Report
on
Phase II Pilot Study on
Standardized Needs Assessment Tool
for Admission to Residential Services for People
with Disabilities

Sub-Group on Pilot Study
Task Group on Universal Care Need Assessment Tool
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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 needs assessment tool for persons with mental/physical handicap applying for residential rehabilitation services. A draft assessment tool (tentatively and previously named as the Universal Care Need Assessment Tool) and assessor manual was developed in September 2003 after coordinated and concerted efforts of parents of persons with mental handicap and rehabilitation professionals from various disciplines.

1.2 This standardized needs assessment tool is devised to identify the residential care need of persons with mental/physical handicap applying for residential rehabilitation services, and to match them to appropriate services including appropriate types of residential homes. This structured multidimensional assessment instrument is designed to focus on key domains (ie nursing care need, functional impairment, challenging behavior, family coping) and indicators that have particular bearings on service streaming.

1.3 The Sub-group on Pilot Study[1] 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. After endorsement of the proposal on the pilot study by the Steering Group, Phase I of the study formally commenced in October 2003. The empirical data collected during this phase contributed to improving the practicality and utility of the draft assessment tool as well as its administration procedures, and to enhancing the user-friendliness of the draft assessor manual. Details and findings of Phase I pilot study, which were fully discussed in the Task Group, are already described in *Report on Phase I Pilot Study on Universal Care Need Assessment Tool* (January 2004).

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[1] Members of the Sub-group on Pilot Study included Ms Jeanette CHAN (Caritas-Hong Kong), Mrs Margaret LEE (Tung Wah Group of Hospitals), Mr LO Kam Wah (Hong Kong Red Cross), Mr Davis KWAN (from February 2004) (Research and Statistics Section, Social Welfare Department), Mr Vincent WU (Central Para-medical Support Service, Social Welfare Department), Ms Grace S K CHAN (till February 2004), Mr David NG and Ms Vivian TAM (from March 2004) (Rehabilitation and Medical Social Services Branch, Social Welfare Department). Mr William CHEUNG (Clinical Psychological Service Branch, Social Welfare Department) served as Convenor of the Sub-group.

1.4 Based on recommendations of the report on Phase I pilot study, the Steering Group in March 2004 adopted the draft assessment tool and assessor manual as the provisional blueprint of the assessment protocol of the standardized needs assessment tool for persons with mental/physical handicap applying for residential rehabilitation services. Refinement was then made to re-calibrate the draft assessment tool (such as re-wording/re-phrasing of terms/items, modification of presentation layout and scoring systems) and the assessor manual (such as clarification and elaboration of meaning of terms/items, addition of illustrative examples and pictures/photos) in accordance with the suggestions put forward in the report and by the Task Group.

Objectives of Phase II Pilot Study

1.5 Phase II of the pilot study, which mainly focused on the technical aspects of the resulting revised version of the assessment tool, commenced in March 2004. The specific objectives of Phase II pilot study are to collect empirical data:

(a) to examine the inter-rater reliability of the revised version of the standardized needs assessment tool;
(b) to examine the validity of the revised version of the standardized needs assessment tool; and
(c) to obtain the views of informants about the comprehensibility of the standardized needs assessment and their subjective experience during the assessment process.

Overview of the Report

1.6 This report was prepared by the Convenor of the Sub-group on Pilot Study, and it presents the data collected and the suggestions agreed by all members of the Sub-group. Chapter 2 briefly outlines the methods and procedures used in obtaining the results of Phase II pilot study. Chapter 3 summarizes the results from various facets of the study. Finally, conclusion based on the results reported is made in Chapter 4.

CHAPTER 2 Method

Development Sample of Phase II 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 needs assessment tool as possible (eg in terms of range and level of disabilities).

2.2 A total of 80 target persons (and their family/primary carers) already waitlisted for residential service were invited to participate in Phase II pilot study. Their proportion in the sample was commensurate with the actual number of referrals for various types of residential homes in the central waiting list as at January 2004. Of the 80 target persons, 28 (35%) were referred from integrated/ family services centres, 24 (30%) were referred from special schools, 14 (17.5%) were referred from adult rehabilitation units, and 14 (17.5%) were referred from medical social services units. Of the 80 target persons, 3 (3.7%) were on the waiting list for Supported Hostel (SHOS), 18 (22.5%) were on the waiting list for Hostel for Moderately Mentally Handicapped Persons (HMMH), 47 (58.8%) were on the waiting list for Hostel for Severely Mentally Handicapped Persons (HSMH), 3 (3.7%) were on the waiting list for Hostel for Severely Physically Handicapped Persons (HSPH), and 9 (11.3%) were on the waiting list for Care and Attention Home for Severely Disabled Persons (C&A/SD).

Assessors in Phase II Pilot Study

2.3 A total of 40 assessors were recruited from existing referrers who are registered social workers at the rank of Social Work Assistant or above. Of the 40 assessors, 20 (50%) are from Social Welfare Department and 20 (50%) are from NGOs and the Hospital Authority. 14 (35%) are working in integrated/ family services centres, 12 (30%) are working in special schools, 7 (17.5%) are working in adult rehabilitation units, and 7 (17.5%) 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 January 2004.

Recruitment Procedures and Training Workshop

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 this phase 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 April 2004. 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 assessors 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 relatively smooth at this phase of the pilot study, and 40 assessors were recruited. Each assessor who agreed to participate in this phase of the study was individually informed of the details of the study in late March 2004. The revised 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 revised version 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, operational definitions of terms, scoring systems of various domains, illustrative examples and relevant pictures/photos can be found in the revised assessor manual. All assessors were requested to familiarize themselves with the assessment tool and the instructions of the assessor manual, and they were given the details (eg topics to be covered, trainers) of the one-day training workshop (Annex C) arranged for them.

2.6 All assessors attended the one-day training workshop scheduled on 2 April 2004. Members of the Task Group and Steering Group with professional expertise in various domains of the revised assessment tool were invited as trainers of this workshop. The training workshop aimed at facilitating all assessors to better understand the areas/domains included in the assessment tool, as well as assisting them to apply the instrument and administration procedures. In accordance with the recommendations of

the report on Phase I pilot study, updates on community support services, case discussion and a practice session with role-playing exercises which can enable the assessors to rehearse their assessment skills (including applying the scoring systems of various sections), were included in this training workshop. The practice module and details of the exercises can be seen in Annex D. The involvement of the assessors in this phase of the pilot study was also reiterated at the end of the workshop in order to ascertain that the assessors were clear about the data gathering process.

Ethical Considerations

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

Collection of Reliability Data

2.8 Each assessor was requested to conduct four assessment sessions at field trial sites after the training workshop 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. As mentioned above, the application of the assessment tool was elaborated by trainers and rehearsed among assessors during the training workshop so that all assessors could administer the instrument in the same way. Of the four assessment sessions, the first assessment session was meant to be a real-case practice session. Except for the practice case, all cases on which the assessors conducted the standardized needs assessment were not their known cases.

2.9 Each assessor paired up with another assessor (ie the partner assessor), resulting in 20 pairs of assessors, and both assessors of each pair were present to rate the responses of the same case at each assessment session. The pairing of assessors was pre-arranged, and assessors were provided with the particulars (eg contact numbers) of her/his partner assessor in the training workshop. In each session, one assessor served as an interviewer while another served as a silent second assessor, and the assessors switched roles in alternate assessment sessions to minimize interviewer bias. The assessor who played the interviewer role was responsible to initially contact the target person and her/his family/primary carers to arrange the assessment session, and to obtain written consent from the concerned parties. After each assessment session, both assessors were required

to separately fill in the assessment form as soon as practicable and return the completed form to the Sub-group, therefore leading to independent assessment results. Discussion as to how to fill in the form or exchange of information between the assessors during the session was not allowed except for the real-case practice session. All completed assessment forms were returned by June 2004.

Collection of Informant Feedback

2.10 In addition to conducting the standardized needs assessment, feedback from the informants (both the target persons and/or their family/primary carers) on the assessment process was also collected after each assessment session through verbal administration of a short structured questionnaire. The assessor who took the silent role in the preceding assessment session administered this feedback questionnaire in the absence of the other assessor (ie the interviewer of the session) so that the informants could express their views on the assessment process more readily.

2.11 Two similar versions of this feedback questionnaire (Annex E and Annex F) were prepared, one for target persons and the other for family/primary carers. In this feedback questionnaire, apart from some basic items on background information of the informant and the assessment situation, one set of questions was designed to tap the opinion of the informant on the duration of the assessment and on her/his level of understanding about the purpose and content of the assessment. Another set of questions generated responses about the subjective experience of the informant related to her/his level of comfort during the assessment process. Two open-ended questions were included to gather suggestions pertaining to areas for improvement on the content of the assessment tool and the assessment process. Each questionnaire had a code and personal particulars were not put down to assure anonymity. Moreover, care was taken when designing the questionnaire to ensure that it was easily comprehensible, especially for the version administered to target persons, and clear instructions on completion were given. Both versions of the questionnaire had been pre-tested among a group of people with mental handicap and their family/primary carers, and circulated to members of the Task Group, before being put to use. All completed feedback questionnaires were returned by June 2004.

Collection of Validity Data

2.12 Eleven cases from the reliability study were selected for independent and in-depth

case analyses by a group of six professional experts[2] of various disciplines (including clinical psychologist, nurse, occupational therapist, psychiatrist, social workers) in the rehabilitation field formed under this pilot study in August 2004. The members of this professional group, also commonly known as expert group, are experienced practitioners in the field but were not directly involved in developing the standardized needs assessment tool. A detailed guide (Annex G), endorsed by the Task Group, with information on (a) terms of reference and composition of the professional group, (b) selection of cases, (c) meetings of the professional group, and (d) general principles in service matching, was provided to the members of the professional group after they consented to participate in this part of the pilot study. Case profiles of the selected cases, without identifying names, were also sent to the members. Each case profile included (a) relevant clinical information based on the case summary prepared by the concerned case social worker, and (b) available professional reports (eg clinical psychologist report) of the case. However, the professional group was blinded to the standardized needs assessment results of these cases. The group met in September 2004 and assessed the cases on their need for residential rehabilitation services, and recommended for each case a suitable rehabilitation service from existing provision. The main considerations and decisions made on each case were recorded in the form of minutes of meeting which were confirmed by members of the professional group afterwards.

Data Analysis

2.13 Reliability data gathered from simultaneous rating based on pilot administrations of the instrument, together with views of informants gathered from informant feedback questionnaires, were collected and initially collated in June 2004. Validity data based on independent and in-depth analyses of selected cases by the professional group were collated in September 2004. All analyses and conclusion made were discussed by members of the Sub-group in September 2004.

2.14 Statistical analyses for the reliability data and informant feedback were carried out using the Statistical Analysis System (SAS) software (SAS Institute Inc), a statistical and information system that performs sophisticated data management and statistical analysis. For the inter-rater reliability analysis, percentage of overall agreement was calculated, and Spearman rank-order correlation coefficient was used to assess agreement between assessors on binary (eg aggressive behavior present yes or no, item

[2] Members of the professional group included Mr Alfred CHAN (Clinical Psychology Unit 2, Social Welfare Department), Ms Connie CHAN (Tung Wah Group of Hospitals), Mr Aldous KWAN (Fu Hong Society), Dr W M KWOK (Kwai Chung Hospital, Hospital Authority), Ms NG Chui Ling (Hong Chi Association) and Mr TONG Siu Hon David (Caritas-Hong Kong).

A1 in section *challenging behavior*) and ordinal data (eg five levels of skin problem, item 1 in section *nursing care need*), whereas interval data (eg total score of sub-section A *activities of daily living that demand intensive assistance* in section *functional impairment*) agreement was measured by Pearson product-moment correlation coefficient. Confidence intervals (95%) were also computed for the reliability coefficients. Although it is reckoned that Cohen's kappa is widely used as an inter-rater reliability coefficient in the literature, concerns among researchers about its interpretability have been raised (eg Cicchetti & Feinstein, 1990[3]), and hence kappa statistic was not used in the present study. For other analyses, descriptive statistics were used to describe the data collected from the informant feedback questionnaires. In-depth analyses of selected cases by the professional group were used for the purpose of exploring validity of the assessment tool, and results derived from the assessment tool were compared to the considerations and independent decisions of the professional group.

[3] Cicchetti and Feinstein (1990) give examples in their paper where inter-rater reliability coefficients produced by the kappa statistic are surprisingly low when the data tend to indicate a significant agreement level between raters.

CHAPTER 3 Results

Inter-rater Reliability

3.1 A total of 60 target persons (and their family/primary carers) at multiple field trial sites were included in the inter-rater reliability analysis in this pilot study. The target persons consisted of 19 female and 41 male, and their demographic characteristics are shown in Tables 1 and 2. For each case, two trained assessors independently assessed the target person in the same session, adhering to the agreed method. Data derived from the 20 real-case practice sessions were excluded for obvious reason.

Table 1: Age distribution (*n*=60)

Age	Number	Percent
15 - 24	26	43.3%
25 - 34	16	26.7%
35 - 44	15	25%
45 - 54	3	5%

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

Table 2: Disability (*n*=60)

Disability	Number	Percent
Mild degree of mental handicap	8	13.3%
Moderate degree of mental handicap	33	55%
Severe degree of mental handicap	10	16.7%
Profound degree of mental handicap	1	1.7%
No mental handicap	3	5%
Not specified	5	8.3%

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

3.2 Inter-rater reliability, which is one measure to evaluate the reliability or consistency of an assessment instrument, compares the degree of agreement between independent evaluations by two or more data-generating sources (ie assessors or raters) across a group of participants. For the present analysis, percentage of overall agreement was obtained and Spearman or Pearson correlation coefficient was individually calculated

for each item (including sub-section total score) under the sections of *nursing care need*, *functional impairment*, *challenging behavior*, *family coping* (except sub-section A1 for obvious reason), and *assessment summary and conclusion* (except item E3 which is open-ended) of the present standardized needs assessment tool. Reliability is expressed as a decimal value between 0 and 1, with higher values implying greater reliability. By convention, correlation coefficients of .35 to .49 can be interpreted empirically as weak, those of .50 to .79 as moderate and those of .80 or greater as strong.

3.3 Table 3 shows the inter-rater agreement on different items in the section *nursing care need*. Agreement of the items ranges from 93.33% to 100%, with a mean of 97.59%. The reliability coefficients of this section range from .761 to 1, indicating moderate to strong correlation. The values of the correlation coefficients in this section are generally high with all but one (item 2) reaching .80 or above.

Table 3: Inter-rater reliability: percentage agreement and correlation coefficients for items in *nursing care need* (*n*=60)

Item number	% overall agreement	Correlation	95% confidence interval
1	96.67	.907	.848-.944
2	96.67	.761	.628-.850
3	95	-[a]	-
4	100	1	-
5	96.67	.955	.925-.973
6	100	-[a]	-
7	100	-[a]	-
8	100	1	-
Section score	93.33	.884[b]	.813-.930

Note.
a As no pair of assessors marked the same score other than "zero" simultaneously, the correlation coefficient cannot be compiled.
b Pearson correlation coefficient, while all other correlations are Spearman correlation coefficients.

