處理 在過往一個月內是否： | | | | <input type="checkbox"/> 須接受恆常抽吸處理。 |
| 8. 長期臥床 在過往一個月內是否： | | | | <input type="checkbox"/> 須長期臥床並完全倚賴他人照顧。 |

¹ 長期使用藥物只限於糖尿及心臟藥物，並須跟進藥物反應；如使用糖尿藥物，須監察血糖水平，使用心臟藥物，須監察心律。

² 完全失禁指大小便在不自覺或不受控制的情況下排出。

³ 無法處理日常作息指小量活動便引致氣促。

IV. 功能缺損⁴

A 類：要求人手協助較多的自我照顧項目

評分準則

- 0：當事人完全獨立完成該活動項目，並在可接受的時間內安全地達至基本衛生要求（包括使用輔助器具）。
 1：當事人需要別人在旁提示或監督才能完成（包括需要接觸身體的提示）。
 2：當事人需要較多的觸體協助，但他/她仍有參與部份活動（協助程度不涉及大量搬移身體位置或提舉當事人身軀或肢體重量）。
 3：當事人極度倚賴，只有很少或完全沒有參與（照顧者需給予大量體位搬移的協助、提舉當事人身軀或肢體重量或要花費相當力勁才能協助完成某項自理程序）。

| 活動項目 | 完成部份自我照顧活動的協助程度 | 完成整項自我照顧活動的協助程度 |
|--|-----------------|-----------------|
| A1. 洗澡 進行淋浴或坐浴（不包括洗頭） | | |
| A2. 穿脫衣物（需在坐或站立的姿勢完成）（請選取需較多協助的分項作為整項程度的分數） | | |
| A2.1 穿脫上身衣物，包括外衣及內衣（不計算扣鈕） 進行活動時的姿勢：*坐 / 站 | | |
| A2.2 穿脫下身衣物，包括面褲及內褲 | | |
| A2.3 穿脫鞋襪（包括使用手托或義肢） | | |
| A3. 位置轉移 指身體如何由一處移動至另一處的情況（例：床過櫈 / 輪椅，輪椅過坐廁等） 請列出需要的輔助工具 / 助行器材： | | |

* 刪去不適用者

B 類：要求人手協助較少的自我照顧項目

評分準則

- 0：當事人完全獨立完成該活動項目，並在可接受的時間內安全地達至基本衛生要求（包括使用輔助器具）。
 1：當事人需要別人在旁提示或監督才能完成（包括需要接觸身體的提示）。
 2：當事人需觸體協助至完全倚賴。

| 活動項目 | 完成部份自我照顧活動的協助程度 | 完成整項自我照顧活動的協助程度 |
|--|-----------------|-----------------|
| B1. 如廁（使用坐廁或蹲廁） 指有便意時上廁所，大小便後的清潔情況(包括更換成人尿片)。 | | |
| B2. 進食及進飲（請選取需較多協助的分項作為整項程度的分數） | | |
| B2.1 進食情況（不包括管灌餵食） 食物種類：*一般 / 切碎 / 醬狀 | | |
| B2.2 進飲情況 進飲輔助工具： | | |
| B3. 室內行動能力（只需回答 B3.1 或 B3.2）（請選取適用的分項作為整項程度的分數） | | |
| B3.1 室內行走約兩分鐘 所使用的助行器具： | | |
| B3.2 室內使用輪椅 輪椅類別：*手動 / 電動 | | |

* 刪去不適用者

⁴ 評估是透過面談了解學員的自我照顧能力；若有需要，可臨床觀察以下活動進行：(a)喝水；(b)穿衣褲；(c)身體位置轉移，如來回床至座櫈、來回輪椅至座櫈等；(d)室內行走。

V. 行為問題

| | | |
|---|------------------------------------|---|
| A. 攻擊行為 | | |
| 1. 在過去一年內，當事人有否向他人表現攻擊行為（如用拳猛擊他人，掌摑他人，推撞他人，踢人，夾人，抓人，扯人頭髮，咬人，用武器攻擊人，扼人喉嚨）？ | <input type="checkbox"/> 否 | <input type="checkbox"/> 有 |
| （請轉問項目 B1） | | |
| 2. 在過去一年內，有否發生當事人攻擊人事故，引致他人身體嚴重受傷，需要即時醫治？ | <input type="checkbox"/> 否 (0分) | <input type="checkbox"/> 有 (1分) |
| B. 自我傷害行為 | | |
| 1. 在過去一年內，當事人有否表現自我傷害行為（如搥自己，咬自己，拳擊或掌摑自己頭部，撞頭，把身體撞向其他東西，扯脫自己頭髮，拳擊或掌摑自己身體，插自己眼，夾自己，用工具割自己，插自己，用工具撞自己，咬唇，扯脫自己指甲，把牙齒撞向其他東西）？ | <input type="checkbox"/> 否 | <input type="checkbox"/> 有 |
| （請轉問項目 C1） | | |
| 2. 在過去一年內，當事人有否表現自我傷害行為，引致自己身體嚴重受傷，每月至少一次需要醫生即時治理？ | <input type="checkbox"/> 否 (0分) | <input type="checkbox"/> 有 (1分，請轉問項目 C1) |
| 3. 在過去一年內，當事人有否每星期至少一次表現自我傷害行為？ | <input type="checkbox"/> 否 (0分) | <input type="checkbox"/> 有 (1分) |
| C. 破壞行為 | | |
| 1. 在過去一年內，當事人有否表現破壞行為（如用擊打，撕扯，切割，投擲，燒毀，塗污或抓刮方法導致傢俱、家居裝置、建築物、車輛等損毀）？ | <input type="checkbox"/> 否 | <input type="checkbox"/> 有 |
| （請轉問項目 D） | | |
| 2. 在過去一年內，當事人有否導致嚴重物資破壞，和/或導致六次或以上輕微物資破壞？ | <input type="checkbox"/> 否 (0分) | <input type="checkbox"/> 有 (1分) |
| D. 其他行為問題 | | |
| 在過去一年內，當事人有否表現其他行為問題，如不恰當性行為（包括公眾地方暴露自己，公眾地方自慰，滋擾他人），厭惡行為（包括尖叫，反芻吞下的食物，發出喧鬧聲，用口水或糞便塗污，或其他同類厭惡行為），重覆行為（包括搖晃身體，重覆翻動手掌，彈手指，踱來踱去，持續奔跑，或同類重覆行為）？ | <input type="checkbox"/> 否 | <input type="checkbox"/> 有 |
| 請註明(可選多項)： | | |
| <input type="checkbox"/> 不恰當性行為 | | |
| <input type="checkbox"/> 厭惡行為 | | |
| <input type="checkbox"/> 重覆行為 | | |
| （當項目 A1, B1, C1 或 D 至少一項的答覆是「有」，方可繼續回答 E 項。） | | |
| E. 應付問題 | | |
| 請問照顧者在處理以上行為時，覺得非常困難嗎？ | <input type="checkbox"/> 否 (0分) | <input type="checkbox"/> 是 (1分) |

| | |
|--------------------------|--|
| 項目 A2, B2, B3 和 C2 的總得分* | |
| 項目 E 的得分* | |

* 任何沒有發問的項目，請給予 0 分。

VI. 家人 / 照顧者的應付能力

A 項：照顧系統

1. 當事人（殘疾人士）是否有照顧者？ 否（請轉答 B 項）
 是，現正接受政府資助院舍照顧（請轉答第 VII 部分）
 是，現正接受家人、私營院舍或自負盈虧院舍照顧

| | 姓名 | 年齡 | 關係 | 是否同住 | 職業(全職 / 兼職) | 每天照顧時數 |
|------------------------|----|----|----|------|-------------|--------|
| (a) 主要照顧者 ⁵ | | | | | | |
| (b) 次要照顧者 | | | | | | |
| (c) 其他照顧者 (可多於一位) | | | | | | |

2. 由於以下各種因素，轉介者認為當事人現存的照顧系統已面臨相當程度的風險： 否 是
 (請轉答 B 項)
- (a) 主要照顧者年紀已達 60 歲或以上 (1 分)
 (b) 主要照顧者個人健康轉差或有長期病患以致無法照顧當事人 (1 分)
 (c) 主要照顧者為肢體傷殘人士、弱智人士或嚴重精神病患者 (1 分)
 (d) 主要照顧者出現情緒困擾（例如長期沮喪、憂鬱）以致無法照顧當事人 (1 分)
 (e) 主要照顧者須照顧同住的其他家庭成員（例如長期病患者、其他殘疾人士）以致無法照顧當事人 (1 分)
 (f) 主要照顧者須長時間工作而無經濟能力聘請傭人，以致無法照顧當事人 (1 分)

就以上各項答案，請詳述情況： _____

B 項：人際關係

1. 當事人是否與家人或其他人士同住？ 否（請轉答第 3 項） 是
 2. 過去三個月內，當事人至少兩次曾與家人 / 同居者發生嚴重衝突 (1 分)
 3. 過去三個月內，當事人至少兩次曾滋擾鄰舍而引致嚴重衝突 (1 分)