3.4 As seen in Table 4, agreement of the items between assessors in the section *functional impairment* ranges from 86.67% to 100%, with a mean of 92.92%. The inter-rater reliability for all items is excellent, since all values of the correlation coefficients are well above .80. This indicates that there is excellent agreement between the assessors.

3.5 Table 5 presents the extent of agreement between assessors on different items in the section *challenging behavior*. Agreement of the items ranges from 91.67% to 100%,

with a mean of 96.25%. The reliability coefficients of this section range from .796 to 1, indicating moderate to strong correlation. The values of the correlation coefficients in this section are generally high with all but one (item B3) reaching .80 or above.

Table 4: Inter-rater reliability: percentage agreement and correlation coefficients for items in *functional impairment* (*n*=60)

Item number	% overall agreement	Correlation	95% confidence interval
A1	93.33	.976	.959-.985
A2	91.67	.948	.914-.969
A3	100	1	-
Total score of sub-section A	86.67	.989[a]	.981-.993
B1	95	.973	.955-.984
B2	91.66	.868	.788-.919
B3	98.33	.955	.926-.973
Total score of sub-section B	86.67	.974[a]	.957-.985

Note.
a Pearson correlation coefficient, while all other correlations are Spearman correlation coefficients.

Table 5: Inter-rater reliability: percentage agreement and correlation coefficients for items in *challenging behavior* (*n*=60)

Item number	% overall agreement	Correlation	95% confidence interval
A1	96.67	.915	.861-.948
A2	100	-[a]	-
B1	100	1	-
B2	100	-[a]	-
B3	95	.796	.680-.874
C1	96.67	.902	.840-.940
C2	96.67	.856	.769-.912
D	96.67	.927	.880-.956
E	93.33	.818	.711-.887
Total score of A1, B1, C1 and D	95	.971[b]	.951-.982
Total score of A2, B2, B3 and C2	91.67	.868[b]	.788-.919
Total score of E	93.33	.818[b]	.711-.887

Note.
a As no pair of assessors marked the same score other than "zero" simultaneously, the correlation coefficient cannot be compiled.
b Pearson correlation coefficient, while all other correlations are Spearman correlation coefficients.

3.6 Agreement between assessors in the section *family coping* ranges from 75% to 100%, with a mean of 95.22% (Table 6). The reliability coefficients range from .665 to 1, implying moderate to strong correlation. Assessor agreement in this section is very good as shown in the values of the correlation coefficients, with all but one (item A2d) coefficient reaching .80 or above.

3.7 As listed in Table 7, agreement of the items in the section *assessment summary and conclusion* ranges from 75% to 95%, with a mean of the 88.57%. The reliability coefficients range from .562 to 1, implying moderate to strong correlation. 55% of the coefficients are in the range .50 to .79 and 45% exceed .80. The values of the correlation coefficients in this section vary from fair to high. It is noted that generally the first item of each sub-section (ie A1, B1and C1), which involves transfer of a score from previous sections, achieves a better correlation value relative to the remaining items of that sub-section.

Table 6: Inter-rater reliability: percentage agreement and correlation coefficients for items in *family coping* (*n*=60)

Item number	% overall agreement	Correlation[a]	95% confidence interval
A2a	100	1[b]	-
A2b	95	.891[b]	.771-1
A2c	98.33	1[b]	-
A2d	90	.665[b]	.417-.913
A2e	96.67	.838[b]	.619-1
A2f	96.67	1[b]	-
A2g	80	-[c]	-
A2h	75	-[c]	-
B1	98.33	1[b]	-
B2	100	1[b]	-
B3	100	-[c]	-
C1	98.33	-[c]	-
C2	100	-[c]	-
C3	100	1	-
C4	100	1	-

Note.
a All correlations are Spearman correlation coefficients.
b Inapplicable cases are excluded when calculating the correlation coefficient.
c As no pair of assessors marked the same score other than "zero" simultaneously, the correlation coefficient cannot be compiled.

Table 7: Inter-rater reliability: percentage agreement and correlation coefficients for items in *assessment summary and conclusion* (*n*=60)

Item number	% overall agreement	Correlation[a]	95% confidence interval
A1	95	.803[b]	.690-.878
A2	95	1[b]	-
A3	93.33	.633[b]	.096-1[c]
B1	93.33	.950[b]	.917-.970
B2	90	.783[b]	.497-1
B3	85	.741[b]	.503-.979
C1	93.33	.967[b]	.945-.980
C2	95	.808[b]	.620-.995
C3	88.33	.562[b]	.264-.859
D1	91.67	-[d]	-
D2	78.33	.608[b]	.378-.837
D3	75	.633[b]	.409-.858
E1	86.67	-[d]	-
E2	80	-[d]	-

Note.
a All correlations are Spearman correlation coefficients.
b Inapplicable cases are excluded when calculating the correlation coefficient.
c The confidence interval is wide since only six pairs of observations are included in the calculation. The majority of assessors marked "inapplicable".
d Correlation coefficient cannot be compiled for nominal data.

Informant Feedback

3.8 Responses of the informants to the assessment situations have already been observed and initially explored in Phase I of the pilot study, and this area is presently re-visited with a larger sample and from the perspectives of the informants (both the target persons and their family/primary carers) themselves.

Feedback from Informants (Family/Primary Carers)

3.9 A total of 79 usable informant feedback questionnaires (family/primary carer version) were returned. Of the 79 questionnaires, 73 (92.41%) were completed by parents of the target persons, 4 (5.06%) by siblings, and 2 (2.53%) by relatives. 48 (60.76%) of these assessments took place at the natural homes of the target persons, 18 (22.78%) at schools, or day/residential rehabilitation units, 11 (13.92%) at other places, and 2 (2.53%) did not specify. Pre-requisites for the feedback to be used in this study include (a) the informant (ie parent, sibling or relatives of the target person) has actively

participated in the standardized needs assessment process and (b) s/he is willing to respond to this questionnaire. The ensuing sections highlight the major results gathered from these questionnaires.

3.10 As shown in Table 8, all informants (ie parents, siblings or relatives of the target persons) indicated that the duration of each assessment (ie normally completable within 60 minutes) is appropriate. About 86% of them reported that they generally understood the purpose of the assessment (Table 9), and all of them expressed that on the whole they could comprehend the content of the assessment (Table 10).

Table 8: Opinion of informants (family/primary carers) on duration of the assessment (*n*=79)

Duration of the assessment	Number	Percent
Too long	0	0%
Appropriate	79	100%
Too short	0	0%

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

Table 9: Opinion of informants (family/primary carers) on level of understanding about the purpose of the assessment (*n*=78)

Level of understanding	Number	Percent
Understand	55	70.51%
Average understanding	12	15.38%
Not understand	11	14.10%

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

Table 10: Opinion of informants (family/primary carers) on level of understanding about the content of the assessment (*n*=79)

Level of understanding	Number	Percent
Understand	74	93.67%
Average understanding	5	6.33%
Not understand	0	0%

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

3.11 The majority of the informants (ie parents, siblings or relatives of the target persons)

perceived that the assessors conveyed a friendly attitude during the standardized needs assessment (Table 11). Moreover, nearly all of them indicated that they participated in the assessment process comfortably and did not experience negative feelings such as pressure or embarrassment (Tables 12 and 13).

Table 11: Opinion of informants (family/primary carers) on subjective perception of friendliness of assessors (*n*=79)

Level of friendliness	Number	Percent
Friendly	77	97.47%
Average friendliness	2	2.53%
Not friendly	0	0%

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

Table 12: Opinion of informants (family/primary carers) on subjective experience of pressure during the assessment process (*n*=78)

Subjective experience of pressure	Number	Percent
Yes	1	1.28%
No	77	98.72%

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

Table 13: Opinion of informants (family/primary carers) on subjective experience of embarrassment during the assessment process (*n*=78)

Subjective experience of embarrassment	Number	Percent
Yes	1	1.28%
No	77	98.72%

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

3.12 Only nine comments were received as responses to the open-ended question pertaining to areas for improvement on the content of the assessment tool and the assessment process. Comments by the informants (ie parents, siblings or relatives of the target persons) include: the content is not in-depth enough; the items are too detailed; difficulties encountered in caring of autistic persons can be included; outdoor mobility should be assessed; differentiation of various levels of emotional disturbance in *family coping* can be made; conflicts between family/primary carer and other family members can be included. Other general comments gathered include: more community support

services and resources are needed; priority service should be provided to those in need; more coverage of the pressure and concerns of parents in the content of assessment tool can be made; preceding time periods used in the assessment should be six to nine months instead of three.

Feedback from Informants (Target Persons)

3.13 A total of 19 usable informant feedback questionnaires (target person version) were returned. Of the 19 target persons, 4 (21.05%) have mild level of mental handicap, 6 (31.58%) have moderate level, 2 (10.53%) have severe level, 1 (5.26%) has profound level, 3 (15.79%) have no mental handicap, and 3 (15.79%) did not specify. 12 (63.16%) of these assessments took place at the natural homes of the target persons, 3 (15.79%) at schools, or day/residential rehabilitation units, and 4 (21.05%) at other places. Pre-requisites for the feedback to be used in this study include (a) the informant (ie target person) has actively participated in the standardized needs assessment process and (b) s/he is willing to respond to this questionnaire. The ensuing sections present the major results gathered from these questionnaires.

3.14 As shown in Table 14, all informants (ie target persons) expressed that the duration of each assessment (ie normally completable within 60 minutes) is appropriate. Only about 53% of them indicated that they generally understood the purpose of the assessment (Table 15), and about 74% of them conveyed that on the whole they could comprehend the content of the assessment (Table 16).

Table 14: Opinion of informants (target persons) on duration of the assessment (*n*=18)

Duration of the assessment	Number	Percent
Too long	0	0%
Appropriate	18	100%
Too short	0	0%

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

Table 15: Opinion of informants (target persons) on level of understanding about the purpose of the assessment (*n*=19)

Level of understanding	Number	Percent
Understand	6	31.58%
Average understanding	4	21.05%
Not understand	9	47.37%

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

Table 16: Opinion of informants (target persons) on level of understanding about the content of the assessment (*n*=19)

Level of understanding	Number	Percent
Understand	10	52.63%
Average understanding	4	21.05%
Not understand	5	26.32%

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

3.15 The majority of the informants (ie target persons) perceived that the assessors conveyed a friendly attitude during the standardized needs assessment (Table 17). Moreover, nearly all of them indicated that they participated in the assessment process comfortably and did not experience negative feelings such as pressure or embarrassment (Tables 18 and 19).

Table 17: Opinion of informants (target persons) on subjective perception of friendliness of assessors (*n*=18)

Level of friendliness	Number	Percent
Friendly	17	94.44%
Average friendliness	1	5.56%
Not friendly	0	0%

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

Table 18: Opinion of informants (target persons) on subjective experience of pressure during the assessment process (*n*=18)

Subjective experience of pressure	Number	Percent
Yes	2	11.11%
No	16	88.89%

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

Table 19: Opinion of informants (target persons) on subjective experience of embarrassment during the assessment process (*n*=18)

Subjective experience of embarrassment	Number	Percent
Yes	0	0%
No	18	100%

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

Validity Study

3.16 Validity refers to the extent to which the assessment instrument actually assesses what it is designed to assess. Since the standardized needs assessment tool is the first of its kind in the local setting and no other contemporary instrument with such specific assessment objective is available, there is some difficulty identifying the "gold standard" to which the applied usefulness of it can be compared. However, evidence in support of the validity of the assessment tool can, to some extent, be gathered through examining whether the assessment content is relevant and appropriate to its designed purpose based on in-depth analysis by experts/experienced practitioners who are knowledgeable about the subject area, and whether independent judgment of such experts is comparable to the results derived from the present assessment instrument.

3.17 In assessing the need for residential rehabilitation services of the 11 selected cases, the professional group had the following main considerations: (a) physical health conditions of the target persons (eg incontinence, being bed-ridden); (b) level of dependence in activities of daily living (eg feeding) of the target persons; (c) mobility of the target persons; (d) work ability of the target persons; (e) behavioral problems or inappropriate behaviors of the target persons (eg self-harm, aggression, running away from home, inappropriate sexual behavior); (f) age of the family/primary carers; (g) physical health conditions of the family/primary carers; (h) psychological health conditions (eg anxiety disorder) of the family/primary carers; (i) family support; (j) relationship between the target persons and other family members; and (k) safety issues at home. From this analysis, it becomes apparent that these expert considerations are in line with the content of the specific items included under various domains of the present standardized needs assessment tool, suggesting its assessment content is appropriate to its purpose of identifying the residential care need of persons with mental/physical handicap.

3.18 Of the 11 cases analyzed by the professional group, there is clear concordance between the recommendation of the group and the main evaluation result derived from the standardized needs assessment tool (ie whether there is a need for residential rehabilitation services) for six of them. Of the five cases without concordance, one case was in fact considered by the group as "borderline" (ie difficult to decide whether there is a need for residential rehabilitation services), while the professional group recommendation of another one case was conditional on further information on the health condition of the family/primary carer. For the remaining three cases, the professional group recommended day rehabilitation/community support services while

the results derived from the assessment tool indicated residential rehabilitation services. Further analyses of them revealed that for these three cases, the standardized needs assessment identified and highlighted issues such as severe behavioral problems of the target person, emotional disturbance of the family/primary carer, family coping problems and conflicting family relationship, all of which appeared less pronounced or were even absent in the case information. It is probable that the recommendations of the professional group for these three cases might be different if such important aspects had been included in the analyses, bearing in mind that these aspects are also the main considerations used by the professional group in determining the residential care need of persons with mental/physical handicap.

CHAPTER 4 Conclusion

4.1 In this Phase II pilot study, the revised assessment protocol has been piloted on 80 target persons (and their family/primary carers) waitlisted on rehabilitation residential services, with the assistance of 40 assessors recruited from existing referrers. An independent professional group with six experts/experienced practitioners of various disciplines as members was also formed to provide in-depth analyses of 11 selected cases. The main objectives are to collect inter-rater reliability and validity data of the assessment tool, and to gather feedback from the informants about the assessment. 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) are similar to that of the target population and assessors in eventual implementation of the standardized needs assessment tool for persons with mental/physical handicap applying for rehabilitation services. In this chapter, conclusion based on results of this pilot study is made.

Technical Aspects of Assessment Tool

4.2 The inter-rater reliability coefficient is an important statistical tool that practitioners/researchers regularly use to control the quality of their data collection instrument or method. Examination of the reliability data gathered in the present study shows that agreement between assessors for most items (including sub-section total scores) under the sections of *nursing care need*, *functional impairment*, *challenging behavior* and *family coping* of the present standardized needs assessment tool, is generally high and very satisfactory. The section *assessment summary and conclusion* also has moderate to high agreement and is satisfactory. Even for the four level ordinal response measure of sub-section A of *functional impairment*, it is found there are very high rates of agreement suggesting that the assessors were really evaluating the target persons in the same way, thus reaching a high degree of consistency. The items included in the present standardized needs assessment tool on the whole show good levels of stability. In other words, high levels of inter-rater agreement suggest that the instrument is well operationalized, and the assessors have been appropriately trained to apply the criteria in the same way. **In sum, the present reliability study provides evidence that evaluations of the residential care need of persons with mental/physical handicap applying for residential rehabilitation services can be made with high repeatability through appropriate application of the standardized needs assessment tool**.

4.3 Furthermore, detailed reading of the reliability data also yields useful information for further refinement of the assessment tool. For instance, it is noted re-phrasing is logically required for item 2 in *nursing care need*, as a two point response overlaps with a three point response and this may lead to irregularity. The choice of the category "inapplicable" as a response for sub-sections A2 and B in *family coping* is superfluous. Operational elaboration of item A2d in the same section may be helpful. The items 2 and 3 of sub-sections A to D under section *assessment summary and conclusion* can be improved to achieve even better agreement.

4.4 The extensive development process of the standardized needs assessment tool in the past years has been grounded in numerous discussion/focus groups and wide consultation involving a large number of rehabilitation professionals from various disciplines as well as parents of persons with mental handicap. Different perspectives were taken into account and comments were incorporated into the evolved version of the tool. It has been suggested that such rigorous, specific and critical scrutiny of the content and structure of the assessment instrument by so many experts and experienced practitioners in the rehabilitation field already contributed to establishing acceptable consensual validity for the assessment tool. **Validity data generated in the present study, based on independent and in-depth expert analysis of selected cases, further lend credence to the claim that the standardized needs assessment tool is a valid instrument, which effectively identifies relevant, appropriate and useful areas/domains that constitute the residential care need of persons with mental/physical handicap applying for residential rehabilitation services**.

Practicality of Assessment Tool Revisited

4.5 **The direct feedback from informants, including both the target persons and their family/primary carers, further re-affirms the practically and utility of the present standardized needs assessment tool.** The duration of the assessment is deemed appropriate, and nearly all informants, both target persons and their family/primary carers alike, expressed that they participated in the assessment process comfortably. The purpose and content of the assessment are also comprehensible to the majority of informants who are family/primary carers, although a few may have difficulty distinguishing between the purpose of the assessment situation (which is part of a pilot study to test out the instrument) and the purpose of the assessment tool (which is to identify the residential care need of persons with mental/physical handicap applying for residential rehabilitation services). The latter will not occur in clinical application of the assessment tool in daily service practice. Besides, it is only

understandable that some target persons, especially those with more severe degree of mental handicap, are less likely to fully comprehend the purpose and content of the assessment. It is expected that most often the standardized needs assessment tool be administered to an informant who is a family/primary carer.

Conclusion

4.6 The results of Phase II of the pilot study offer preliminary evidence that the present standardized needs assessment tool, as an instrument which identifies relevant areas useful in determining the residential care need of persons with mental/physical handicap applying for residential rehabilitation services, has a degree of validity and good reliability. The tool provides a more objective, structured and consistent means through which social workers rendering service across different settings, given they have appropriate training on the application of the instrument, can assess areas of particular relevance to evaluating the residential need of this group of clients they serve. The assessment tool is on the whole easy to comprehend from the perspectives of the informants and they can participate in the assessment process comfortably, and this echoes the main finding in previous phase of the study that the assessment protocol is practicable and suitable for day-to-day service application. Finally, it must be cautioned that the relatively small scale of the present study (eg small sample size, lack of multiple methods) imposes limits on the generalisability of the results.

Reference

Cicchetti, D.V., & Feinstein, A.R. (1990). High agreement but low kappa: II. Resolving the paradoxes. *Journal of Clinical Epidemiology*, *43*(6), 551-558.

Annexes

Annex A Revised Assessment Tool

社會福利署

弱智人士及肢體傷殘人士住宿服務評估［擬稿］

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	☐中西區	☐灣仔	☐東區	☐南區	☐離島
九龍	☐觀塘	☐黃大仙	☐九龍城	☐旺角	☐油麻地
	☐尖沙咀	☐深水	☐將軍澳	☐西貢	
新界	☐上水及粉嶺	☐馬鞍山	☐沙田	☐大埔	☐荃灣
	☐葵涌及青衣	☐屯門	☐元朗	☐天水圍	

6. 現正接受的服務（可選擇多項）

☐無 ☐特殊學校 ☐特殊學校寄宿服務

社區支援服務

☐家居訓練及支援服務 ☐暫託住宿服務 ☐其他，請註明：

日間訓練服務

☐輔助就業 ☐庇護工場 ☐展能中心

住宿服務

☐中度弱智人士宿舍 ☐嚴重弱智人士宿舍 ☐嚴重肢體傷殘人士宿舍

☐殘疾人士護理院 ☐自負盈虧殘疾人士院舍 ☐私營院舍

醫療服務

☐精神科住院服務 ☐非精神科住院服務 ☐日間醫院服務

☐門診服務，請註明：

II. 有關殘疾及健康問題的資料

1. 肢體傷殘

☐並非肢體傷殘（請轉答第 2 項）

☐缺失上或下肢 ☐缺失手／腳掌或手／腳趾 ☐上肢或下肢癱瘓 ☐左／右半身不遂

☐大腦癱瘓 ☐四肢癱瘓 ☐其他，請註明：

2. 弱智

☐並非弱智

☐極度嚴重 ☐嚴重 ☐中度 ☐輕度

心理評估日期：______年 ____月 ____日

3. 其他殘疾（可選擇多項）

☐言語障礙 ☐聽覺受損／弱聽 ☐視覺受損（☐失明／☐弱視）

☐自閉症 ☐精神病 ☐其他，請註明：

4. 疾病／健康問題 若有，請註明：

III. 護理需要

護理範圍	護理項目	分數
1. 皮膚問題 皮膚是否：	4 在過往一個月內褥瘡有見骨情況。 3 在過往一個月內皮膚出現潰瘍、褥瘡須接受無菌換症。 2 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。 1 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。 0 沒有以上任何一種情況。	
2. 餵食情況 在過往一個月內是否：	4 須用導管餵食，當事人為嚴重／極度嚴重弱智人士。 3 須加凝固粉進行餵食，或經常出現哽塞。 3 須用導管餵食，當事人並非嚴重／極度嚴重弱智人士。 2 須加凝固粉進行餵食。 2 有吞嚥問題。 0 沒有以上任何一種情況。	
3. 使用藥物情況 在過往一個月內當事人是否：	2 長期使用藥物，並須跟進藥物反應[i]。 2 須每天接受藥物注射，當事人為嚴重／極度嚴重弱智人士。 1 須每天接受藥物注射，當事人並非嚴重／極度嚴重弱智人士。 0 沒有以上任何一種情況。	
4. 排泄控制 在過去一個月內的排泄能力：	3 大小便完全失禁[ii]。 3 使用導尿管。 1 間中失禁。 0 沒有以上任何一種情況。	
5. 癲癇情況 在過去三個月是否有癲癇發作：	4 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)。 1 曾有癲癇發作。 0 沒有以上任何一種情況。	
6. 氧氣治療 在過往一個月內是否須接受氧氣治療：	4 當事人為弱智人士，在使用氧氣後仍能處理日常作息。 4 當事人在使用氧氣後仍無法處理日常作息[iii]。 3 當事人並非弱智人士，在使用氧氣後仍能處理日常作息。 0 沒有以上任何一種情況。	
7. 抽吸處理 在過往一個月內是否：	4 須接受恆常抽吸處理。 0 沒有以上情況。	
8. 長期臥床 在過往一個月內是否：	4 須長期臥床並完全倚賴他人照顧。 0 沒有以上情況。	
	上述各項目的**最高**分數	

[i] 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。

[ii] 完全失禁指大小便在不自覺或不受控制的情況下排出。

[iii] 無法處理日常作息指小量活動便引致氣促。

IV. 功能缺損[iv]

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（包括需要口頭或接觸身體的提示）
2 當事人需要較多的觸體協助，但他／她仍有參與部份活動（不需要大量體位搬移的協助、或提舉當事人身軀或肢體）
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，或要花費相當力勁才能協助完成該項目）

活動項目	分數
A1. 洗澡 進行淋浴或坐浴（不包括洗頭）	
A2. 穿脫衣物 A2.1 以坐或站的姿勢穿脫上身衣物，包括外衣及內衣（不計算扣鈕）............... (　　) A2.2 以坐或站的姿勢穿脫下身衣物，包括外褲及內褲 .... (　　) A2.3 穿脫鞋襪（包括手托或義肢） .... (　　) （請選取 A2.1 至 A2.3 的最高分數作為右方 A2 整項的分數）	
A3. 位置轉移 指身體如何由一處移動至另一處的情況（例：床過座椅／輪椅，輪椅過座廁等） 請列出需要的輔助工具／助行器具：	
A1 至 A3 項的**總分**	

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（包括需要口頭或接觸身體的提示）
2 當事人需觸體協助至完全倚賴

活動項目	分數
B1. 如廁（使用坐廁或蹲廁） 大小便後的清潔情況（包括更換成人尿片）	
B2. 進食及進飲 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：*飲管／雙耳杯／切口杯／有蓋啜飲杯／其它： （請選取 B2.1 至 B2.2 的較高分數作為右方 B2 整項的分數）	
B3. 室內行動能力（只需回答 B3.1 或 B3.2） B3.1 室內行走約兩分鐘.. (　　) 使用的助行器具：*拐杖／三或四腳拐杖／助行架／輪子助行架／其它： B3.2 室內使用輪椅.. (　　) 輪椅類別：*手動／電動 （請選取適用的分項作為右方 B3 整項的分數）	
B1 至 B3 項的**總分**	

* 刪去不適用者

當事人有否因家居環境問題（如缺乏合適的扶手裝置）而減低其上述功能表現？若有，請註明：

[iv] 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，如來回床至座椅、來回輪椅至座椅等；(d)室內行走。

V.　行為問題

行為問題類別	行為問題項目	分數
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）？ 0 否（請轉問 B1 項） 1 有	
	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？ 0 否 1 有	
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（如搣自己, 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）？ 0 否（請轉問 C1 項） 1 有	
	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護人員即時治理？ 0 否 1 有 （請轉問 C1 項）	
	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？ 0 否 1 有	
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）？ 0 否（請轉問 D 項） 1 有	
	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？ 0 否 1 有	
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）？ 0 否 1 有, 請註明（可選多項）: ☐不恰當性行為 ☐厭惡行為 ☐重覆行為	
E. 應付問題	（當項目 A1, B1, C1 或 D 至少一項有 1 分, 方可繼續發問 E 項。） 請問照顧者在處理以上行為時, 覺得非常困難嗎？ 0 否 1 有	
	A1, B1, C1 和 D 項的總分	
	A2, B2, B3 和 C2 項的總分*	
	E 項的得分*	

* 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. 照顧系統

1. 照顧者資料

「主要照顧者」與「次要照顧者」是指會為當事人提供照顧或協助的家人，包括父母、家屬或親人。倘若當事人沒有主要或次要照顧者，請於相關的「姓名」一欄填「無」。「其他照顧者」是指會提供協助的鄰居、朋友，或受聘照顧當事人的家庭傭工，但不包括院舍或醫院職員。

照顧者類別	姓名	性別／年齡	關係	是否同住	職業及工作時間	每週照顧時數
(a)主要照顧者						
(b)次要照顧者						
(c)其他照顧者（可多於一位）						

2. 照顧系統所面臨的危機因素／風險

由於出現以下情況，轉介者認為現有照顧系統已面臨相當的危機或風險：

× 不適用（可能因為當事人沒有主要照顧者）
1 出現所述的情況
0 沒有所述的情況

(a) 主要照顧者年齡已達 60 歲或以上	
(b) 主要照顧者健康轉差或有長期病患，以致無法照顧當事人	
(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	
(d) 主要照顧者出現情緒困擾（例如：長期沮喪或抑鬱），以致無法照顧當事人	
(e) 主要照顧者須同時照顧其他患有殘疾或長期病患的家庭成員，以致無法照顧當事人	
(f) 主要照顧者須長時間工作，且無能力安排其他照顧者照顧當事人	
(g) 當事人與家人及親友失去聯絡，無人可提供所需照顧	
(h) 當事人為社會福利署署長監護個案，在離開現有服務後並無家人或親友可提供所需照顧	

B. 人際關係

由於出現以下情況，轉介者認為當事人現時的人際關係已出現嚴重問題：

× 不適用（可能因為當事人沒有家人、同住者或鄰居）
1 出現所述的情況
0 沒有所述的情況

1. 當事人在過去三個月內，曾至少兩次與家人或同住者發生嚴重衝突	
2. 當事人在過去三個月內，曾至少兩次滋擾鄰居而引致嚴重衝突	
3. 當事人曾與家人發生嚴重衝突，並須接受精神科住院治療，至今家人仍拒絕接納當事人回家	

C. 其他風險／危機因素

由於以下的情況，轉介者認為當事人的安全現時存在相當危機或風險，並曾作出適當跟進：

1 出現所述的情況
0 沒有所述的情況

1. 當事人被家人虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
2. 當事人被其他人士虐待或侵犯（包括身體虐待、心理虐待、性侵犯等）	
3. 當事人被疏忽照顧	
4. 當事人有不受控制行為（包括離家出走、縱火、參與非法活動等），請註明：	

VII. 總結

A. 護理需要

1. 第 III 部分評估結果（只勾選一項）	沒有／低度護理需要（請轉答 B1）	
	中度護理需要	
	高度護理需要	
	極高護理需要	
2. 現時有沒有家人或親友可提供所需的照顧？	0 有，請註明： 1 沒有 × 不適用*	
3. 現有社區支援或社康護理服務能否提供所需協助？	0 能夠，請註明： 1 不能夠 × 不適用*	

B. 功能缺損

1. 第 IV 部分評估結果（只勾選一項）	沒有功能缺損（請轉答 C1）	
	低度功能缺損	
	中度功能缺損	
	高度功能缺損	
2. 現時有沒有家人或親友可提供所需的協助？	0 有，請註明： 1 沒有 × 不適用*	
3. 現有社區支援或日間訓練能否提供所需協助？	0 能夠，請註明： 1 不能夠 × 不適用*	

C. 行為問題

1. 第 V 部分評估結果（只勾選一項）	沒有行為問題（請轉答 D1）	
	有行為問題，但無需有較多員工的康復服務	
	有行為問題，並需要有較多員工的康復服務	
2. 現時有沒有家人或親友可提供所需的協助？	0 有，請註明： 1 沒有 × 不適用*	
3. 現有日間訓練、治療或輔導服務能否提供協助？	0 能夠，請註明： 1 不能夠 × 不適用*	