就以上各項答案，請詳述情況： _____

C 項：其他風險因素

- 由於以下各種因素，轉介者認為當事人現時的安全情況已面臨相當程度的風險： 否（請轉答 D 項） 是
- (a) 家人對當事人身體虐待 / 精神虐待 / 性侵犯 (1 分)
 (b) 外人對當事人身體虐待 / 精神虐待 / 性侵犯 (1 分)
 (c) 當事人被疏忽照顧 (1 分)
 (d) 當事人有不受控制行為（例如離家出走、參與非法活動） (1 分)

就以上各項答案，請詳述情況： _____

⁵ 「主要照顧者」是指每天用最多時間照顧 / 協助當事人的人士：主要是指父母、家人或親友，但不包括傭人或院舍職員。傭人及院舍職員應歸入「其他照顧者」。

D 項：其他協助（包括社區照顧服務）

1. （若果上述 A 至 C 項的總分為 0 分，請轉答第 2 題）除了主要照顧者外，有否其他人士（包括 A 項所述的次要或其他照顧者，或任何人士）可取代／協助提供照顧（若有，請註明） 有 否

取代者： _____

協助者： _____

2. 現時有否接受社區照顧服務（例如：日間訓練、緊急住宿、暫托、綜合家居照顧服務、家居訓練及支援服務、社工／心理輔導）或申請體恤安置 有 否

若有，請註明： _____

3. 轉介者會否轉介當事人及／或其家人接受（其他）合適的社區照顧服務或申請體恤安置 會 否
請轉答 VII 部 請轉答第 4 項

若會，請註明： _____

4. 若第 3 項答「否」，請詳述原因： _____

VII. 總結

| 項目 | 評估結果 | <u>轉介者認為現有照顧系統連同社區照顧服務 是否能夠提供所需照顧</u> | |
|--|--|---|----------------------------|
| 1. 護理需要 | <input type="checkbox"/> 沒有護理需要 (請轉答第 2 項) <input type="checkbox"/> 低度護理需要 <input type="checkbox"/> 中度護理需要 <input type="checkbox"/> 高度護理需要 <input type="checkbox"/> 極高護理需要 | <input type="checkbox"/> 是 | <input type="checkbox"/> 否 |
| 2. 功能缺損 | <input type="checkbox"/> 沒有缺損 (請轉答第 3 項) <input type="checkbox"/> 低度缺損 <input type="checkbox"/> 中度缺損 <input type="checkbox"/> 高度缺損 | <input type="checkbox"/> 是 | <input type="checkbox"/> 否 |
| 3. 行為問題 | <input type="checkbox"/> 沒有行為問題 (請轉答第 4 項) <input type="checkbox"/> 有行為問題 (評估如下): <input type="checkbox"/> 無需設有較多員工的康復服務 <input type="checkbox"/> 需要設有較多員工的康復服務 | <input type="checkbox"/> 是 | <input type="checkbox"/> 否 |
| 4. 家人 / 照顧者 的應付能力 | 現存照顧系統已面臨相當程度的風險： <input type="checkbox"/> 是 <input type="checkbox"/> 否 當事人有嚴重人際關係問題： <input type="checkbox"/> 是 <input type="checkbox"/> 否 當事人的安全情況已面臨相當程度的風險： <input type="checkbox"/> 是 <input type="checkbox"/> 否 有其他人士可取代 / 協助提供照顧： <input type="checkbox"/> 是 <input type="checkbox"/> 否 <input type="checkbox"/> 不適用 | | |
| 5. 綜合上述所有答案，轉介者經考慮當事人及 / 或其家人的情況，認為現有照顧系統連同社區照顧服務無法能夠提供所需照顧，以致當事人現時需輪候院舍服務 | | <input type="checkbox"/> 是 | <input type="checkbox"/> 否 |

若是，請詳述原因，及長遠安排⁶：

並請根據「評估流程」，建議所需院舍類別：

中度弱智人士宿舍 (HMMH)
 嚴重弱智人士宿舍 (HSMH)
 嚴重肢體傷殘人士宿舍 (HSPH)
 殘疾人士護理院 (C&A/SD)

⁶ 轉介者在考慮當事人對院舍服務需要的同時，亦須與當事人及 / 或其家人訂定有關的長遠安排。若所遇問題屬於短期問題，轉介者應考慮當事人可否先接受暫托服務 [或短期院舍服務]

社會福利署
弱智人士及肢體傷殘人士住宿服務評估
評估員手冊草稿

社會福利署
康復及醫務社會服務科
二 三年九月

社會福利署
弱智人士及肢體傷殘人士住宿服務評估
評估員手冊

背景

1. 政府在 2000 年施政報告承諾會檢討各類住宿服務的入住準則並改善入住程序。其後，社會福利署成立了一個名為「檢討殘疾人士住宿服務督導委員會」的跨專業督導委員會，負責督導有關檢討工作。委員會確定就使用者和輪候人士的概況和服務需要進行調查，並由社會福利署於 2001 年委託顧問公司進行一項殘疾人士住宿服務意見調查。調查結果於 2002 年公佈，其中發現超過 24%的家長希望在五年或以後才獲編配宿位。此外，根據社署紀錄，住宿服務當事人拒絕宿位編配的個案，自 2000 年起一直佔總編配數目 30%以上。
2. 上述數字反映很多家長為其殘疾子女申請住宿服務時抱「買保險」心態。此外，現時住宿服務除了要求當事人必須為殘疾人士外，並無其他附帶條件，申請時亦不會要求當事人提供所需的護理程度或家庭背景等資料。
3. 基於以上情況，委員會於 2002 年 9 月成立工作小組，研究並設計統一評估機制。小組成員包括家長代表、康復專科醫生、精神科醫生、臨床心理學家、物理治療師、職業治療師、護士和社工等。以下是工作小組就評估工具所制訂的內容。

評估目的

4. 此評估工具的目的是透過評估 15 歲或以上的弱智人士 / 肢體傷殘人士（以下簡稱「當事人」）日常生活的四個重要範疇，包括護理需要（nursing care need）、功能缺損程度（functional impairment）、行為問題（challenging behaviour），以及家人 / 照顧者的應付能力（family coping），從而界定當事人是否需要院舍服務、需要甚麼類型的院舍服務，及是否可以先讓當事人接受社區照顧服務，直至所提供的支援不再足夠照顧他們的需要才入住院舍。

制訂評估工具之考慮

5. 根據上述目的，評估工具在設計上依循下列幾個原則：
 - (a) 評估須以當事人此時此刻的需要（needs）及危機因素（risk factors）為基礎。
 - (b) 此工具的主要用途是為界定當事人是否需要院舍服務，以及把需要不同類型院舍服務的殘疾人士作出服務分流（streaming），而不是用以取代專業人員為康復及治療用途而進行的深入評估。一般而言，在未進行此項評估之前，殘疾人士已接受過不少專業人員的深入評估、訓練、治療和輔導，他們入住院舍後，亦可按需要繼續接受有關服務。因此，轉介者的責任並不是要重覆專業人員的工作，而是要掌握足夠資料，以決定當事人是否需要院舍服務以及甚麼類型的院舍服務。
 - (c) 由於現有服務類別有限，而評估工具只為決定當事人是否需要院舍服務、及作出服務分流，因此評估工具需要搜集的資料亦以上述目標為依歸，因此跟服務分流無關的項目並沒有被納入評估表內。此工具力求簡潔，一般來說社會工作助理（SWA）職級以上都能在一小時內完成整個評估過程。
 - (d) 評估工具在設計時已考慮到現時服務的資源及人手編制，以配合實際服務運作情況。

轉介者的責任

6. 轉介者須為註冊社工（社會工作助理或以上），鑑於院舍服務是根據殘疾人士及其家人的實際需要（非其意願）而提供的服務，亦由於資源有限，轉介者須盡量保持客觀，根據其專業判斷去衡量當事人現時的照顧系統是否能夠提供所需照顧。若當事人現時的照顧系統連同現有社區照顧服務仍未能配合當事人實際的需要，轉介者便須為當事人輪候院舍服務。

轉介者須知

7. 轉介者須向當事人及其家人闡明評估的整體目的和此工具的用途，並取得他們的同意才進行評估，在評估過程中亦須清楚介紹各部份的目的。此外，轉介者亦須向當事人及其家人展示《個人資料（私隱）條例》所述有關收集資料的用途、查閱和更改資料的途徑的單張，或口頭上向他們闡述有關內容。
8. 轉介者須留意當事人及其家人的情緒，並尊重他們的感受，遇有需要時作合適的輔導或轉介。
9. 評估的對象主要是指當事人（包括弱智人士及肢體傷殘人士）。就弱智人士而言，轉介者須考慮他是否能夠如實回答問題，否則轉介者可向他的家人／照顧者提問。由於 V 及 VI 部涉及當事人的行為問題和家人／照顧者的應付能力，因此須主要由家人／照顧者作答。若轉介者熟悉當事人及其家人的情況（例如當事人的殘疾程度），轉介者可自行填寫，但須讓當事人及其家人知悉有關內容。
10. 遇有需要時，轉介者可要求受訪者出示有關證明文件（例如醫生證明書），或取得受訪者的同意而向其他人士（例如其他照顧者或專業人士）核實有關資料（例如殘疾程度），或作家訪。
11. 轉介者須盡量引用評估表內的文字來提問，但遇有需要時，可嘗試用淺白的文字解釋有關內容，並重點記錄下來，日後用作改善評估表文本的基礎。
12. 轉介者須綜合其所見所聞，根據客觀事實去填寫最合適的答案。
13. 轉介者須按照《弱智人士服務需要評估流程》或《肢體傷殘人士服務需要評估流程》（附錄一）所涉及的有關範疇，決定當事人所需的服務。
14. 轉介者須跟據評估流程表作合適的分流建議，並盡量熟識各類型的院舍服務及社區照顧服務，以便協助當事人及其家人了解不同服務的特點。
15. 轉介者須向當事人及其家人交代其建議。若當事人或其家人不同意轉介者所作的建議，轉介者須記錄在案，再交由轉介者的上司處理。