D. 家庭／照顧者的應付能力

1. 第 VI 部分評估結果（請勾選適用的項目）	現有照顧系統已面臨相當的危機或風險	
	當事人的人際關係已出現嚴重問題	
	當事人的安全存在相當的危機或風險	
2. 現時有沒有家人或親友可提供所需的協助？	0 有，請註明： 1 沒有 × 不適用*	
3. 現有社區支援、家庭服務等能否提供所需協助？	0 能夠，請註明： 1 不能夠 × 不適用*	

* 「不適用」指當事人在該項目評估中顯示沒有／低度護理需要、沒有功能缺損、行為問題或其他危機／風險。

E. 評估結果

1. 綜合上述 A 至 D 項評估結果，顯示（只勾選一項）：	現有照顧系統、日間訓練或社區支援服務等已能提供所需的照顧或協助, 現階段並不需要輪候院舍服務（倘若當事人日後有需要，可再行申請及進行評估）	
	現有照顧系統連同社區支援服務等均不能提供所需照顧或協助，當事人有需要輪候院舍服務	
2. 根據《評估員手冊》中的《服務需要評估流程》，建議當事人所需服務類別為（只勾選一項）：	社區支援服務（轉介者將直接向有關服務機構申請）	
	社區住宿服務（轉介者將直接向有關服務機構申請）	
	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)	
	療養院服務（轉介者將向醫院管理局提交有關申請）	

3. 倘若出現評估過程未有提及的情況而導致當事人需要輪候院舍服務，請詳細列明及建議所需服務類別：

社會福利署
弱智／肢體傷殘人士住宿服務評估
評估員手冊

社會福利署
康復及醫務社會服務科
二〇〇四年三月

社會福利署
弱智／肢體傷殘人士住宿服務評估
評估員手冊

A. 背景

1. 政府在 2000 年施政報告承諾，會檢討各類康復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「檢討殘疾人士住宿服務督導委員會」，負責督導有關檢討工作。委員會委託顧問公司於 2001 年進行一項殘疾人士住宿服務意見調查，以了解使用者和輪候人士的概況和服務需要。調查結果於 2002 年公佈，其中發現在住宿服務輪候隊伍中，超過 24%的家長希望在五年或以後才獲編配宿位。此外，根據社會福利署康復服務中央轉介系統資料，自 2000 年起，每年均有 30%以上的住宿服務申請人拒絕宿位編配。上述數字反映不少家長為其殘疾子女申請住宿服務時抱「買保險」心態，而非基於現時及真實的照顧需要。

2. 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。

B. 評估目的

3. 此評估工具的目的是透過評估 15 歲或以上的弱智或肢體傷殘人士（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），從而了解當事人是否需要院舍服務，及需要甚麼類型的院舍服務。評估亦會考慮在院舍服務的選擇以外，家人、親友等支援網絡或社區照顧服務能否提供協助，直至所提供的協助不足以照顧當事人的需要，才進而接受院舍服務。

C. 評估的主要原則

4. 根據上述目的，評估主要依循下列幾個原則：

(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，是了解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（service streaming）。它並不是用來取代各專業人士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) 由於現有服務種類有限，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限於上述目標，與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。

D. <u>對轉介者的要求</u>

5. 轉介者須為註冊社工（社會工作助理或以上）。由於評估的目的是確立當事人是否有實際需要接受院舍服務，轉介者實際上亦擔當公共資源分配者的角色，因此轉介者在評估過程中須保持客觀，並根據當事人的實際需要而非其意願作出評估。倘若當事人的支援網絡及社區照顧服務等均不能解決當事人的住宿及照顧需要，轉介者便須根據評估工具及本手冊的建議，為當事人安排住宿服務。相反，倘若當事人經過評估後確定並無需要院舍服務，轉介者亦須考慮可否安排適當的社區支援或日間訓練以滿足當事人的需要。

E. <u>轉介者須知</u>

6. 轉介者須向當事人及其家人清楚解釋評估的目的和評估表的用途，並取得他們的同意才進行評估。此外，根據《個人資料（私隱）條例》，轉介者亦須向當事人及其家人解釋收集資料的用途、查閱和更改資料的途徑。

7. 評估的對象主要是指當事人，即需要服務的弱智人士或肢體傷殘人士。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 部分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。

8. 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。

9. 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。遇有疑問（例如不同來源的資料出現不協調的情況），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、或是否出現某類行為問題），或作家訪以作實地觀察，並根據轉介者本身的專業知識及技巧作出判斷。

10. 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）的有關指引，決定當事人所需的服務。

11. 轉介者須對各類社會服務有基本了解，並儘可能熟悉各類院舍服務、日間服務、社區照顧服務等的分別，以便協助當事人及其家人明白不同服務的特色和要求。

12. 轉介者須向當事人及其家人交代其評估建議，並就有關建議作出適當跟進，如轉介合適的社區支援服務。倘若當事人或其家人不同意轉介者所作的評估內容，轉介者須記錄在案，再交由轉介者的上司處理。

13. 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。

F. 評估工具的內容及流程

14. 除了 I 及 II 部分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。四個評估範疇分別是：護理需要、功能缺損、行為問題及家人／照顧者的應付能力。

15. 弱智／肢體傷殘人士的護理需要直接影響到他們能接受的服務類別與所需的專業護理照顧，因此住宿服務評估也先從護理需要開始。護理需要評估的項目包括：皮膚問題、餵食情況、使用藥物情況、排泄控制、癲癇情況、氧氣治療、抽吸處理，及長期臥床的護理。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。

16. 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。

17. 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，行為問題評估主要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，以及照顧者在處理以上行為問題時是否遇到困難。透過各項評估的得分，可得知當事人是否有行為問題，及是否需要設有較多員工的康復院舍服務。

18. 至於家人／照顧者應付能力的評估，其作用是為了識別照顧系統所面臨的危機或風險因素、人際關係問題、及其他潛在的危機或風險因素。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能力安排其他照顧者照顧當事人、家庭成員關係、當事人有否被虐待或侵犯、疏忽照顧、離家出走或參與非法活動等因素。

19. 在總結部分，轉介者須總結以上四個評估範疇的結果，並考慮：一、現有家人或親友是否能提供有關協助及照顧？二、現有社區支援服務（參考附錄二，惟轉介者須定時更新有關資料）能否提供有關協助及照顧？倘若在任何一個評估範疇內，現有家人、親友及社區支援服務等均不能提供有關照顧或協助，即表示當事人需接受院舍服務。相反，倘若在所有範疇中家人、親友或社區支援服務等能提供有關照顧，即表示當事人並無照顧困難，亦不需要院舍服務。轉介者須按照評估表及本手冊內的指引，完成有關評估，並根據《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）所載指示，建議當事人所需的服務。

20. 倘若轉介者發覺有某些因素於決定當事人的住宿需要有重要影響，而評估表並沒有涵蓋的話，可先

完成上述評估，然後再另行補充（即總結 E 部分第 3 項）並作出相關服務建議。轉介者須將原有評估結果及其服務建議一併呈交社會福利署作出審核。

21. 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。

22. 倘若殘疾人士被評估為：低度或沒有護理需要、沒有功能缺損、亦沒有行為問題，遇有需要時（例如在沒有照顧者的情況下），轉介者可為當事人安排社區住宿照顧（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]）並過半獨立的生活；並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。

23. 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 ，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。

* * *

G. 住宿服務評估工具各部分的說明

I. 個人資料

1. 此部分為當事人的基本個人資料，每項均為必須填寫。
2. 在填寫當事人的香港身分證號碼前，轉介者須核實當事人的身分證，避免錯誤。

II. 有關殘疾及健康問題的資料

1. 有關弱智程度的分類，轉介者可參考有關的心理評估報告的評估結果。
2. 轉介者應就「其他殘疾」中的各項目，儘可能取得有關斷症的資料。例如「精神病」一項應指當事人被精神科醫生確診為患有精神病，而不是指當事人定期往精神科診所覆診。
3. 倘若當事人由於意外或其他原因導致認知受損，可於「其他殘疾」中的「其他，請註明」一項填寫「認知受損」。

III. 護理需要評估

評估準則

(a) 以選取各項目的最高護理分數為評估結果，例如：若同時有兩項為 1 分，一項為 2 分，則評估結果為 2 分。

(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，轉介者可在第 VII 部分「總結」相關部分詳述有關護理需要以考慮當事人所需服務。

1. 皮膚問題

<table>
<tr><td>目的</td><td colspan="2">部分當事人有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。</td></tr>
<tr><td>程序</td><td colspan="2">當事人會被直接問及他在過去一年或一個月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。</td></tr>
<tr><td>定義</td><td colspan="2">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。</td></tr>
<tr><td rowspan="4">範例</td><td>例如：</td><td>評估分數</td></tr>
<tr><td>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。</td><td>1</td></tr>
<tr><td>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。</td><td>2</td></tr>
<tr><td>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分皮膚脫落形成褥瘡。</td><td>3</td></tr>
</table>

2. 餵食情況

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	1. 凝固粉：一種粉狀物質加入液體中使液體改变為啫喱狀，或使液體凝結成半固體。從而延長吞嚥時間，減低哽塞風險。 2. 吞嚥問題：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，部分食物仍留在口腔，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：	評估分數
	1. 阿珍為嚴重弱智人士，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分食物仍留在口腔內，須鼓勵她慢慢咀嚼，才可把食物吞下。	2
	2. 啟明有吞嚥因難，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。	2
	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。	3
	4. 阿輝交通意外後，失去吞嚥能力，須用導管餵食攝取營養。	3

3. 使用藥物情況

目的	部分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	1. 長期使用藥物：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. 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：	評估分數
	1. 麗珠為嚴重弱智人士，患有糖尿病，須早晚注射糖尿針，控制血糖。	2
	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。	2
	3. 大雄為嚴重弱智人士，患有心臟病，須服用心臟藥物 Digoxin，故每天服藥時，須量度心律。	2

4. 排泄控制

目的	部分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	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：	評估分數
	1. 玉芬為中度弱智人士，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。	1
	2. 文生為極度嚴重弱智人士，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。	3
	3. 志明為嚴重弱智人士，母親表示只要每隔二至三小時給志明如廁，便無須給他穿上紙尿片。但間中也會因趕不及如廁而弄濕褲。	1

5. 癲癇情況

目的	部分當事人可能患有癲癇症。此項目為協助了解當事人癲癇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。故在界定護理需要程度上，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癇的情況。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	癲癇情況仍不能控制指當事人服用癲癇藥物後，癲癇發作仍然頻密，經醫生證明，癲癇情況不能被藥物控制。	
範例	例如：	評估分數
	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。	1
	2. 小超為嚴重弱智人士並患有癲癇症，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。	4

6.　氧氣治療

目的	部分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：指作出少量活動如起立、取物、走路等會出現氣喘情況。	
範例	例如：	評估分數
	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。	3
	2. 劉女士為長期病患者，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。	4

7.　抽吸處理

目的	部分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：	評估分數
	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。	4

8. 長期臥床

目的	部分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，大部分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：	評估分數
	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。	4

護理需要評分準則

護理需要評估項目的最高分數	護理需要程度
0 分	無護理需要
1 分	低度護理需要
2 分	中度護理需要
3 分	高度護理需要
4 分	極高護理需要

IV. 功能缺損評估

<u>注意事項</u>

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、其家人或照顧者均須出席提供有關當事人在個人自理活動上的資料。

<table>
<tr><th colspan="3">功能缺損評估的設計</th></tr>
<tr><td rowspan="4">A 類項目</td><td colspan="2">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。這三項的自理活動均在時間、人手協助或頻密程度上較為顯著。</td></tr>
<tr><td>洗澡</td><td>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。</td></tr>
<tr><td>穿脫衣服</td><td>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痲痺患者，穿脫衣物需更多的協助。</td></tr>
<tr><td>位置轉移</td><td>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。</td></tr>
<tr><td rowspan="4">B 類項目</td><td colspan="2">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、進食及進飲和室內行動能力。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。</td></tr>
<tr><td>如廁</td><td>因評估範圍只限於便後清潔，並不包括表達如廁需要及在如廁過程中涉及的穿脫褲子及位置轉移，所以人手協助便相對較少。</td></tr>
<tr><td>進食及進飲</td><td>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。</td></tr>
<tr><td>室內行動能力</td><td>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。</td></tr>
<tr><td>評分</td><td colspan="2">如上述所論，A 類項目無論在時間、人手協助的要求或頻密程度都較為顯著，所以我們以較細緻的方法將 A 類項目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院舍服務。
相對而論，B 類項目的自理活動需要人手較少，我們亦以較簡易的三級評分（即 0 至 2 分）來界定其人手需求。</td></tr>
</table>

評分內容

A 類項目

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（包括需要口頭或接觸身體的提示）

2 當事人需要較多的觸體協助，但他／她仍有參與部分活動（不需要大量體位搬移的協助、或提舉當事人身軀或肢體）

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，或要花費相當力勁才能協助完成該項目）

B 類項目

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（包括需要口頭或接觸身體的提示）

2 當事人需觸體協助至完全倚賴

功能缺損程度換算表

第一條件	第二條件	功能缺損程度
A 類項目總分為 7 至 9 分	--	高度缺損
A 類項目總分為 4 至 6 分	--	中度缺損
A 類項目總分為 3 分或以下	B 類項目總分為 4 至 6 分	中度缺損
	A 類加 B 類的總分為 3 至 6 分	低度缺損
	A 類加 B 類的總分為 2 分或以下	沒有缺損

功能缺損評估項目說明

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，以免著涼。	0
	陳女士在洗澡時經常需要別人在旁提點，甚至輕碰她拿著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著他的手來洗擦未清潔的身體部分。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。然而，以躺臥姿勢完成的則不作評估，因日常穿脫衣服的環境（如：廁所、浴室等）一般不容許當事人以此姿勢進行。	
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
	李女士患有大腦痲痺症，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／脫下衫褲。	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分；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座椅等生活情況）。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，需要用手按著固定的傢俱如桌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
	阿強因大腦痲痺問題，雙腳活動欠佳，以輪椅代步。由於他的理解力較差，每次由輪椅過座椅，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，轉坐在座椅上。	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，他的雙腳不能伸直著地。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，包括如廁步驟、便後清潔、使用便椅 （如適用）等。但在如廁活動中涉及的穿／脫褲子則不予評分。同時，轉介者亦要記錄當事人所用的廁所種類（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
	阿容是嚴重弱智學生，一向住在宿舍，她雖然未能準確地表達如廁需要，但大致能跟著院舍時間表上廁所及完成各如廁步驟。	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厠紙掉進馬桶。	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著尿壺排尿，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 進食情況（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，如有部分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著她的手腕，協助她把切碎食物送到口中。	2

B2.2 進飲情況

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。若果當事人需要用輔助器具幫助飲水,轉介者亦應作記錄。以下列出的是一般常見的進飲輔助工具： 飲管　雙耳杯　切口杯　有蓋啜飲杯	
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，飲水時需要照顧者輕碰她的手肘，並提示她把手肘固定在　面上，然後拿緊雙耳杯飲水。	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）。以下列出的是常用的助行器具： 拐杖 + 手肘/腋下杖 四腳拐杖 + 三腳拐杖 助行架 + 承托前臂助行架 輪子助行架 前/後/四輪子推架 + 梯架/梯背椅	
定義	在一般性的室內環境行走約兩分鐘（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，影響雙腳活動，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[*]

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	1. 「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）四個範疇。「其他行為問題」（D）包括不恰當性行為、厭惡行為及重覆行為。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。 2. 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護人員即時治理。項目 C2 中的「嚴重物資破壞」，指其嚴重程度引致該物資重要功能或其外觀受永久性／嚴重損壞。項目 D「其他行為問題」沒有包括離家出走或偷走。如有這類行為問題，可記錄在 *VI.家人／照顧者的應付能力*中的項目 C4 內。 3. 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。 4. 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。
得分計算	1. 任何沒有發問的項目，請給予 0 分。 2. 評估員可參考附表的指示，得出本範疇的評估結果。
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

<table>
<tr><th>項目 A1、B1、C1
和 D 的總分</th><th>項目 A2、B2、B3
和 C2 的總分</th><th>項目 E 的得分</th><th>評估結果</th></tr>
<tr><td>0 分</td><td>--</td><td>--</td><td>沒有行為問題</td></tr>
<tr><td rowspan="4">1 分或以上</td><td rowspan="2">1 分或以上</td><td>1 分</td><td>有行為問題，並需要有較多員工的康復服務</td></tr>
<tr><td>0 分</td><td rowspan="3">有行為問題，但無需有較多員工的康復服務</td></tr>
<tr><td rowspan="2">0 分</td><td>1 分</td></tr>
<tr><td>0 分</td></tr>
</table>

[*] 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

A 項：照顧系統

目的	了解當事人現存的照顧系統所面臨的危機因素或風險。
程序	本項評估適用於以下情況： 1. 當事人現時在家接受照顧； 2. 當事人現正接受院舍、醫院或特殊學校寄宿服務，在這情況下轉介者可透過了解當事人回家渡假時的照顧安排，從而了解主要照顧者的狀況。倘若當事人已有一段長時間沒有回家，轉介者應以當事人離開院舍後會為當事人提供照顧的人士為評估對象。 在了解照顧系統所面臨的危機因素或風險時，轉介者可直接向主要照顧者查詢有關情況，並以客觀事實為準，有需要時可要求出示有關紀錄或證明，或在取得受訪者同意下向其他人士核實有關資料。
定義	1. 主要照顧者及次要照顧者：指現今或可見將來會為當事人提供照顧或協助的家人，包括父母、家屬或親人。若當事人沒有主要照顧者，可於主要照顧者的姓名一欄填「無」。倘若當事人長時間在院舍、醫院或特殊學校寄宿，則應以當事人離開院舍後會為當事人提供照顧的人士為主要／次要照顧者。 2. 其他照顧者：指提供協助的鄰居、朋友，或受聘照顧當事人的家庭傭工，但不包括院舍職員或醫院員工。 3. 照顧：指為當事人提供日常自理或基本護理，或就此提供指導或幫忙；但不包括院舍或醫院探望、沒有口頭提示或身體接觸的看顧，或純粹金錢上的援助。 4. 協助：指各種形式的照應或援助，包括沒有口頭提示或身體接觸的看顧。 5. 每周照顧時數：指照顧者每周在日常自理、基本護理等活動上提供的幫忙或指導所需的時間，並以小時為單位計算。照顧時數並不計算院舍或醫院探望、沒有口頭提示或身體接觸的看顧，或金錢援助所花的時間。 6. 照顧系統：指為當事人提供照顧及協助的支援網絡，包括家人、親友、鄰居、家庭傭工等。 7. 相當的危機或風險：指有客觀跡象顯示照顧系統在目前（或可見未來）會無法為當事人提供照顧或協助。

B 項：人際關係

目的	了解當事人現時是否有嚴重人際關係問題。
程序	轉介者可直接向主要照顧者查詢有關情況，並以客觀事實為準，有需要時可要求出示有關紀錄或證明，或在取得受訪者同意下向其他人士核實有關資料。
定義	嚴重衝突：指由於當事人本身的性格或行為長期對家人、鄰居構成滋擾而引起的衝突，並須警方或專業人士介入。由於鄰居歧視行為引起的衝突或一般家庭糾紛不屬此列。

C 項：其他風險／危機因素

目的	了解當事人現時的安全是否存在相當危機或風險。
程序	轉介者可直接向主要照顧者查詢有關情況，並以客觀事實為準，有需要時可要求出示有關紀錄或證明，或在取得受訪者同意下向其他人士核實有關資料。
定義	相當危機或風險：指有跡象顯示當事人現時的安全情況正受到威脅。這些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，並作出適當跟進以防止問題惡化。

照顧系統評分準則

照顧系統所面臨的危機因素／風險項目的總分	結果
1 分或以上	現有照顧系統已面臨相當的危機或風險
0 分	現有照顧系統並無危機或風險

人際關係評分準則

人際關係項目的總分	結果
1 分或以上	當事人的人際關係已出現嚴重問題
0 分	當事人的人際關係並沒有嚴重問題

其他風險／危機因素評分準則

其他風險／危機因素項目的總分	結果
1 分或以上	當事人的安全存在相當的危機或風險
0 分	當事人的安全並沒有危機或風險

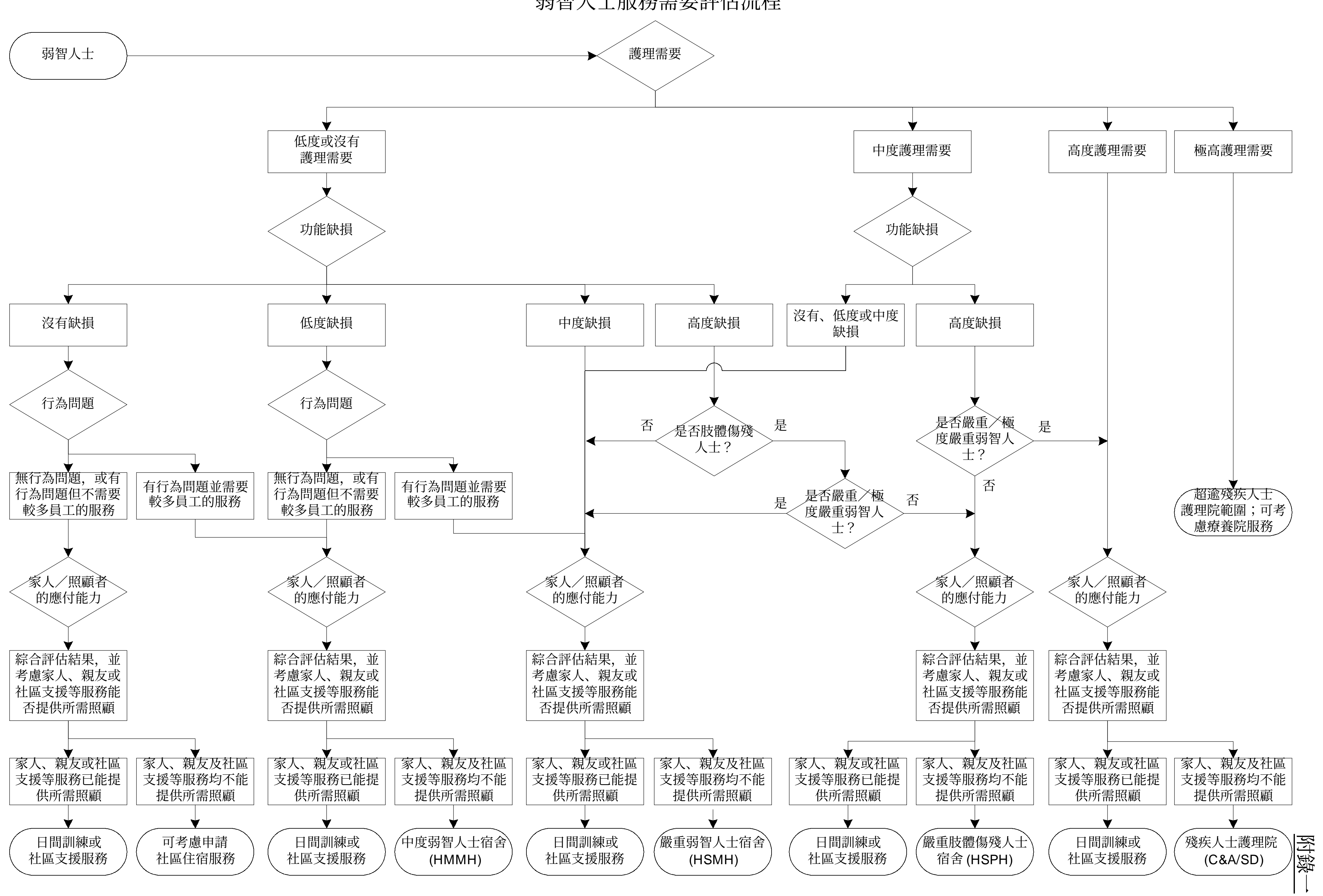
VII. 總結

目的	綜合評估結果，並考慮照顧系統連同社區支援服務是否能夠提供所需照顧，以決定當事人是否需輪候院舍服務。
程序	1. 轉介者須根據本手冊四個主要評估範疇，即護理需要、功能缺損、行為問題及家人／照顧者的應付能力所列的評分準則，決定每一個範疇的評估結果（即 A 至 D 各部分的第 1 項）。 2. 轉介者可根據家人或照顧者所提供的資料，再加上社工的評估，判斷現時有沒有家人或親友可提供所需的照顧或協助（即 A 至 D 各部分的項目 2）。 3. 轉介者再根據家人或照顧者所提供的資料，再加上社工的評估，判斷現有服務（包括社康護理、社區支援、日間訓練、家庭服務、體恤安置、各種治療及輔導等，參考附錄二）可否提供所需的協助（即 A 至 D 各部分的項目 3）。 4. 倘若當事人的照顧系統及現有服務均不能在任何一個範疇內提供當事人所需照顧或協助（即 A 至 D 任何一個範疇內的項目 2 與項目 3 的總分為 2 分），當事人有需要輪候院舍服務。若當事人的照顧系統或現有服務已可提供所需照顧或協助（即每個範疇內的項目 2 與項目 3 的總分都低於 2 分），當事人現時無須輪候院舍服務。E1 部分須完全根據前面 A 至 D 項資料填寫，評估員不應另行作出判斷。 5. 評估員再根據本手冊中的《服務需要評估流程》（附錄一），建議當事人所需服務類別。E2 部分須完全根據前述評估結果及《服務需要評估流程》，評估員不應另行判斷適合當事人的服務類別。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。 6. 倘若當事人被評估為不需要輪候院舍服務，但評估員發覺有評估過程未有提及的情況而導致當事人需要某類院舍服務，或評估員認為所建議的服務未能滿足當事人的需要，可於 E3 項詳細列明該情況及需要院舍服務的原因，並建議所需服務的類別。然而 E3 的補充資料不應改變原有列於 E1 及 E2 的評估結果。
定義	1. 提供所需照顧／協助：指評估員從評估中所得知的具體需要，可以由家人、照顧者或各類社區支援服務所滿足或解決。

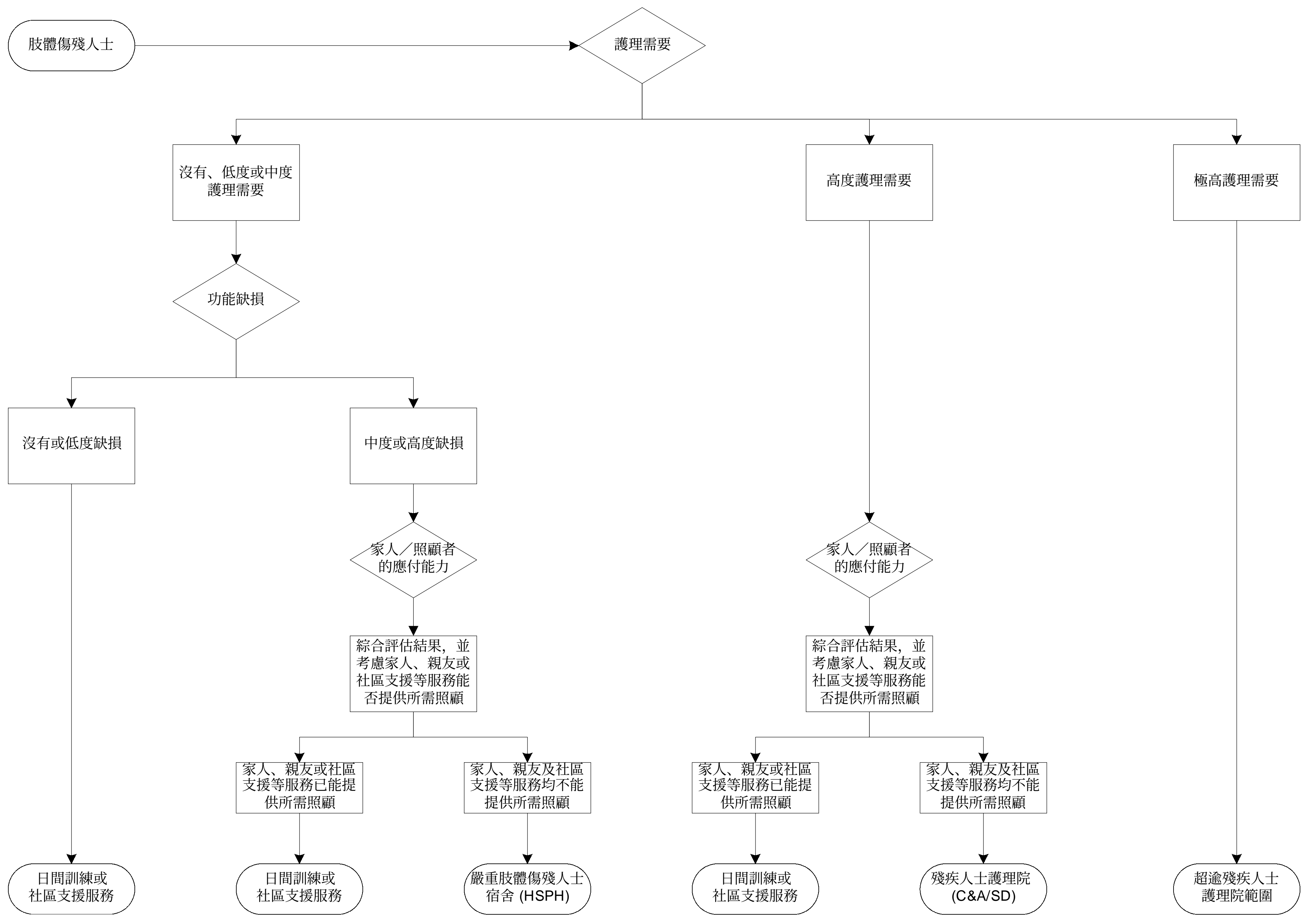
總結 E1 部分評估標準

評分準則	結果
A 至 D 四個範疇內，有任何一個範疇的項目 2 與項目 3 的總分為 2 分	現有照顧系統連同社區支援服務等均不能提供所需照顧或協助，當事人有需要輪候院舍服務
A 至 D 四個範疇內，每個範疇的項目 2 與項目 3 的總分皆少於 2 分	現有照顧系統、日間訓練或社區支援服務等已能提供所需的照顧或協助，現階段並不需要輪候院舍服務