評估工具的內容及流程

16. 除了 I 及 II 部涉及個人資料和有關殘疾及健康問題的資料外，此評估工具包括四個評估範疇和總結。
17. 由於現時殘疾人士院舍主要為殘疾人士提供護理及生活上的照顧，因此，此評估工具主要的兩個評估範疇分別為護理需要評估以及功能缺損評估。
18. 先從護理需要入手的好處是，有極高護理需要的殘疾人士可直接考慮申請醫院管理局轄下的療養院服務；而有高護理需要的殘疾人士，經評估其家人／照顧者應付能力後，亦可直接輪候殘疾人士護理院服務，而不需考慮其功能缺損的程度。評估護理需要項目包括皮膚護理、進食、使用藥物情況、排泄控制、癩癩情況、氧氣治療及抽吸處理。透過評估當事人所需最高護理程度的項目，可決定其護理需要的程度。
19. 評估功能缺損的目的，是為識別當事人日常生活的基本自我照顧能力及需要何種程度的協助。評估項目以所需人手協助的程度分為兩類，其中要求人手協助較多的項目包括洗澡、穿脫衣物及身體位置轉移；而要求人手協助較少的項目包括如廁、進食、進飲及在室內行動的能力。透過有關評估分數的換算表，可決定功能缺損的程度。
20. 此外，對於有低度或沒有護理需要，而沒有功能缺損的殘疾人士，遇有需要時（例如在沒有照顧者的情況下），轉介者可轉介當事人入住社區的小型宿舍¹過半獨立的生活；在沒有合適的社區住宿服務時，才考慮讓當事人輪候中度弱智人士宿舍。
21. 至於行為問題方面，一般而言，行為問題須由臨床心理學家或精神科醫生處理，並由院舍員工作出配合。但考慮到一些比較嚴重的行為問題可能需要較多院舍員工提供支援，因此，行為問題評估的作用是為識別需要額外人手照顧的個案，以調節所需服務的類別。例如：一名輕度弱智人士本身適合入住社區的小型宿舍，但鑑於其行為問題，則需被安排輪候中度弱智人士宿舍。由於當事人在相當程度上有半獨立生活能力，中度弱智人士宿舍的員工便可集中地處理他的行為問題。行為問題的評估項目包括攻擊行為、自我傷害行為、破壞行為，其他行為問題²，以及照顧者在處理以上行為問題時所到遇的困難。透過各項評估的得分，可決定當事人是否需要設有較多員工的康復院舍服務。
22. 至於家人／照顧者應付能力的評估，其作用並非為了分流，而是為了識別照顧者因照顧殘疾人士而引起的適應困難，並識別潛在的風險因素，以決定該殘疾人士現時是否需要入住院舍。評估過程中，轉介者在考慮家人／照顧者應付能力的同時，亦須考慮現有社區照顧服務是否可以協助提供所需照顧，並作合適轉介。評估項目包括照顧者的年紀、健康及情緒狀況、是否須照顧其他殘疾人士、是否須長時間工作而無人照顧、家庭成員關係、當事人有否被虐待、疏忽照顧、離家出走或參與非法活動、及有沒有其他照顧者能提供協助等因素。
23. 在總結部份，轉介者須按照以上四個評估範疇的結果，在中間那一欄（即「評估結果」）如實作答；然後

1 有別於院舍照顧（institutional care），社區住宿照顧（community residential care）包括自負盈虧宿舍（self-financing hostel）及半獨立式生活輔助宿舍（supported hostel - SHOS）

2 至於其他行為問題，雖然不存在為識別需要額外人手照顧而分流的問題，然而轉介者可視乎其個別情 以及家人／照顧者的應付能力，在 VII 部份第 4 項考慮現存照顧系統連同社區照顧服務是否能夠提供所需照顧，並在第 5 項詳述有關原因。

參考附件二所列的社區照顧服務(轉介者須恆常更新有關資料),把有關的社區照顧服務跟所需照顧作配對,以決定現有照顧系統連同社區照顧服務是否能夠在相當程度上提供前三個範疇所需照顧(即護理需要、功能缺損程度,以及行為問題),並如實在右欄作答。若當事人及/或其家人只是剛剛被轉介接受社區照顧服務,轉介者則須考慮是否應等上一段時間(一般三個月)才作此評估。

24. 由於評估表未能盡錄所有與當事人服務需要有關的因素,轉介者亦可在最後的問題上作補充(即總結第5項),並詳述評估工具未曾提及而轉介者卻認為對申請住宿服務有決定性影響的事實。轉介者最終須綜合所有客觀資料,根據評估流程表及其專業判斷去決定當事人現時是否需要輪候院舍服務,或是否先讓當事人接受社區照顧服務。
25. 此外,若轉介者認為當事人有迫切需要住宿服務,便須因應當事人的情況,按既定程序為當事人申請緊急住宿服務、優先輪候服務,或暫居服務。

* * *

以下就 III 至 VII 部的內容作詳細闡述：

III. 護理需要評估

評估準則

- (a) 以選取最高一項護理需要為評估結果，例如：若同時有兩項為「低度護理需要」，一項為「中度護理需要」，則評估結果為「中度護理需要」。
- (b) 轉介者在考慮當事人的護理需要時，如所需的護理照顧在上述各項中未能反映，轉介者可在總結第五項詳述有關護理需要以考慮當事人所需服務。

1. 皮膚問題

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| 目的 | 部份當事人需要接受皮膚或傷口護理。此項目為協助識別他們需要護理的程度。 | |
| 程序 | 當事人會被直接問及他在過去一年內皮膚或傷口所需的護理。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | <ol style="list-style-type: none"> 1. 醫生處方藥膏：由註冊西醫處方的皮膚藥膏。 2. 損傷：因碰撞、摩擦造成的皮膚損傷。 3. 發炎情況：指損傷皮膚出紅腫及含膿。 4. 褥瘡：因壓力、摩擦造成的皮膚或肌肉損傷，甚至深層組織潰瘍壞死。 5. 無菌換症：指由護理人員執行消毒程序清洗傷口。 | |
| 範例 | 例如： <ol style="list-style-type: none"> 1. 亞明中度弱智人士，他母親表示亞明經常小腿皮膚痕癢，每年多次出癬，須求醫診治。 2. 亞輝經常出現自傷行為，用硬物擊打手背，做成皮膚損傷，傷口因經常受到損傷致無法癒合，甚至出現發炎現象。 3. 小玲四肢癱瘓，須長期坐輪椅，因不能自行轉動身體，盤骨位置因長期受壓導致部份皮膚脫落形成褥瘡。 | 評估結果 <ol style="list-style-type: none"> 1. 低度護理 2. 中度護理 3. 高度護理 |

2. 進食問題

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| 目的 | 了解當事人在進食方面是否因病理性或功能性原因，引致不能正常地進食。如吞嚥困難出現，評估當事人恰當的餵飼方法及特別措施，使當事人能安全地進食。 | |
| 程序 | 當事人會被直接問及他在過去一個月內進食的情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | <ol style="list-style-type: none"> 1. 凝固粉：粉狀物質加入液體中使液體加強質感，使液體凝結成半固體。 2. 吞嚥困難：食物經咀嚼後，不能憑舌頭及咽喉運動經食道順利送入胃內，部份食物仍留在口腔，造成哽塞危機。 3. 哽塞：進食時出現吞嚥困難，吞嚥時食物阻塞氣道，引致呼吸困難。 4. 導管餵食：利用胃喉攝取流質食物養份。 | |
| 範例 | 例如： <ol style="list-style-type: none"> 1. 阿珍嚴重弱智人士，手部活動緩慢，能自行進食，在進食過程中，發現阿珍吞嚥後大部份食物仍留在口腔內，須鼓勵她慢慢咀嚼，才可把食物吞下。 2. 啟明有吞嚥困難，經治療師或醫生評估後，認為進食流質食物時，須加入凝固粉方能進食。進食期間須別人餵食及觀察進食情況防止哽塞情況出現。 3. 阿輝因大腦痙攣，須他人餵食，在餵食期間經常咳嗽，更經常出現哽塞現象。 4. 阿輝交通意外後，失去吞嚥能力，須用導管餵食攝取營養。 | 評估結果 <ol style="list-style-type: none"> 1. 中度護理 2. 中度護理 3. 高度護理 4. 高度護理 |