弱智人士服務需要評估流程



肢體傷殘人士服務需要評估流程



弱智人士服務配對表

護理需要	功能缺損	是否有行為問題並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／社區支援能否提供協助？	建議服務
極高護理需要						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

護理需要	功能缺損	照顧者／社區支援能否提供協助？	建議服務
極高護理需要			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

附錄二

住宿服務以外的各類日間訓練及社區支援服務

服務名稱	護理服務	職業/日間訓練	日間照顧	職業/物理治療	心理/行為輔導	社交及支援	短期住宿	居所安排
社康護士服務	✓							
嚴重殘疾人士日間照顧服務	✓		✓			✓		
殘疾人士在職培訓計劃		✓						
輔助就業		✓						
庇護工場		✓						
綜合職業康復訓練中心		✓						
展能中心	✓	✓	✓	✓		✓		
家居訓練及支援服務		✓	✓	✓		✓		
家務指導服務		✓						
綜合家居照顧服務	✓		✓	✓				
日間暫顧服務			✓					
假期照顧服務			✓					
家居暫顧服務			✓					
延展照顧服務			✓					
家庭服務中心/綜合家庭服務中心					✓			
醫務社會服務					✓			
康復機構熱線輔導服務					✓			
社會福利署臨床心理服務					✓			
殘疾人士家長/親屬資源中心						✓		
殘疾人士社交及康樂中心						✓		
結伴行計劃			✓			✓	✓	
健樂會						✓		
弱智成人教育						✓		
輪椅維修服務						✓		
短暫住宿服務							✓	
緊急住宿服務							✓	
愛心連結計劃（家庭暫顧）			✓				✓	
體恤安置								✓

Annex C Schedule of Training Workshop

One-day Training Workshop
Pilot Study (Phase II) on
Standardized Assessment Tool
For Residential Services for Persons with Mental/Physical Handicap

Date:	2 April 2004 (Friday)
Time:	8:45 a.m. to 5:15 p.m.
Venue:	Room 206, Lady Trench Training Centre 44 Oi Kwan Road, Wan Chai
Moderator:	Mr William CHEUNG, Social Welfare Department

0845 - 0900	Registration
0900 - 0925	Development of the draft Assessment Tool and General Assessment Principles Mr David NG, Social Welfare Department
0925 - 1015	Domain on Nursing Care Need Ms Tracy WONG, Haven of Hope Christian Service
1015 - 1055	Domain on Family Coping Mr David NG, Social Welfare Department
1055 - 1110	Tea Break
1110 - 1210	Domain on Functional Impairment Mr Ivan SU, The Spastics Association of Hong Kong Mr Vincent WU, Social Welfare Department
1210 - 1240	Domain on Challenging Behavior Mr William CHEUNG, Social Welfare Department
1240 - 1400	Lunch Break
1400 - 1420	Community Support Services for Persons with Mental/Physical Handicap Mr Charles LEUNG, Social Welfare Department

1420 - 1450 Assessment Summary and Service Recommendations

Mr David NG, Social Welfare Department

1450 - 1505 Practice Sessions -- Introduction

Miss Grace SO, Social Welfare Department

1505 - 1520 Tea Break

1520 - 1700 Practice Sessions -- Exercises

Miss Grace SO, Social Welfare Department

1700 - 1715 Phase II Pilot Study and Conclusion

Mr William CHEUNG, Social Welfare Department

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

Practice Module of Training Workshop: Phase II Pilot Study on Standardized Needs Assessment Tool for Admission to Residential Services for People with Disabilities

Commencement

1 Session starts at about 1450. Miss Grace SO gives introductory remarks as to the overall objectives and arrangement (eg divides all assessors into three small groups; each assessor must pair up with her/his partner assessor) of the practice session, and underscores the importance of ascertaining accuracy and objectivity of assessment results.

Responsibilities of Facilitators

2 After tea break, the three groups of assessors go to Rooms 206, 209 and 406 as arranged. Each location is manned by at least two facilitators. The facilitators in each location are responsible to (a) brief the group of assessors in that room on how each practice exercise is to be conducted before each exercise, (b) distribute the relevant training materials, (c) answer queries about the exercises, and (d) ascertain that the assessors complete each exercise on time. The facilitators may also make observations about the difficulties experienced by the assessors when doing the exercises.

List of Facilitators

3 The facilitators are as follows:

Room	*Leading Facilitator*	*Assistant Facilitator*
206	William CHEUNG	Vivian TAM
209	Grace SO	LO Kam Wah/ David NG
406	Vincent WU	Jeanette CHAN

Time Schedule

4 The completion time for all three exercises is about 50 minutes. Assuming the assessors start the practice exercises at 1520 as scheduled, the exercises are completed by about 1610. The facilitators should ensure that all assessors in the room return to Room 206 at about 1615.

Feedback Session

5 The feedback session is conducted in Room 206 from 1615 till 1700, with Miss Grace SO and Mr William CHEUNG as moderator and assistant moderator respectively. The assessors are facilitated to share their experience and difficulties when they do the practice exercises, and all trainers present can make clarification and further elaboration (eg definitions of terms) on the Assessment Tool and the Assessor Manual based on feedback of the assessors. The moderator also crosschecks the answers to Exercises Two and Three with the assessors, with a view to elaborating the scoring systems of the Tool as well as stimulating the assessors to further reflect on the administration procedures and content of the assessment protocol.

Exercise One

Objectives

- To assist assessors to get familiar with the items of various domains of the instrument.
- To sensitize assessors to the definitions of the terms used (especially specific terms of a technical nature) in the instrument as well as the instructions given in the assessor manual.
- To facilitate assessors to administer the instrument in a way that is best understood by the informants (eg rephrase of items/terms in a colloquial way).

Format

Each assessor pairs up with her/his partner assessor in a dyad.

Time Required

Approximately 20 minutes.

Materials

- A copy of the Assessment Tool and the Assessor Manual for each assessor.
- Blank paper and pens/pencils for the assessors.

Process

1 Facilitator assists the assessors to pair up and announces the start of the

exercise.

2 One assessor is asked to play the role of an interviewer, and to administer all items of the domains *Nursing Care Need* (section III) and *Family Coping* (section VI) to her/his partner assessor who plays the informant role.
3 There is no need for the informant assessor to give any response, and the interviewer assessor should focus on administering the items of the domains verbally and following the instructions for the concerned domains detailed in the Assessor Manual.
4 The interviewer assessor (a) pays attention to the important aspects of the items administered (eg duration of preceding time periods), (b) tries to administer the items in a colloquial way easily understood by prospective informants, and (c) tries to rephrase items/terms that appear difficult or technical.
5 The informant assessor jots down significant observations or difficulties experienced during the process (eg difficulties in rephrasing).
6 Next the assessors switch roles. This time the interviewer assessor administers all items of the domains *Functional Impairment* (section IV) and *Challenging Behavior* (section V) to her/his partner assessor who plays the informant role. Process 3 to 5 is repeated.
7 Facilitator may sit beside the dyads in turns to make observations, and jot down difficulties experienced by the assessors.

Exercise Two

Objectives

- To assist assessors to apply the scoring systems of various domains of the instrument.
- To sensitize assessors to the differentiation of scoring rules of these scoring systems.

Format

Each assessor pairs up with her/his partner assessor in a dyad.

Time Required

Approximately 20 minutes.

Materials

- A copy of Annex I: *Clinical Situations* for each pair of assessors.
- A copy of Annex II: *Blank Assessment Form* for each pair of assessors.
- A copy of the Assessor Manual for each pair of assessors.
- Pens/pencils for the assessors.

Process

1 Facilitator distributes one copy of Annex I: *Clinical Situations* and Annex II: *Blank Assessment Form* to each pair.
2 Facilitator asks each dyad to discuss between themselves the score for each of the clinical situations described.
3 After discussion, the score for each of the clinical situations is put down on the *Blank Assessment Form.* Assessors may make reference to the Assessor Manual as and when needed, and pay particular attention to the definitions of terms and scoring rules of the scoring systems.
4 Assessors may jot down difficulties they experience during the process on the *Blank Assessment Form.*

Exercise Three

Objectives

- To assist assessors to get acquainted with transferring the scores of individual domains onto *Assessment Summary and Conclusion* (section VII) of the instrument.
- To facilitate assessors to use the *Service Streaming Flow Charts* (appendix I) of the Assessor Manual.

Format

Each assessor completes this exercise individually.

Time Required

Approximately 10 minutes.

Materials

- A copy of Annex III: *Case Examples* for each assessor.
- A copy of the Assessor Manual for each assessor.

- Pens/pencils for the assessors.

Process

1 Facilitator distributes one copy of Annex III: *Case Examples* to each assessor.
2 Facilitator asks each assessor to go through the cases individually and fill in the composite scores of each domain and the blank *Assessment Summary and Conclusion* for each of the cases.
3 Assessors are reminded to make reference to the scoring systems of various domains and the *Service Streaming Flow Charts* (appendix I) of the Assessor Manual as and when needed.
4 Assessors may jot down difficulties they experience during the process.

Practice Module developed by
William CHEUNG, Grace SO and Vincent WU
March 2004

Annex E　Informant Feedback Questionnaire (Target Person Version)

評估編號：___________

填寫日期：___________

社會福利署
弱智 / 肢體傷殘人士住宿服務評估
預試研究第二期

受訪者(當事人)意見問卷

當評估完成後，請以本問卷收集受訪者(當事人)對評估過程的意見。

請在下列適當的空格內加上「✓」號。

1. 資料提供情況
   - ☐ 有參與評估過程
   - ☐ 沒有參與評估過程 (不須作答下列問題)

2. 受訪者對問卷回應
   - ☐ 願意接受問卷調查
   - ☐ 不願意接受問卷調查 (不須作答下列問題)

3. 評估地點：
   - ☐ 當事人家中
   - ☐ 當事人之*學校／日間中心／宿舍 (*請刪去不適用者)
   - ☐ 其他(請註明：_______________)

	太長(-------)	適中(---)	太短(-)
4. 今次評估所需時間是否適中？(「正話訪問　時間會唔會太長、太短、還是都 OK？」	☐	☐	☐

	了解(✓)	一般(😐)	不了解(✕)
5. 你了解今次評估的目的嗎？(「你明唔明白點解要　訪問你？」	☐	☐	☐

	明白(✓)	一般(😐)	不明白(✕)
6. 整體來說你明白評估員所發問的內容嗎？(「正話佢問你　問題，你明唔明白？」)	☐	☐	☐

若「不明白」，請詳述：

7. 你覺得評估員的態度友善嗎？

(「你覺得正話個評估員好唔好人？」)

若「不友善」，請詳述：

友善 (☺) ☐　　一般 (😐) ☐　　不友善 (☹) ☐

____

8. 在評估過程中，你感到有壓力嗎？

(「正話訪問　時候，你有無覺得好似被人逼住咁？」)

若「有壓力」，請詳述：

無壓力 (☺) ☐　　有壓力 (☹) ☐

____

9. 在評估過程中，你覺得有無問題令你尷尬或不安嗎？

(「正話問　　問題，有無令你覺得唔舒服？」)

若「尷尬」，請詳述：

無尷尬 (☺) ☐　　尷尬 (☹) ☐

____

10. 就評估工具的內容及評估過程，你有什麼建議？

(「正話我　做　個訪問，同埋問　　問題，你認為我　有邊度仲可以做得好　？」)

____

____

11. 其他意見：

____

____

— 多謝 —

Annex F Informant Feedback Questionnaire (Family/Primary Carer Version)

評估編號：___________

填寫日期：___________

社會福利署
弱智 / 肢體傷殘人士住宿服務評估
預試研究第二期

受訪者(家人)意見問卷

當評估完成後，請以本問卷收集受訪者(家人)對評估過程的意見。若受訪的家庭成員多於一位，請以提供較多資料者為調查對象。

請在下列適當的空格內加上「✓」號。

1. 受訪對象(與當事人關係)

   ☐ 父母親　　☐ 兄弟或姊妹

   ☐ 親戚　　☐ 其他(請註明：_______________)

2. 資料提供情況

   ☐ 有參與評估過程　　☐ 沒有參與評估過程 (不須作答下列問題)

3. 受訪者對問卷回應

   ☐ 願意接受問卷調查　　☐ 不願意接受問卷調查 (不須作答下列問題)

4. 評估地點：

   ☐ 當事人家中　　☐ 當事人之*學校／日間中心／宿舍

   ☐ 其他(請註明：_______________)　　(*請刪去不適用者)

	太長	適中	太短
5. 今次評估所需時間是否適中？(「正話訪問　時間會唔會太長、太短、還是都 OK？」	☐	☐	☐

	了解	一般	不了解
6. 你了解今次評估的目的嗎？(「你明唔明白點解要　訪問你？」	☐	☐	☐

7. 整體來說你明白評估員所發問的內容嗎？ 明白 □ 一般 □ 不明白 □
(「正話佢問你 問題，你明唔明白？」)
若「不明白」，請詳述：

---

8. 你覺得評估員的態度友善嗎？ 友善 □ 一般 □ 不友善 □
(「你覺得正話個評估員好唔好人？」)
若「不友善」，請詳述：

---

9. 在評估過程中，你感到有壓力嗎？ 無壓力 □ 有壓力 □
(「正話訪問 時候，你有無覺得好似被人逼住 咁？」)
若「有壓力」，請詳述：

---

10. 在評估過程中，你覺得有無問題令你尷尬或不安嗎？ 無尷尬 □ 尷尬 □
(「正話問 問題，有無令你覺得唔舒服？」)
若「尷尬」，請詳述：

---

11. 就評估工具的內容及評估過程，你有什麼建議？
(「正話我 做 個訪問，同埋問 問題，你認為我 有邊度仲可以做得好 ？」)

---

12. 其他意見：

— 多謝 —

Guide for Members of the Professional Group: Phase II Pilot Study on Standardized Assessment Tool for Residential Services for Persons with Mental/Physical Handicap

Background

1. In view of the growing demand for residential places albeit a significant increase in provision in the past ten years, the Social Welfare Department (SWD) set up a multi-disciplinary Steering Group on Admission Procedures for Residential Care Homes for People with Disabilities in 2001 to steer a review on admission criteria and admission process of residential homes for people with disabilities (PWD). As a first step, a survey was conducted. It was found that 24% of the parents of the waitlistees for residential service indicated that they did not require residential placement within the next five years. On the other hand, the median age of the waitlistees was only 28, with 30% of total waitlistees aged 15 to 20. The median age of their parents was only 52. This indicates that the general waitlistees are rather young in age. In view of the survey findings, the Steering Group decided to form a Task Group comprising parents and various professionals to devise a standardized assessment tool (the Tool) to ascertain the urgency of each application and match the service need.

2. The Tool developed by the Task Group was revised upon various consultation sessions with parents groups, special school social workers, operators of rehabilitation units, Rehabilitation Advisory Committee and the LegCo Panel on Welfare Services. A two-phase pilot study started in September 2003 is being conducted by a Sub-Group on Pilot Study (the Sub-Group) to further refine the Tool and the Assessor Manual and to establish the reliability and validity of the Tool. Reliability data will be collected through inter-rater reliability study of 60 cases, while validity data will be collected by comparing the assessment results of the Tool to the independent judgment made by a Professional Group to be set up by the Sub-Group.

Terms of Reference of the Professional Group

3. The terms of reference of the Professional Group can be found in Annex 1.

Composition of the Professional Group

4. The Professional Group is composed of six members coming from the following disciplines and sectors:

(a) 1 registered nurse from a NGO rehabilitation unit;
(b) 1 occupational therapist from a NGO rehabilitation unit;
(c) 1 clinical psychologist from SWD;
(d) 1 psychiatrist from HA;
(e) 1 social worker from a special school; and
(f) 1 social worker from SWD/a NGO rehabilitation unit.

5. Representative(s) from SWD will also be present in the Professional Group meetings as resource person(s) to provide background information if necessary.

Selection of cases for study

6. The Sub-Group will select around 10 cases that participated in the inter-rater reliability study of Phase II Pilot Study for in-depth examination by the Professional Group. The selection will be made according to the assessment results and cases with different service needs in both residential and community support services will be selected, i.e. there will be cases assessed to be suitable for C&A/SD, HSPH, HSMH, HMMH and SHOS service, and there will also be cases with corresponding disability levels but assessed to be suitable for community support only. This would ensure a broad representation of service needs given the limited number of cases to be studied.

Meetings of the Professional Group

7. Upon selection of the cases, the Sub-Group will request the caseworkers concerned to seek consent from the prospective participants (the consent form is at Annex 2) and prepare for each case a case summary, the items of which are detailed in Annex 3. The target persons and their families will be assured that the decisions made by the Professional Group would not affect their existing application of rehabilitation services. The caseworker will then send to the Sub-Group the case summary together with a written consent signed by the target person or his/her family member.

8. The following materials will be provided by the Sub-Group to Members of the Professional Group before its meetings:

(a) Terms of reference of the Professional Group;
(b) A Guide for Members of the Professional Group; and
(c) Case profiles of the selected cases based on the case summaries.

9. The Group will elect one of the Members to be the Chairperson. In the meetings, Members will discuss the cases based on the case profiles provided and see whether it is possible to decide on the type of rehabilitation service suitable for each case. If necessary, interviews with or visits to these target persons and their families may be arranged by the Sub-Group as far as practicable, and the caseworkers and assessors concerned may also be invited to attend these interviews/visits. Information on the rehabilitation services available is detailed in Annex 4 and Annex 5 and the general principles in matching the case to the appropriate service delineated below should be followed.

10. In case no consensual view can be reached on a particular case, the decision of the simple majority will be followed. If a decision cannot be reached due to equal votes on each side, the chairperson will have the casting vote.

11. The discussion process and the decision made on each case will be recorded in the form of minutes of meeting. The minutes of meeting will be circulated to all Members before confirmation.

12. The case information and minutes of meeting should be handled in a confidential manner by the Professional Group. The Professional Group will be dissolved after all the selected cases are discussed and decisions for the cases are made in its meetings, and no follow-up work will be required.

Analyses on judgment made by the Professional Group

13. The minutes of meeting and other related materials will be made available to the Sub-Group for analyses. The results of these analyses will be included in the final report on Phase II Pilot Study of the Sub-Group.

General principles in service matching

14. The policy objectives of rehabilitation service is to provide PWD with necessary means which will enable them to live independently as full participating members of the community. As such, residential services are provided for those who cannot live independently and cannot be cared for adequately by their families. For those PWD who can live in the community with family support, day training and/or community support services, residential service is not recommended. For example, a mentally handicapped person with behavioural problem should receive therapy from clinical psychologist or treatment from psychiatrist, coupled with training programmes in a day centre, instead of having him/her placed in a residential home to solve the problem.

15. With regard to the identification of suitable service for the PWD, it should be noted that the case concerned should fall within the target group of the service, and the service so identified can meet the special needs of the case concerned without sacrificing the general welfare of the case. For example, if a moderately mentally handicapped person with need for residential service and insulin injection is matched to a Hostel for Severely Mentally Handicapped Persons (HSMH), the special need for injection can be met with the Hostel's nursing support, yet his general welfare is sacrificed since his ability is well beyond that for a HSMH. Instead, the case may be considered for a Hostel for Moderately Mentally Handicapped Persons (HMMH) with a condition that support from Community Nursing Service or local clinic(s) may be sought. A summary table on existing day training and community support services is in Annex 4 and information on major rehabilitation services for mentally/physically handicapped persons is detailed in Annex 5.

Sub-Group on Pilot Study
August 2004

Annex 1

Terms of Reference
For Professional Group of
Pilot Study on Standardized Assessment Tool for Residential Services for Persons with Mental/Physical Handicap

(a) To assess the cases selected for review by the Professional Group on their need for residential service; and

(b) To recommend for each case a suitable rehabilitation service from existing provision.

Sub-Group on Pilot Study
August 2004

Annex 2

社會福利署
弱智／肢體傷殘人士住宿服務評估預試研究
專業小組研究同意書

*本人 ______________________，為年滿十八歲的弱智／肢體傷殘人士，
*本人 ____________________，為 ____________________的家長／監護人，
經評估員解釋後，現同意接受有關「弱智人士及肢體傷殘人士住宿服務評估」預試研究的下列安排：

1. 受訪者及其家庭背景的資料（包括個案撮要、受訪者的心理報告及護理人員、物理治療師、職業治療師、醫生、精神科醫生或職業訓練中心所作的報告）會經個案社工轉往一個由本測試計劃成立的專業小組作出討論及分析；

2. 在有需要的情況下，專業小組亦會安排受訪者及家人作面談或家訪，以作更深入的研究；及

3. 整個評估測試過程會以保密形式進行。社會福利署不會向外界透露受訪者的個人資料，有關資料亦會於分析後銷 。

此預試研究的目的是用作確立《弱智／肢體傷殘人士住宿服務評估表》的效度，**研究結果將不會影響受訪者目前申請康復服務的情況**。

*年滿十八歲的受訪殘疾人士簽署：____________________

*家長／監護人簽署：____________________

日期：____________________

* 刪去不適用者

Annex 3

社會福利署

弱智／肢體傷殘人士住宿服務評估預試研究

專家小組研究

個案撮要

說明：

- 多謝你參與「社會福利署弱智／肢體傷殘人士住宿服務評估」預試研究專家小組研究。這個研究的目的是確立住宿服務評估工具的「效度」(validity)。
- 以下的個案撮要會交由一個由本預試計劃成立的專業小組作出討論及分析。在有需要的情況下，專業小組亦會安排受訪者及家人作面談或家訪，以作更深入的研究。
- 整個評估測試過程會以保密形式進行。社會福利署不會向外界透露受訪者的個人資料，有關資料亦會於分析後銷　。
- 請根據下列項目，運用當事人最新的資料提供一份個案撮要，字數不限。
- 此預試研究的目的是用作確立《弱智／肢體傷殘人士住宿服務評估表》的效度，**研究結果將不會影響當事人目前申請康復服務的情況**。

1. 申請人個人資料：

出生日期	
性別	
病症(病歷) / 弱能情況	
教育程度	

2. 家庭狀況

姓　名	關　係	年　齡	職　業	收　入 HK$	備　註

3. 現時困難 (Presenting Problems)
4. 健康狀況 (Health Condition)
5. 活動能力及 (Mobility and Hand Function)
6. 個人自理能力 (Self Care Ability)
7. 情緒行為問題 (Emotional and Behavioral Problems)
8. 家庭關係 (Family Relationship)
9. 家庭經濟狀況 (Family Financial Condition)
10. 家庭處理問題能力 (Family Coping Ability)
11. 曾接受的服務(Services Received)
12. 其他值得提及的情況 (Other Circumstances Worthy of Mentioning)

Annex 4

住宿服務以外的各類日間訓練及社區支援服務

服務名稱	護理服務	職業/日間訓練	日間照顧	職業/物理治療	心理/行為輔導	社交及支援	短期住宿	居所安排
社康護士服務	✓							
嚴重殘疾人士日間照顧服務	✓		✓			✓		
殘疾人士在職培訓計劃		✓						
輔助就業		✓						
庇護工場		✓						
綜合職業康復訓練中心		✓						
展能中心	✓	✓	✓	✓		✓		
家居訓練及支援服務		✓	✓	✓		✓		
家務指導服務		✓						
綜合家居照顧服務	✓		✓	✓				
日間暫顧服務			✓					
假期照顧服務			✓					
家居暫顧服務			✓					
延展照顧服務			✓					
家庭服務中心/綜合家庭服務中心					✓			
醫務社會服務					✓			
康復機構熱線輔導服務					✓			
社會福利署臨床心理服務					✓			
殘疾人士家長/親屬資源中心						✓		
殘疾人士社交及康樂中心						✓		
結伴行計劃			✓			✓	✓	
健樂會						✓		
弱智成人教育						✓		
輪椅維修服務						✓		
短暫住宿服務							✓	
緊急住宿服務							✓	
愛心連結計劃（家庭暫顧）			✓				✓	
體恤安置								✓

Sheltered Workshop

Abbreviation: SW

Introduction

SWs provide persons with mental and/or physical disabilities a working environment specially designed to accommodate the limitations arising from their disabilities, in which they can be trained to engage in income-generating work process, learn to adjust to normal work requirements, develop social skills and relationships and prepare for potential advancement to supported/ open employment where possible. It is a welfare-oriented service without an employer/employee relationship between the workshop operators and the trainees.

Purpose and objectives

The objective of a SW is to provide vocational rehabilitation service through:

- work opportunity in a planned environment;
- opportunities for work adjustment and advancement with the ultimate objective of enabling people with disabilities to move on to supported or open employment where possible; and
- training to people with disabilities to develop and maintain social and economic potential.

Nature of service

The services provided by a SW include:

(a) provision of income-generating work process;

(b) provision of training on work habits and skills and on-going assessment on progress;

(c) provision of work-related referrals and referrals for other appropriate services where required; and

(d) provision of activities to meet developmental and social needs.

Note

Most of the existing SWs are operating five days per week from 9 a.m. to 5 p.m. All the trainees are encouraged and expected to attend the workshop on time daily.

Target group

The target group is people with disabilities aged 15 and above with a need for sheltered work.

Eligibility criteria

To be eligible for a SW place, an applicant should be:

- capable of basic self-care (disabled persons requiring personal care but with bowel and bladder control could be admitted to sheltered workshops for persons with severe physical handicap);

- mentally and emotionally stable with no active infectious disease and severe disturbing behaviour; and
- demonstrate to have work motivation/ ability through an assessment prior to admission.

Staffing

Notional staffing for standard SWs with 100, 120 and 140-160 places respectively are:

	Capacity 100		Capacity 120		Capacity 140-160	
either	SSWA	1	SSWA	1	SSWA	1
	WI II	1	WI II	1	WI II	1
			SWA	1	SWA	1
or	WI I	1	WI I	1	WI I	1
	SWA	1	WI II	1	WI II	1
			SWA	1	SWA	1
Plus	WI III	5	WI III	6	WI III	7/8
	ACO	1	ACO	1	ACO	1
	CA	1	CA	1	CA	1
	MD	1	MD	1	MD	1
	WM II	3	WM II	4	WM II	4/5

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Supported Employment

Abbreviation: SE

Introduction

SE provides support to people with disabilities in employment. It allows them to work in an integrated open setting with necessary support service and to have access to the usual benefits of having a job such as income at market rates and job security. It is a welfare-oriented service without an employer/employee relationship between the service providers and the service users.

Purpose and objectives

The objectives of SE are:

- to serve as an avenue for upward mobility of people with disabilities in sheltered workshops and a necessary step towards integration for those people with disabilities who otherwise cannot take up open employment; and

- to prepare people with disabilities to work in an open and competitive setting independently.

Nature of service

The services provided by SE include:

(a) arrangement of job placement such as job analysis and job matching;

(b) provision of support services including employment related skills training, on-the-job coaching and supervision, job-related guidance and advice to the service users, their family members and the job providers; and

(c) the programme will allow flexibility to go with the changing needs of the labour market and economic structure to ensure that its supports to service users are matching with reality.

Target group

- people with moderate disablement with working abilities lying between sheltered workshop and open employment without support, i.e. the majority of people with moderate grade mental handicap and those with mild grade mental handicap coupled with other disabilities; and

- people with moderate disablement with good working abilities but who are unable to adjust to the competitive open job market in the absence of support, i.e. those people with severe physical, sensory, visceral or psychiatric disabilities.

Eligibility criteria

To be eligible for a SE place, an applicant should be:

- aged 15 and above;

- people with disabilities who are assessed to be capable of or likely capable of open employment if provided with special support programme;

- has adequate self-care and daily living skills; and
- has motivation to take up open employment.

Staffing

Notional staffing for a SE unit of 30 places is:

WI II	1
WI III	2

Service operators are given the flexibility in employing any suitable staff for the service.

Referral channel

Referrals can be made by medical social workers, family caseworkers, staff of rehabilitation units and school social workers to the Central Referral System for Rehabilitation Services. Referrers or applicants can also approach the operating units for direct application for the service

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5147

Integrated Vocational Training Centre

Abbreviation: IVTC

Introduction

IVTCs aim to provide people with disabilities a series of seamless one-stop vocational training and rehabilitation services including skills training and retraining, supported employment, job attachment etc. There are two IVTCs, namely, Caritas Lok Mo IVTC (previously known as Caritas Lok Mo Skills Centre) and Hong Chi Pinehill IVTC (previously known as Hong Chi Pinehill Advanced Training Centre), and both are under the subvention of the Social Welfare Department with effect from April 2003.