3. 使用藥物情況

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| 目的 | 部份當事人需使用各種不同類型的藥物，或接受藥物注射，此項目為協助識別他們在使用某些特定藥物時的護理需要。 | |
| 程序 | 當事人會被直接問及他在過去一個月內使用藥物的情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | 跟進藥物反應：指需了解當事人對服用某些藥物前的情況及使用藥物後的反應加以跟進。（如使用糖尿藥物、須監察血糖、心臟藥物、須監察心律。） | |
| 範例 | 例如： <ol style="list-style-type: none"> 1. 麗珠嚴重弱智人士，患有糖尿病，須早、晚注射糖尿針，控制血糖。 2. 小生是糖尿病患者，每天在服用糖尿藥前，須驗血糖，醫生指示如血糖低過4度，無須服用糖尿藥物。 3. 大雄嚴重弱智人士，患有心臟病，須服用心臟藥物 Digoxin，故每天服藥時，須量度心律。 | 評估結果 <ol style="list-style-type: none"> 1. 中度護理 2. 中度護理 3. 中度護理 |

4. 排泄控制

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| 目的 | 部份當事人失去控制排泄能力。此項目為協助識別他們在排泄控制上的護理需要，如為間中失禁者提供小便失禁訓練，為完全失禁者選用合適的失禁輔助用具，保護皮膚避免受損。 | |
| 程序 | 當事人會被直接問及他在過去一個月內排泄控制的情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | <ol style="list-style-type: none"> 1. 失禁：分大便失禁及小便失禁兩類。 2. 小便失禁：指失去控制排小便能力。 3. 大便失禁：指失去控制排大便能力。 4. 完全失禁：指大小便失去控制，不自覺或不受控制的排出。 5. 導尿管：因失去控制小便能力，須使用尿管導尿。 | |
| 範例 | 例如： <ol style="list-style-type: none"> 1. 玉芬中度弱智人士，經常因小事發脾氣，有時因鬧情緒，間中有遺尿出現，故意引人注意。這情況如能給她多點關心或提點，將可改善。 2. 文生極度嚴重弱智人士，四肢活動能力緩慢，不能說話，及不能意識到自己何時須要如廁，經常不自覺地排小便或大便。 | 評估結果 <ol style="list-style-type: none"> 1. 低度護理 2. 高度護理 |

5. 癲 情況

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| 目的 | 部份當事人可能患有癲 症。此項目為協助了解當事人癲 發作的情況及嚴重性，以識別他們需要的護理程度。一般情況下，如癲癇發作出現不省人事，臉色變藍，抽搐時引致受傷或癲癇發作次數頻密等情況下，都須送院治療。故在介定護理需要程度上，癲癇發作視作一般護理，唯某些當事人癲癇發作頻密程度經治療後仍未能受控制者，則須極高護理照顧。 | |
| 程序 | 當事人會被直接問及他在過去三個月內癲 的情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | 癲 情況仍不能控制指當事人服用癲 藥物後，癲 發作仍然頻密，經醫生證明，癲癇情況不能被藥物控制。 | |
| 範例 | 例如： <ol style="list-style-type: none"> 1. 美玲覆診腦內科，因癲癇症須服用藥物，癲癇發作情況並不頻密約一年一至二次。 2. 小超嚴重弱智人士患有癲癇症，經常癲癇發作，曾因癲癇發作致不醒人事，須送院治療，經治療及服用藥物後，情況未有改善，經醫生證明，癲癇情況不能受藥物控制。 | 評估結果 <ol style="list-style-type: none"> 1. 低度護理 2. 極高護理 |

6. 氧氣治療

| | | |
|----|--|----------------------------|
| 目的 | 部份當事人因呼吸問題需使用氧氣，此項目為協助識別他們在使用氧氣治療後，所需的護理照顧程度。 | |
| 程序 | 當事人會被直接問及他在過去一個月內使用氧氣及呼吸情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | 無法處理日常作息：指作出一般活動如起立、取物、走路等會出現氣喘情況。 | |
| 範例 | 例如： 1. 李生肢體傷殘，患有肺氣腫，當氣喘時須用氧氣治療，使用一段時間後，可作簡單活動。 2. 劉女士長期病患者，患有心臟病及肺氣腫，須長期使用氧氣，當暫停使用氧氣作一些簡單活動時，便感吃力、氣喘、疲憊不堪。 | 評估結果 1. 高度護理 2. 極高護理 |

7. 抽吸處理

| | | |
|----|--|--------------|
| 目的 | 部份當事人有需要接受抽吸護理。此項目為協助識別他們所需要護理的程度。 | |
| 程序 | 當事人會被直接問及他在過去一個月內抽吸護理的情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | 恆常抽吸處理：指須 24 小時留意當事人涎痰哽塞情況，並作出即時抽吸處理使氣道暢通。 | |
| 範例 | 例如： 美美患有痙攣及有吞嚥困難，經常因有很多涎痰哽塞氣道，引致呼吸困難，須護理人員經常（24 小時）留意其情況，並作出即時抽吸處理。 | 評估結果 極高護理 |

8. 長期臥床

| | | |
|----|--|--------------|
| 目的 | 部份當事人因身體機能轉變須長期臥床。此項目為協助識別他們因長期臥床所需的護理照顧程度。 | |
| 程序 | 當事人會被直接問及他在過去一個月的活動能力及臥床情況。如果當事人的家人或日常照顧者在場，轉介者可和他們交談了解情況，或向他們借閱有關的醫療記錄。 | |
| 定義 | 長期臥床：指當事人因身體機能上的衰退或疾病的影響，致不能坐下多過 2 小時，大部份的日常活動須在臥床進行。如進食、穿衣、如廁等，並須要護理照顧，如轉換身體受壓位置、更換紙尿片、預防褥瘡等問題。 | |
| 範例 | 例如： 小秋因大腦受損，四肢萎縮，無法坐在椅上，日常照顧如進食、如廁都須臥床進行。 | 評估結果 極高護理 |

IV. 功能缺損評估

注意事項

1. 是項評估乃透過與當事人、其家人或日常照顧者面談而了解當事人在主要個人自理項目上所需的照顧程度；評估者須以當事人在最近一個月內情緒穩定時的一般表現為依歸，並須確定當事人在過去一個月內病情沒有突發轉變。
2. 若有需要（如評估者認為面談內容與當事人情況不符），應輔以現場觀察以下活動之進行：
 - (a) 喝水；
 - (b) 穿衣褲；
 - (c) 身體位置轉移，如：來回床椅；及
 - (d) 家內行走。
3. 面談或觀察須於當事人熟悉的生活環境中進行（如學校、家居），而當事人、其家人或日常照顧者均須出席。

| 功能缺損評估的設計 | | |
|-----------|---|---|
| A 類 | 要求較多人手協助的個人自理項目。在這評估工具中，我們選取了洗澡、穿脫衣服及位置轉移。這三項的自理項目均在時間、人手協助或頻密度上較為顯著。 | |
| | 洗澡 | 過程最為複雜及需時，在單一時間內所需的人手協助也最多。 |
| | 穿脫衣服 | 包括早上更換衣服，如廁前後的穿脫褲子及洗澡前後的穿脫衣服， 頻密的程度 十分高；對於有肢體傷殘的人士如大腦麻痺的人士，穿脫衣物需更多的協助。 |
| | 位置轉移 | 此項目的 重覆次數 乃最頻密，任何轉換身體位置如坐至企，輪椅至坐廁或床至輪椅等也涵蓋在內。 |
| B 類 | 要求較少人手協助的個人自理項目。在這評估工具中，我們選擇了如廁、進食及進飲和行動能力。這三項自理項目中在時間、人手協助或頻密程度相對 A 類項目為少。 | |
| | 如廁 | 因評估範圍只限於表達如廁需要及便後清潔，並不包括穿脫褲子及如廁過程中涉及的位置轉移，所以人手協助便相對較少。 |
| | 進食及進飲 | 一般弱智及肢體傷殘人士在這方面的動機較佳，主動性較強，所以需要人手的協助也較輕。 |
| | 行動能力 | 這項目包括的範圍是指日常行動的情況，不包括訓練時的步行練習。對於完全需協助的人士，實際多以輪椅代步。 |
| 評分 | 如上述所論，A 類項目無論在時間、頻密程度及人手協助的要求都較為顯著，所以我們以較細緻的方法將 A 項的評分數目分為四級（即 0 至 3 分），希望藉較敏感的計分系統分辨出那些人士真正需要較多人手供應的宿位服務。 相對而論，B 類的自理活動需要人手較少，我們亦以較簡易的三級評分來界定其人手需求。 | |

評分內容

A 類項目

- 0：當事人完全獨立完成該活動項目，並達至合理水平*（包括使用輔助器具）。
- 1：當事人需要別人在旁提示或監督才能完成（包括需要接觸身體的提示）。
- 2：當事人需要較多的觸體協助，但他/她仍有參與部份活動（協助程度不涉及大量搬移身體位置或提舉當事人身軀或肢體重量）。
- 3：當事人極度倚賴，只有很少或完全沒有參與（照顧者需給予大量體位搬移的協助、提舉當事人身軀或肢體重量或要花費相當力勁才能協助完成某項自理程序）。

B 類項目

- 0：當事人完全獨立完成該活動項目，並達至合理水平*（包括使用輔助器具）。
- 1：當事人需要別人在旁提示或監督才能完成（包括需要接觸身體的提示）。
- 2：當事人需觸體協助至完全倚賴。

* 合理水平的定義是在可接受的時間內安全地達至基本衛生要求。

| 功能缺損程度 | A 類項目 (總分) | B 類項目 (總分) | 備註 |
|--------|---------------|---------------|---------------------------|
| 高度缺損 | 7-9 分 | -- | 不計算 B 類項目 |
| 中度缺損 | 4-6 分 | 4-6 分 | |
| 低度缺損 | 1-3 分 | 1-3 分 | $3 \leq (A + B) \leq 6$ 分 |
| 沒有缺損 | 0-1 分 | 0-1 分 | $(A + B) \leq 2$ 分 |

功能缺損換算表的設計理念

1. A 類要求較多人手協助的個人自理項目；B 類要求較少人手協助的個人自理項目。
2. 以 A 類及 B 類的整體表現為原則，以同一類別項目的總分為換算的基礎。
3. A 類及 B 類項目的總分出現於不同程度的缺損範圍，則選取缺損程度較高者為準則。

功能缺損評估

A1. 洗澡

| | | |
|----|--|------|
| 目的 | 記錄當事人在過去一個月內在洗澡上的表現及需要別人協助的情況。 | |
| 程序 | 轉介者首先要掌握當事人能夠自己完成洗澡的部位；再了解當事人何時需要協助及辨別屬那類協助的模式（如：口頭提示、觸體提示、或 / 及身體協助）。 | |
| 定義 | 當事人如何進行洗澡如坐浴或淋浴（不包括洗頭）。洗澡應包括清潔雙臂、大腿、小腿、胸部、腹部、背部和私處。 | |
| 範例 | 活動表現 | 評估分數 |
| | 黃先生是輕度弱智人士。每天洗澡前，他的母親需要替他準備好衣服及調較水溫。至於洗澡程序，他能夠沖洗及抹乾身體，但速度較慢，需要別人催促，以免着涼。 | 0 |
| | 陳女士在洗澡時經常需要別人在旁提點，甚至輕碰她拿着花洒的手沖洗身體各部位。 | 1 |
| | 李先生只懂得清潔自己的胸部及腹部，不懂得洗擦頸、背、腋窩、手腳及私處需要別人拿着他的手來洗擦未清潔的身體部份。他在整個洗澡過程中沒有抗拒。 | 2 |
| | 何先生因大腦痙攣而手腳控制不太靈活；故此，照顧者需要完全協助他洗澡。因他的肌肉張力較高，照顧者要用頗大的氣力來舉起他的手臂及張開雙腿進行清潔。 | 3 |

A2. 穿衣

| | | |
|----|--|------|
| 目的 | 記錄當事人在過去一個月內在穿衣活動的表現及需要別人協助的情況。 | |
| 程序 | 轉介者首先要掌握當事人能夠自己完成穿衣的部位；再了解當事人何時需要協助及辨別屬那類協助的模式（如：口頭提示、觸體提示、或 / 及身體協助）。如有需要，可要求當事人穿脫外衣及/或外褲，確定其穿脫衣服的能力。 | |
| 定義 | 「穿衣」是指穿脫上身衣服（包括外衣及內衣）下身衣服（包括面褲及內褲）及鞋襪；不過，扣鈕及縛鞋結是不計算在內的。 | |
| 範例 | 活動表現 | 評估分數 |
| | 陳女士的母親每天將衣服放在她的床邊，她在梳洗後便自覺地換衣服而不需她母親提點或督促。 | 0 |
| | 何先生手腳活動，靈活但沒有動機穿衣服，家人要在旁督促及鼓勵，而間中亦要觸碰他的手腳，協助他穿衫和褲。 | 1 |
| | 轉介者發覺鄭女士的理解能力較弱，不明白口頭及觸體提示。她需要家人拿起衫和張開衫袖洞，才會伸手入衫袖及對齊左右襟，然後讓別人扣鈕。 | 2 |
| | 李女士患有大腦痙攣症，四肢活動欠佳，雙腳關節有攣縮現象。每次更換衣服時，都要躺在床上，讓照顧者抬起她的身軀及雙腳，慢慢穿上/除下衫褲。 | 3 |

A3. 位置轉移

| | | |
|----|--|------|
| 目的 | 記錄當事人在過去一個月內進行位置轉移的表現及需要別人協助的情況。 | |
| 程序 | 轉介者首先要掌握當事人能夠自己完成位置轉移的部份；再了解當事人何時需要協助及辨別屬那類協助模式（如：口頭提示、觸體提示、或 / 及身體協助）。 | |
| 定義 | 當事人如何由一處移動至另一處的表現（例：床過輪椅，輪椅過坐廁及輪椅過 等生活情況）。如有需要，可要求當事人現場做一次，確定其實際表現。 | |
| 範例 | 活動表現 | 評估分數 |
| | 鄭女士下肢有痙攣的問題，日常行動需靠四腳拐杖輔助。當她由椅子站起來時，需要用手按着固定的傢俱如枱面或扶手才能穩定地起身，反之亦然。在過程中，她不需別人在旁監督或協助。 | 0 |
| | 阿強因大腦麻痺問題，雙腳活動欠佳，以輪椅代步。由於他的理解力較差，每次由輪椅過枱，都需要照顧者一步一步提點，他才會解開安全帶，翻起腳踏，然後抓緊扶手站起身，轉坐在枱上。 | 1 |
| | 張先生走動時平衡十分弱，所以日常需靠輪椅代步。由輪椅過床及坐廁時，他需要別人在旁攙扶才能完成轉移位置。 | 2 |
| | 轉介者記錄得李先生的四肢關節有攣縮的情況，他的雙腳不能伸直着地。故此，李先生在日常轉移位置時需要兩位家人抱起他過床或轉到輪椅。 | 3 |

B1. 如廁

| | | |
|----|---|------|
| 目的 | 了解及記錄當事人過去一個月內在如廁上的表現及所需協助。 | |
| 程序 | 向當事人及 / 或其照顧者查詢當事人在如廁過程中的表現，包括在感到有便意時上廁所、如廁步驟、便後清潔、使用便椅（如適用）等。同時，亦要記錄所用的廁所種類（如坐廁、蹲廁）。 | |
| 定義 | 如廁能力是指當事人在排小便和大便時的功能表現。就當事人的個別需要，這包括使用廁所 / 尿壺 / 便器、更換紙尿片、處理造口 / 導管、便後清潔等。 | |
| 範例 | 活動表現 | 評估分數 |
| | 大明患有大腦麻痺，需用手杖行走。如廁時，他能抓緊扶手，慢慢坐在廁板上及完成整個過程。但他因手部控制較差，在排便後的清潔，間中會把糞便沾褲子，需要換褲。 | 0 |
| | 阿平在如廁時，需要別人在旁提點他除褲及坐好，否則他會大叫和四處奔跑。如廁完畢後，亦需要別人一步一步的提示他便後清潔及督促他把廁紙掉進馬桶。 | 1 |
| | 劍雄是肌肉萎縮病患者，以電動輪椅代步，全身肌力微弱，手腳多處關節變形。小便時需要照顧者替他拿 尿壺排尿，大便後亦完全需要別人協助，更換尿片。 | 2 |

B2. 進食及進飲

B2.1 進食（不包括外置喉管進食）

| | | |
|----|--|------|
| 目的 | 了解及記錄當事人過去一個月內進食的情況及所需協助。 | |
| 程序 | 透過面談，向當事人及／或其照顧者查詢當事人進食時的表現，常用的餐具及所需要的協助等。至於食物種類方面，轉介者亦應留意及加以記錄，如有部份當事人會因咀嚼或吞嚥困難而需要吃切碎／醬狀食物。 | |
| 範例 | 活動表現 | 評估分數 |
| | 玉芬是失明人士，若桌面上的餐具位置不變，她能夠自己拿起羹吃飯。 | 0 |
| | 卓健有過度活躍問題，集中能力很低。每餐飯都需要母親提示他拿起羹，甚至間中亦需要觸碰他的手腕拿緊匙羹吃飯。 | 1 |
| | 阿貞因大腦痙攣，四肢活動欠靈活。進食時，要佩戴手托及要照顧者拿她的手腕，協助她把切碎食物送到口中。 | 2 |

B2.2 進飲

| | | |
|----|--|------|
| 目的 | 了解及記錄當事人過去一個月內飲水的情況及所需協助。 | |
| 程序 | 透過面談，向當事人及／或其照顧者了解當事人喝水的情況及所需要的協助。若果當事人需要用輔助器具幫助飲水，轉介者亦應作記錄。同時，在有需要時，轉介者可請他／她喝幾口水，從而觀察其表現。 | |
| 範例 | 活動表現 | 評估分數 |
| | 阿玲雖然有吞嚥困難，但能夠自己拿起“cut 口”杯，慢慢地飲水。 | 0 |
| | 月潔的手口協調能力欠佳，飲水時需要照顧者先替她固定雙手手肘在面上，然後她會拿緊雙耳杯飲水。 | 1 |
| | 忠明因四肢癱瘓，雙手控制很弱。餵水時，照顧者要替他拿飲管杯，放近嘴邊，讓他吸啜。 | 2 |