Nature of service

The services provided by an IVTC include:

(a) provision of training to develop vocational skills and work habits;

(b) arrangement of job analysis and job matching;

(c) provision of training on application of employment skills in real-work setting through job attachment;

(d) provision of retraining service for retaining and refreshing vocational skills;

(e) provision of work-related referrals and referrals for other appropriate services where required;

(f) provision of activities to meet developmental and social needs;

(g) provision of support services including specific employment related skills training, on-the-job coaching and supervision, job-related guidance and advice to trainees, their families and job providers; and

(h) provision of maintenance programmes of self-care skills;

(i) provision of opportunities and activities to develop self-care skills, daily living, social and communication skills;

(j) provision of opportunities and activities to meet social and recreational needs; and

(k) provision of residential service (for Hong Chi Pinehill IVTC only).

Target group

The target group is people with disabilities aged 15 and above with a need of vocational training and sheltered employment services.

Eligibility criteria

To be eligible for an IVTC place, an applicant should be:

- aged 15 and above;
- capable of self-care;
- mentally and emotionally stable with no active infectious disease and severe distributing behavious;

For Hong Chi Pinehill IVTC (residential service)

- enrolled to Hong Chi Pinehill Integrated Vocational Training Centre (day service); and
- physically and mentally suitable for group living.

Staffing:

Establishment for Caritas Lok Mo IVTC and Hong Chi Pinehill IVTC:

	Caritas Lok Mo Skills Centre	Hong Chi Pinehill Advanced Training Centre
Senior lecturer	1	1
Assistant lecturer	1	1
Certificated master	4	4
WI II	7	6
WI III	7	9
SSWA	1	3
SWA	1	1
SWW	0	2
WW	0	13
OT II	1	0
RN	1	1
ACO	1	1
CA	1	2
Artisan	1	1
WM II	4	5
P Att'd	0	1
Total	31	51

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services, Social Welfare Department. Referrers or applicants can also approach the operating units for direct application for supported employment.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Integrated Vocational Rehabilitation Services Centre

Abbreviation: IVRSC

Introduction

IVRSC provides people with disabilities a series of integrated and seamless vocational rehabilitation services in a training environment specially designed to accommodate the limitations arising from their disabilities, in which they can engage in income-generating work process, learn to adjust to normal work requirements, develop social skills and relationship and prepare for potential advancement to open employment. The service aims to enable people with disabilities to secure, retain and advance in suitable employment and thereby to further their integration into society. It is a welfare-oriented service without an employer - employee relationship between the service operator and trainees.

Nature of service

The services provided by an IVRSC may include:

(a) Centre-based training

Centre-based sub-contract jobs in the form of simple processing, finishing and assembly or sub-assembly work, desk-top publishing, and laundry service, etc.

(b) Non-centre-based training

Non-centre-based training in the form of outdoor contractual services such as car-washing, office cleaning, delivery services, retailing, and leaflet distribution, etc.

(c) Job finding, matching, coaching and follow-through support

Common operational modes of SE such as individual approach, including individual placement model and home-based employment model, group approach, including mobile crew, enclaved model, benchwork model and simulated business

(d) On the Job Training

On the job training includes job attachment, job trial and post-placement service, etc. Attachment allowance to trainees and wage subsidy to employer should be released in line with the programme design of the present SWD-funded On the Job Training Programme for People with Disabilities

(e) Retraining and other vocational training services

Activities such as retraining programmes to enable people with disabilities to secure, retain and advance in open employment and integration into society

(f) Support services

Vocational assessment, counseling, casework support, post-discharge services, family life education activities and other support and recreational activities to the trainees and their families

Target group

The target group is people with disabilities aged 15 and above with a need of sheltered work or in need of support to take up open employment.

Eligibility criteria

To be eligible for an IVRSC place, an applicant should be:

- aged 15 and above;
- having work motivation;
- capable of self-care; and
- mentally and emotionally stable with no active infectious disease and severe distributing behaviour.

Staffing

To be worked out by service operators in accordance with operational need. However, registered social worker(s) must be included in the staffing establishment.

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Supported Hostel

Abbreviation: SHOS

Introduction

SHOS provides group home living for people with disabilities who can only live semi-independently with a fair amount of assistance from hostel staff in daily activities.

Purpose and objectives

The objectives of a SHOS are:

- to provide residential care and facilities for semi-independent living;
- to enhance residents' independent living skills and facilitate their integration into the community; and
- to promote the quality of life of the residents and to maximize their potentials through the provision of a supportive and stimulating environment.

Nature of service

The services provided by a SHOS include:

(a) provision of accommodation, food and meals;

(b) provision of guidance/assistance to residents in performing some domestic tasks and daily activities;

(c) provision of opportunities and activities to develop independent living, social, communication and decision-making skills;

(d) provision of opportunities and activities to meet social and recreational needs; and

(e) provision of opportunities and activities to enable residents to maintain contact with the families and community.

Target group

The target group is people with disabilities aged 15 and above, with a need for accommodation for social reasons, who can manage semi-independent living.

Eligibility criteria

To be eligible for a SHOS place, an applicant should be:

- actively occupied in various forms of employment/day training;
- physically and mentally suitable for group living;
- physically healthy with no active infectious disease or drug/alcoholic abuse; and
- capable of semi-independent living i.e. mastery of self-care skills but may need a fair amount of guidance/assistance in some domestic tasks like cooking or washing or in community living activities like shopping.

Staffing:

Notional staffing for a standard SHOS with 20 places is:

SWA	1
WW	3
WA	1
Cook	1

Referral channel

Referrals can be made by medical social workers, school social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Hostel for Moderately Mentally Handicapped Persons

Abbreviation: HMMH

Introduction

HMMHs provide home living for persons with moderate mental handicap who are capable of basic self-care but lack adequate daily living skills to live independently in the community.

Purpose and objectives

The objectives of a HMMH are:

- to provide residential care and facilities;
- to promote the quality of life of the residents and to maximize their potentials through the provision of a caring and stimulating environment; and
- to maintain their health and capability and to provide care support to enable them to live as independently as possible in the community.

Nature of service

The services provided by a HMMH include:

(a) provision of accommodation and meals;

(b) provision of maintenance programmes of self-care skills;

(c) provision of opportunities and activities to develop daily living, social and communication skills;

(d) provision of opportunities and activities to meet social and recreational needs; and

(a) provision of opportunities and activities to enable residents to maintain contact with the community and families.

Target group

The target group is moderately mentally handicapped persons aged 15 and above.

Eligibility criteria

To be eligible for a HMMH place, an applicant should be:

- actively occupied in or being arranged for admission to a day placement; and
- physically and mentally suitable for group living, such as physically healthy with no active infectious diseases.

Staffing

Notional staffing for a standard HMMH with 50 places is:

SSWA	1	WM II	1
SWA	1	CA	1
WW	3	Cook	2
WA	6		

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Day Activity Centre

Abbreviation: DAC

Introduction

DACs provide day care and training in daily living skills and simple work skills to mentally handicapped persons who are unable to benefit from vocational training or sheltered employment.

Purpose and objectives

The purpose of a DAC is to provide day activities to the trainees, to train them to become more independent in their daily lives, and to prepare them for better integration into the community or for transition to other forms of service or care where appropriate.

The objectives of a DAC are:

- to train the traniees to acquire skills in the areas of basic self-care, social and simple work skills;
- to meet the physical, social and emotional needs of the traniees through the provision of day care and meaningful activities;
- to enable the traniees to become more independent in their daily living and social functioning so as to enable them to live as independently as possible; and
- to prepare the traniees for transition to other forms of service or care, including progression to sheltered employment where feasible, or to alternative care when increased care is necessary.

Nature of service

The services provided by a DAC include:

(a) assessment, on an initial and regular basis, to identify the degree of disability and capability of individuals;

(b) development of individual plans and training programmes to address the needs of individuals;

(c) training programmes, conducted on an individual or group basis in the areas of motor skills, self-help skills, communication skills, domestic skills, community living skills, simple work skills, social and interpersonal skills, leisure and recreation skills;

(d) social and recreational activities, including participation in community events and activities;

(e) caring activities, including:

- provision of nursing and personal care
- arranging of mid-day meals
- transporting or escorting of individuals to and from the centre, where a need exists and depending on the resources available

(f) supportive services, such as physiotherapy, occupational therapy and clinical psychology, through either the service operator or through the SWD central pool.

Centres may also provide additional services to the core services listed above, where identified or assessed as appropriate by the service operator in meeting the needs of individual the trainee.

Target group

The target group is severely mentally handicapped persons aged 15 and above.

Eligibility criteria

To be eligible for a DAC place, an applicant should be:

- mentally handicapped;
- not bed-ridden nor requiring infirmary care;
- without severe aggressive behaviour endangering self and others; and
- without infectious disease.

Staffing

Notional staffing for a standard DAC with 50 places is:

SSWA	1	CA	1
SWA	2	WA	5
WW	5	MD	1
EN	1	(for single DAC only)	

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5157

Hostel for Severely Mentally Handicapped Persons

Abbreviation: HSMH

Introduction

HSMHs provide home living for persons with severe mental handicap who lack basic self-care skills and require assistance in personal and nursing care.

Purpose and objectives

The objectives of a HSMH are:

- to provide residential care and facilities;
- to promote the quality of life of the residents and to maximize their potentials through the provision of a caring and stimulating environment; and
- to maintain their health and to assist them in their varying personal care needs and daily living activities.

Nature of service

The services provided by a HSMH include:

(a) provision of accommodation and meals;

(b) provision of nursing services including administration and supervision of medication;

(c) provision of personal assistance in basic self-care activities;

(d) provision of opportunities and activities to develop daily living, social and communication skills; and

(e) provision of activities organized on a regular basis to meet the social and recreational needs of the residents and to maintain contact with the community and families.

Target group

The target group is severely mentally handicapped persons aged 15 and above.

Eligibility criteria

To be eligible for a HSMH place, an applicant should be:

- actively occupied in or being arranged for admission to receive day service in a Day Activity Centre;

- physically and mentally suitable for group living; and
- without infectious disease.

Staffing

Notional staffing for a standard HSMH with 50 places is:

CSWA/SSWA	1	EN	3
SWA	3	WA	7
WW	9	ACO	1
RN	1	Cook	2
		WM II	2

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No: 2892 5157

Hostel for Severely Physically Handicapped Persons

Abbreviation: HSPH

Introduction

HSPHs provide home living for persons with severe physical disabilities with or without mental handicap who lack basic self-care skills and require assistance in personal and nursing care.

Purpose and objectives

The objectives of a HSPH are:

- to provide residential care and facilities ;
- to promote the quality of life of the residents and to maximise their potentials through the provision of a caring and stimulating environment; and
- to maintain their health and capability and to assist them in their varying personal care needs and daily living activities.

Nature of service

The services provided by a HSPH include:

(a) provision of accommodation and meals;

(b) provision of personal assistance in self-care activities;

(c) provision of nursing services including administration and supervision of medication;

(d) provision of opportunities and activities to develop daily living, social and communication skills; and

(e) provision of activities organised on a regular basis to meet the social and recreational needs of the residents and to maintain contact with the community and families.

Target group

The target group is severely physically handicapped persons aged 15 and above.

Eligibility criteria

To be eligible for a HSPH place, an applicant should be:

- actively occupied in or being arranged for admission to a day placement usually in a sheltered workshop;
- mentally and emotionally stable with no active infectious disease and severe disturbing behaviour; and
- capable of bowel and bladder control.

Staffing

Notional staffing for a standard HSPH with 50 places is :

CSWA/SSWA	1	EN	3
SWA	1	CA	1
WW	5½	MD	1
PCW	12½	Cook	2
RN	1	WM II	7

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5135

Hostel for Severely Physically Handicapped Persons with Mental Handicap

Abbreviation: HSPH/MH

Introduction

HSPH/MHs provide home living for severely physically handicapped persons with mental handicap who lack basic self-care skills and require more assistance in personal and nursing care due to their multiple handicaps but are capable of receiving training in a day activity centre.

Purpose and objectives

The objectives of a HSPH/MH are:

- to provide residential care and facilities ;
- to promote the quality of life of the residents and to maximise their potentials through the provision of a caring and stimulating environment; and
- to meet their health care need and to assist them in their varying personal care needs and daily living activities.

Nature of service

The services provided by a HSPH/MH include:

(a) provision of accommodation and meals;

(b) provision of personal assistance in self-care activities;

(c) provision of nursing services including administration and supervision of medication;

(d) provision of opportunities and activities to develop daily living, social and communication skills and to maintain the motor functioning; and

(e) provision of activities organised on a regular basis to meet the social and recreational needs of the residents and to maintain contact with the community and families.

Target group

The target group is severely physically handicapped persons with mental handicap aged 15 and above.

Eligibility criteria

To be eligible for a HSPH/MH place, an applicant should be:

- actively occupied in or being arranged for admission to receive day service in a Day Activity Centre;
- no active infectious disease; and
- no severe disturbing behaviour.

Staffing

Notional staffing for a standard HSPH/MH with 50 places is:

CSWA/SSWA	1	EN	3
SWA	1	CA	1
WW	5½	MD	1
PCW	12½	Cook	2
RN	1	WM II	7

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5157

Care & Attention Home for Severely Disabled Persons

Abbreviation: C&A/SD

Introduction

C&A/SDs provide home living for persons with severe mental/physical disability who are unlikely to benefit from regular day training placement. They are in need of nursing and intensive personal care but do not yet require infirmary care.

Purpose and objectives

The objectives of a C&A/SD are:

- to provide residential care and facilities;
- to promote the quality of life of the residents through a caring and stimulating environment; and
- to help them maintain their health and to assist them in routine personal care tasks and daily living activities.

Nature of service

The services provided by a C&A/SD include:

(a) provision of accommodation and meals;

(b) provision of nursing care and intensive personal care including assistance with activities of daily living;

(c) provision of therapeutic exercise and treatment to maintain or improve the functioning of the residents;

(d) provision of maintenance programmes on basic living skills; and

(e) provision of regular activities to meet their social and recreational needs, and to enable them to maintain contact with their families and the community.

Target group

The target group is severely mentally handicapped/severely physically handicapped persons aged 15 and above.

Eligibility criteria

To be eligible for a place in C&A/SD, an applicant should be:

- unfit for day training placement;
- in need of intensive personal care, such as assistance in dressing, toileting and meals; and
- not being bed-ridden or requiring substantial medical/nursing care.

Staffing

Notional staffing for a standard C&A/SD with 50 places is:

CSWA/SSWA	1	OT I	1
SWA	1	OTA	1
WW	2	WA	4
PCW	10	ACO	1
RN	1	MD	1
EN	6	Cook	2
PT I	1		

Referral channel

Referrals can be made by school social workers, medical social workers, family caseworkers and staff of rehabilitation service units to the Central Referral System for Rehabilitation Services.

Enquiries

Rehabilitation and Medical Social Services Branch
Social Welfare Department
Tel. No.: 2892 5157