B3. 室內行動能力（只需回答 B3.1 或 B3.2）

B3.1 室內行走

| | | |
|----|---|------|
| 目的 | 了解及記錄當事人過去一個月內於室內環境行走的表現及所需協助。 | |
| 程序 | 轉介者可在面見當事人的時候，觀察其在室內環境行走的情況（如步姿的穩定性及耐力），並記錄所使用的助行器具（如適用）。 | |
| 定義 | 在一般性的室內環境行走約 2 分鐘。（按個別需要，當事人可使用助行器具）。 | |
| 範例 | 活動表現 | 評估分數 |
| | 阿生患有小兒麻痺，一向用手杖行走，能處理簡單家務，當他站立過久而覺疲倦時，便會坐下來休息。 | 0 |
| | 家豪半年前中風，半身不遂，走路時右手拿四腳叉，但身體平衡欠佳，需照顧者在旁給予鼓勵及在有需要時摻扶他，以免跌倒。 | 1 |
| | 嘉平是大腦痙攣人士。在進行步行練習時，他能抓緊推架，但雙腳踏步則需要訓練員一步一步協助。 | 2 |

B3.2 室內使用輪椅

| | | |
|----|---|------|
| 目的 | 了解及記錄當事人過去一個月內於室內環境使用輪椅的能力及所需協助。 | |
| 程序 | 如果當事人需要坐輪椅，轉介者可透過面談了解其在室內操作輪椅的表現及所需要的協助，如開動輪椅，拉 車掣固定輪椅及向不同方向推動輪椅。 | |
| 定義 | 在一般性的室內環境操作輪椅。 | |
| 範例 | 活動表現 | 評估分數 |
| | 阿美有先天性脊椎問題，下肢失去活動能力，上肢控制良好，以輪椅代步。她能在家裡控制輪椅，自我照顧及處理簡單家務。 | 0 |
| | 阿珍患有大腦痙攣，影响雙腳活動，需要坐輪椅。在家中，她能夠慢慢地推動輪椅向前行。遇有障礙物（如傢俬）的時候，則需要別人口頭提示及在轉彎時加以協助。 | 1 |
| | 榮輝是嚴重弱智人士，因大腦痙攣問題，影響四肢活動。日常活動有賴照顧者替他推動輪椅。 | 2 |

V. 行為問題³

| | |
|------|---|
| 目的 | 部分當事人有不同類別及不同程度的行為問題。此部分為協助識別有 嚴重 行為問題的當事人。 |
| 評估方法 | 轉介者可透過下列方法了解情況，進行評估： (a) 當事人及其家人／照顧者提供的資料；及 (b) 有關的醫療紀錄及其他紀錄。 |
| 定義 | <p>「行為問題」包括「攻擊行為」(A1 及 A2)、「自我傷害行為」(B1、B2 及 B3)、「破壞行為」(C1 及 C2) 及「其他行為問題」(D) - (此項包括不恰當性行為、厭惡行為及重覆行為) 四個範疇。項目 A1、B1、C1 及 D 評估當事人在過去一年內有否表現該類行為問題，而項目 A2、B2、B3 及 C2 則評估當事人的行為問題是否達到嚴重程度。</p> <p>每類行為問題的定義／例子及每類行為問題嚴重程度的定義已在相關項目詳細客觀註明。項目 A2 中的「他人身體嚴重受傷」及 B2 中的「自己身體嚴重受傷」，指其嚴重程度引致他人或當事人需要醫生即時治理。在某事件／事例中，當事人表現之行為問題所產生的後果，則不應評估為另一行為問題。例如當事人在表現攻擊行為時，傷害了自己及導致嚴重物資破壞，該行為只應評估為攻擊行為，而不應再評估為自我傷害行為和破壞行為。</p> <p>項目 E 評估當事人家人／照顧者在處理行為問題時，是否覺得非常困難。這項目評估當事人家人／照顧者的主觀感受。</p> |
| 得分計算 | 項目 A2、B2、B3 和 C2 的總得分 (最高得分為 3 分) 及項目 E 的得分 (0 分或 1 分) 應分開計算。任何沒有發問的項目，請給予 0 分。當事人在這部分的評估結果，可參閱附表。 |
| 其他 | 如轉介者得悉當事人有嚴重行為問題，或當事人家人／照顧者在處理行為問題時覺得非常困難，應考慮轉介當事人接受臨床心理服務。 |

附表

| 項目 A2、B2、B3 和 C2 的總得分 | 項目 E 的得分 | 是否需要設有較多員工的康復服務 |
|-----------------------|----------|-----------------|
| 1 分或以上 | 1 分 | 是 |
| 1 分或以上 | 0 分 | 否 |
| 0 分 | 1 分 | 否 |
| 0 分 | 0 分 | 否 |

3 此部分以 Borthwick-Duffy, S. A. (1994). Prevalence of destructive behaviors. In T. Thompson & D. B. Gray (Eds.), *Destructive behavior in developmental disabilities: Diagnosis and treatment* (pp. 3-23). Thousand Oaks, CA: Sage. 作為參考。

VI. 家人 / 照顧者的應付能力

評估準則：

| | | |
|--------|--------|--------------------|
| 照顧系統 | 1 分或以上 | 現存的照顧系統已面臨相當程度的風險 |
| 人際關係 | 1 分或以上 | 當事人有嚴重人際關係問題 |
| 其他風險因素 | 1 分或以上 | 當事人的安全情況已面臨相當程度的風險 |

A 項：照顧系統

| | |
|----|---|
| 目的 | 旨在了解當事人現存的照顧系統是否已面臨相當程度的風險。 |
| 程序 | 轉介者主要是向當事人的「主要照顧者」查詢；惟須盡量客觀，遇有需要時可要求受訪者出示有關證明文件，或取得受訪者的同意而向其他人士（例如其他照顧者）核實有關資料。 |
| 定義 | <ol style="list-style-type: none"> 1. 照顧：指前述有關生活上或基本護理上的照顧。 2. 照顧系統：指以「主要照顧者」為首的照顧系統。由於所列各種因素，轉介者須評估主要照顧者是否需要其他協助，或有其他人士可取代。 3. 協助：在主要照顧者而言，包括從旁監督傭人在照顧方面的工作。 4. 主要照顧者：每天用最多時間照顧 / 協助當事人的人士：主要是指父母、家人或親友，但不包括傭人或院舍職員。傭人及院舍職員應歸入「其他照顧者」。 5. 次要照顧者：指現時有參與照顧的人士，例如兄弟姊妹。 6. 風險：轉介者須盡量以客觀事實評估有關情況是否正受到威脅或已達到危險程度。 7. 相當程度的風險：指主要照顧者由於客觀因素將不能繼續有效地照顧當事人，例如由於主要照顧者年事已高，須為當事人作適時安排。 8. 照顧時數：包括從旁監督傭人在照顧方面工作所需的時間。 |

B 項：人際關係

| | |
|----|--|
| 目的 | 旨在了解當事人本身是否有嚴重人際關係問題。 |
| 程序 | 轉介者須向當事人及 / 或其家人查詢；惟須盡量客觀，遇有需要時可要求受訪者出示有關實證，或取得受訪者的同意而向其他人士（例如其他照顧者）核實有關資料。 |
| 定義 | 嚴重衝突：主要指當事人本身的性格或行為（而非他的殘疾）長期對家人 / 鄰居構成嚴重困擾 / 滋擾，以致引發嚴重衝突。因鄰居歧視或一般家庭糾紛則不屬此項，須另行處理（例如先由社工協助調停）。 |

C 項：其他風險因素

| | |
|----|--|
| 目的 | 旨在了解當事人現時的安全情況是否已面臨相當程度的風險。 |
| 程序 | 轉介者須向當事人及 / 或其家人查詢；惟須盡量客觀，遇有需要時可要求受訪者出示有關實證，或取得受訪者的同意而向其他人士（例如其他照顧者）核實有關資料。 |
| 定義 | 相當程度的風險：指有跡象顯示由於所列因素，當事人現時的安全情況正受到威脅，而有關因素並不限於法例上不容許的行為（例如性侵犯）；轉介者須以專業判斷有關行為的嚴重性，以防止事情的惡化。 |

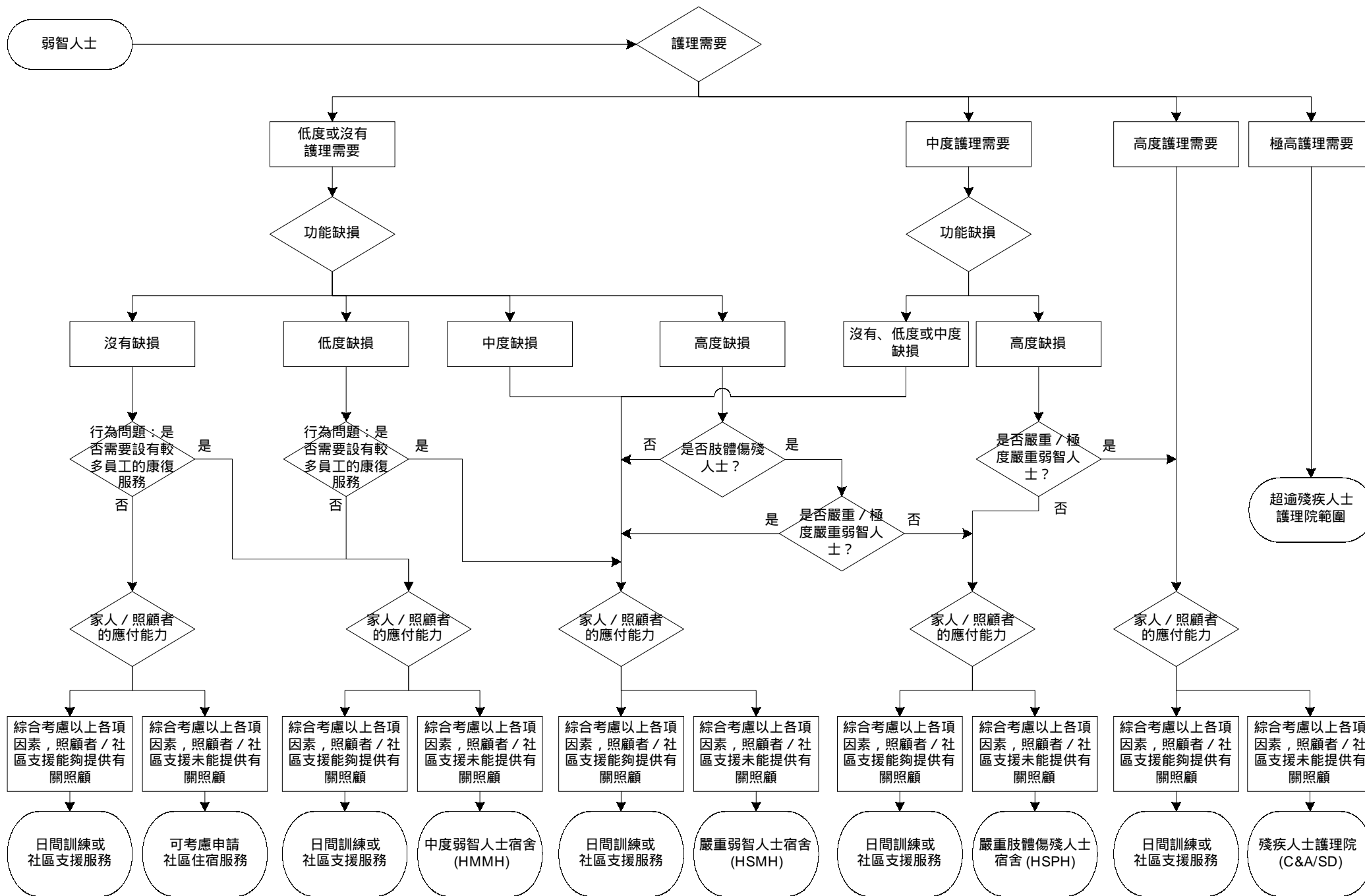
D 項：其他協助（包括社區照顧服務）

| | |
|----|---|
| 目的 | 旨在了解當事人及 / 或其家人現時是否有其他人士或社區照顧服務的協助，或是否需要這些協助。 |
| 程序 | 轉介者主要是向當事人的「主要照顧者」查詢。 |
| 定義 | 1. 取代者：不包括傭人。 2. 協助者：包括鄰居、傭人。 |

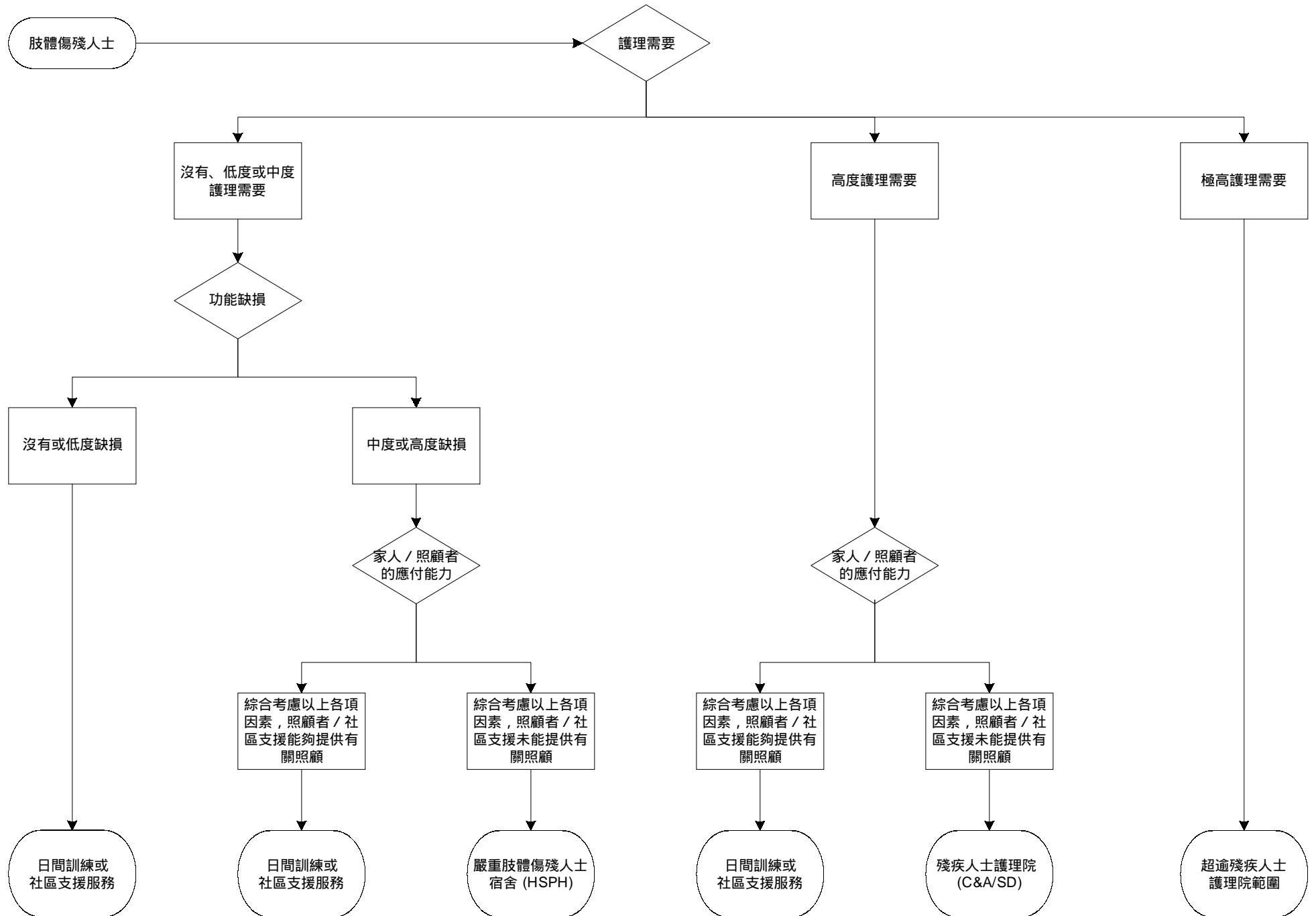
VII. 總結

| | |
|----|--|
| 目的 | 旨在綜合所有評估結果，以衡量現存照顧系統連同社區照顧服務是否能夠提供所需照顧，以致當事人現時是否需輪候院舍服務。 |
| 程序 | 轉介者跟據客觀事實及其專業判斷，遇有需要時經徵詢其主管意見後作出建議。 |
| 定義 | 是否「能夠」提供所需照顧：倘若當事人同時適合社區照顧服務及院舍服務，應優先考慮社區照顧而非院舍服務，以協助他們融入社區。轉介者須根據其專業判斷，衡量現存照顧系統連同社區照顧服務「在相當程度上」是否已能夠提供所需照顧。 |

弱智人士服務需要評估流程草稿



肢體傷殘人士服務需要評估流程草稿



弱智人士服務配對表草稿

| 護理需要 | 功能缺損 | 是否因行為問題而需要較多員工的康復服務？ | 是否肢體傷殘人士？ | 是否嚴重／極度嚴重弱智人士？ | 照顧者／社區支援能否提供照顧？ | 建議服務 |
|----------|------|----------------------|-----------|----------------|-----------------|-------------|
| 超逾康復服務範圍 | | | | | | 可考慮療養院服務 |
| 高度護理需要 | | | | | 能 | 日間訓練或社區支援 |
| 高度護理需要 | | | | | 不能 | 殘疾人士護理院 |
| 中度護理需要 | 高度缺損 | | | 是 | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 高度缺損 | | | 是 | 不能 | 殘疾人士護理院 |
| 中度護理需要 | 高度缺損 | | | 否 | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 高度缺損 | | | 否 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 中度護理需要 | 中度缺損 | | | | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 中度缺損 | | | | 不能 | 嚴重弱智人士宿舍 |
| 中度護理需要 | 低度缺損 | | | | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 低度缺損 | | | | 不能 | 嚴重弱智人士宿舍 |
| 中度護理需要 | 沒有缺損 | | | | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 沒有缺損 | | | | 不能 | 嚴重弱智人士宿舍 |
| 低度／無護理需要 | 高度缺損 | | 是 | 是 | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 高度缺損 | | 是 | 是 | 不能 | 嚴重弱智人士宿舍 |
| 低度／無護理需要 | 高度缺損 | | 是 | 否 | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 高度缺損 | | 是 | 否 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 低度／無護理需要 | 高度缺損 | | 否 | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 高度缺損 | | 否 | | 不能 | 嚴重弱智人士宿舍 |
| 低度／無護理需要 | 中度缺損 | | | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 中度缺損 | | | | 不能 | 嚴重弱智人士宿舍 |
| 低度／無護理需要 | 低度缺損 | 是 | | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 低度缺損 | 是 | | | 不能 | 嚴重弱智人士宿舍 |
| 低度／無護理需要 | 低度缺損 | 否 | | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 低度缺損 | 否 | | | 不能 | 中度弱智人士宿舍 |
| 低度／無護理需要 | 沒有缺損 | 是 | | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 沒有缺損 | 是 | | | 不能 | 中度弱智人士宿舍 |
| 低度／無護理需要 | 沒有缺損 | 否 | | | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 沒有缺損 | 否 | | | 不能 | 可考慮申請社區住宿服務 |

肢體傷殘人士服務配對表草稿

| 護理需要 | 功能缺損 | 照顧者／社區支援能否提供照顧？ | 建議服務 |
|----------|------|-----------------|------------|
| 超逾康復服務範圍 | | | 可考慮療養院服務 |
| 高度護理需要 | | 能 | 日間訓練或社區支援 |
| 高度護理需要 | | 不能 | 殘疾人士護理院 |
| 中度護理需要 | 高度缺損 | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 高度缺損 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 中度護理需要 | 中度缺損 | 能 | 日間訓練或社區支援 |
| 中度護理需要 | 中度缺損 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 低度／無護理需要 | 高度缺損 | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 高度缺損 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 低度／無護理需要 | 中度缺損 | 能 | 日間訓練或社區支援 |
| 低度／無護理需要 | 中度缺損 | 不能 | 嚴重肢體傷殘人士宿舍 |
| 低度／無護理需要 | 低度缺損 | | 日間訓練或社區支援 |
| 低度／無護理需要 | 沒有缺損 | | 日間訓練或社區支援 |

Annexes

Annex C Schedule of Training Session

Half-day Training Session Pilot Study on Universal Care Need Assessment Tool

Date: 11 October 2003 (Saturday)
Time: 9:00 a.m. to 1:00 p.m.
Venue: Room 406, Lady Trench Training Centre
44 Oi Kwan Road, Wan Chai

- 0900 - 0910 Registration
- 0910 - 0940 Development of the draft Assessment Tool and General Assessment Principles
Mr David NG, Social Welfare Department
- 0940 - 1020 Domain on Nursing Care Need
Ms KWONG Ming Sin, Siu Lam Hospital
- 1020 - 1100 Domain on Functional Impairment
Mr Ivan SU, The Spastics Association of Hong Kong
Mr Vincent WU, Social Welfare Department
- 1100 - 1110 Break
- 1110 - 1135 Domain on Challenging Behavior
Mr William CHEUNG, Social Welfare Department
- 1135 – 1200 Domain on Family Coping
Mrs Margaret LEE, Tung Wah Group of Hospitals Jockey Club Rehabilitation Complex
- 1200 – 1225 Assessment and Service Recommendations
Mr David NG, Social Welfare Department
- 1225 – 1300 Questions and Answers
Mr William CHEUNG, Social Welfare Department

** Please bring with you the Assessor Manual and the Assessment Tool when you attend the training session*

社會福利署
弱智及肢體傷殘人士宿舍服務評估工具
現場觀察紀錄

觀察員姓名：_____ 觀察日期：_____

觀察時間：_____ 至 _____

觀察地點：_____

* 請觀察員透過下列問題記錄評估員在運用評估工具時的情況。

1. 評估員資料：

1.1 評估編號：_____ 1.2 工作單位：_____

1.3 任職社工的年資：_____

1.4 處理弱智或肢體傷殘人士的工作經驗：_____

2. 現場環境的安排是否合適？(如有否影響評估的過程)

3. 評估員發問的技巧如何？(包括用詞、語氣及態度等)

4. 被評估者的反應如何？(如緊張不安或輕鬆自如)

5. 家人或照顧者的關注要點是甚麼？

6. 在評估過程中，評估員遇到甚麼困難？

7. 其他（倘若空位不夠，可另加紙）

評估編號：_____

填寫日期：_____

社會福利署
弱智人士及肢體傷殘人士宿舍服務評估工具

評估員意見問卷

當你填妥評估工具後，請填寫本問卷以表達你對評估過程及工具的意見。

請在下列適當的空格內加上「✓」號。

1. 評估員資料：

1.1 工作單位：

- | | |
|--|------------------------------------|
| <input type="checkbox"/> 特殊學校 | <input type="checkbox"/> 綜合/家庭服務中心 |
| <input type="checkbox"/> 醫務社會服務部 | <input type="checkbox"/> 康復服務單位 |
| <input type="checkbox"/> 其他(請列明：_____) | |

1.2 工作經驗

1.2.1 任職社工的年資 (以年或月作單位)：_____

1.2.2 處理弱智或肢體傷殘人士的工作經驗 (以年或月作單位)：_____

2. 這是你第幾次用宿舍服務評估工具？ 第一次 第二次 第三次

3. 你用了多少時間完成此評估工具？ _____

4. 你是否認識被評估者？ 是 否
若「是」，請表示認識的時期： _____
(以年或月作單位)

5. 評估工具內的資料是否很難獲取？ 是 否
若「是」，請詳述那方面的資料及原因： _____

6. 你能理解評估工具的內容。 非常同意 同意 不同意 非常不同意

7. 你認為此評估工具容易使用。

8. 你認為評分制度容易掌握。

9. 你認為評估員手冊能幫助你進行評估。

10. 若你認為評估工具及使用過程有地方需要改善，請提出建議。 [如：用字，定義，評估時段(過往一個月或以上)及評分等。若以下提供的空間不夠填寫，可另加附頁。]

10.1 個人資料：

10.2 護理需要：

10.3 功能缺損：

10.4 行為問題：

10.5 家人/照顧者的應付能力：

10.6 總結：

10.7 其他：

11. 你是否認為有些關乎宿位服務分流之資料仍未涵蓋於評估工具中？若「是」，請提出建議。

12. 你對評估員手冊的意見：

– 多謝完成本問卷 –

註： 每次完成問卷後，請將問卷連同評估工具及同意書一併寄回。為確保郵遞正確，請用本署提供的回郵信封，多謝合作。

Annexes

Annex F Phone Interview Form

社會福利署 弱智人士及肢體傷殘人士宿舍服務評估工具

電話問卷

調查員姓名：_____ 調查日期：_____

調查時間：_____ 至 _____

1. 評估員資料： 評估編號：_____ 工作單位：_____

2. 除面談外，請問你獲取評估資料的其他來源？ (e.g. 醫療報告，離校報告)

3. 在評估過程中有否出現困難？ 有 沒有

如「有」，請詳述那方面的困難：

4. 評估工具的問題是否過於專門化？ 是 否

若「是」，請詳述：

5. 評估問題中有否出現重覆的內容？ 有 沒有

若「有」，請詳述：

6. 評估工具中的問題是否清晰 (包括用字及定義)？

6.1 護理需要 是 否 (若「否」請詳述)

6.2 功能缺損 是 否 (若「否」請詳述)

6.3 行為問題 是 否 (若「否」請詳述)

6.4 家人/照顧者的應付能力 是 否 (若「否」請詳述)

6.5 總結 是 否 (若「否」請詳述)

6.6 其他 是 否 (若「否」請詳述)

7. 評估工具內的評分制度是否容易掌握？

7.1 護理需要 是 否 (若「否」請詳述)

7.2 功能缺損 是 否 (若「否」請詳述)

7.3 行為問題 是 否 (若「否」請詳述)

7.4 家人/照顧者的應付能力 是 否 (若「否」請詳述)

7.5 其他 是 否 (若「否」請詳述)

8. 評估工具中的評估參考時段(如過往一個月)是否恰當及實用? 是 否
若「否」, 請詳述那方面:

9. 評估結果與你所預期的的是否相同? 是 否
若「否」, 請詳述那方面有出入:

10. 你對評估工具的整體內容評價及綜合意見。

11. 評估員手冊能否幫助你明白評估內容及執行細節? 那方面? 能 否

12. 評估工具訓練講座能否幫助你明白評估內容及執行細節? 那方面? 能 否

註: 調查員請在評估員完成三份評估工具後一星期內進行電話問卷調查。