



香港家庭福利會  
Hong Kong Family Welfare Society



香港大學秀圃老年研究中心  
Sau Po Centre on Ageing  
The University of Hong Kong

# Report on Study on Enhancement of Integrated Home Care Service



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*Ms. Amarantha Yip*  
*Executive Director, Hong Kong Family Welfare Society*

## Preface

Most elderly people want to stay in their home and community as they age. Although ageing-in-place has been a policy direction for elderly care in Hong Kong for decades, a considerable proportion of older people are still institutionalized when they become frail. The institutionalization rate in Hong Kong in 2009 is 6.8% of all elderly people aged 65 years or over. The rate is much higher than that in other developed countries, despite the fact that the socio-environmental conditions in Hong Kong including the cultural value of filial piety, instrumental support from a large number of domestic helpers, and co-residence with adult children are presumed to promote ageing-in-place.

We can reduce our dependency on nursing home by increasing the availability of community support services and encouraging older people to maintain healthy lifestyle habits such as regular exercise. Many people believe that if exercise were a prescription drug, it would be the most prescribed medicine in human history. Although many elderly people report that they do exercise regularly, most do not meet the frequency and intensity up to the recommendation by the Leisure and Cultural Services Department, which suggests participation in physical activity of moderate-or-above intensity for an accumulation of at least 30 minutes a day on 3 days a week. Furthermore, most do not do the right kind of exercises, i.e. exercises that enhance their endurance, strength, balance and flexibility.

The Hong Kong Family Welfare Society (HKFWS) has a vision of helping elderly people ageing in place by introducing the Happy n' Healthy Program (Hn'H), integrating exercise program with psychosocial intervention, in their home care service. We are honored to be invited as a partner to assist in developing the exercise protocol and to evaluate its effectiveness. The Hn'H day care program was implemented as an exercise and lifestyle modification program for older people using their Integrated Home Care Services (Ordinary Case).

This report summarizes the impacts of the Hn'H day care program. We are glad to report that the program has achieved its objectives. The results showed that elderly participants increased their exercise frequency and intensity and experienced health benefits that improved their quality of life and physical functioning.

The Hn'H is just a beginning. We are looking forward to having a long term partnership with the HKFWS to promote exercise and active lifestyle among elderly people. It is never too late to start exercising: everyone at all ages can do the right exercise at the right intensity.

*Professor Terry Y.S. Lum*

*Henry G. Leong Professor of Social Work and Social Administration, The University of Hong Kong  
Head, Department of Social Work and Social Administration, The University of Hong Kong  
Associate Director, Sau Po Centre on Ageing, The University of Hong Kong*



# 1. Background of Study

Report on Study on Enhancement of Integrated Home Care Service



# 1. Background of Study

Integrated Home Care Services (IHCS)<sup>1</sup> is an integral part of the long-term care system for older adults in Hong Kong. By providing enhanced care, support and rehabilitation services for frail elders, it aims to enable them to continue living in the community. The IHCS was developed from the re-engineering exercise of the Home Help (HH) service in 2003 through (a) upgrading, i.e. to serve cases suffering from moderate to severe levels of impairment or disability (frail cases, IHCS-FC); and (b) in-situ expansion, i.e. to serve cases from no to mild levels of impairment or disability (ordinary cases, IHCS-OC). For ordinary cases, the scope and content of services mainly include escort, personal care and simple nursing care, general household or domestic duties as well as provision of meals and laundry services. Currently, there are 60 district-based IHCS units throughout Hong Kong to deliver home-based services to the people in need, serving more than 27,000 cases with different levels of frailty.

The Hong Kong Family Welfare Society (HKFWS) is one of the largest IHCS service providers in Hong Kong. According to its internal data collected in 2011, 74.1% of its IHCS-OC users were 75 years or older, and 29% were 85 years or older. Although they were not assessed as suffering from moderate or severe level of impairment, they were depending on various home care services to sustain their living in the community. As this group of pre-frail elders will likely become more frail and will grow in size in coming years, the HKFWS enhances its IHCS by adding a pilot day care component to their home care service. The program aims to enhance participants' physical and psychological health through a center-based health-promoting and psycho-social care intervention. It includes both group physical exercises and social activities led by therapists, social workers and supportive staff. IHCS-OC users are invited to participate in this program. Through regular participation, it is expected that their physical functioning, physical health, and psychological well-being will improve. In October 2012, the HKFWS has secured funding from the Lee Hysan Foundation to support the day care program under the Happy n' Healthy Program (Hn'H) for two and a half years. The Hn'H therefore, supplements the home-based IHCS by strengthening the center-based care of physio-psycho-social health. This enhanced mode of IHCS further empowers older adults to age in place.

<sup>1</sup> Integrated Home Care Services (IHCS) provides a range of community support services to the elderly people, people with disabilities and needy families living in the community. In this report, however, only its services for elderly people are covered.

However, due to the absence of an evidence-based protocol and systematic evaluation of the program, the effectiveness of the Hn'H day care program was unknown. In 2013, the Sau Po Centre on Ageing (COA) at The University of Hong Kong was commissioned by the HKFWS to conduct an evaluation study of the Hn'H day care program. Specifically, this evaluation study involved (a) a review of the day care service content and users' profile; (b) an enhancement of the Hn'H day care program by adding a new evidence-based exercise protocol for frail elders; and (c) an effectiveness evaluation of the enhanced Hn'H day care program. The enhancement was expected to help improve the quality of life of pre-frail elders using the IHCS and prevent pre-mature reliance on long term care services. The evaluation findings would develop evidence base of the Hn'H day care intervention and would help the HKFWS to advocate for a new model of exercise and life style modification program to promote ageing in place.





## 2. Review of Current Happy n' Healthy Day Care Program .....

HKFWS has 15 IHCS service units and altogether they serve nearly 3,000 clients in Hong Kong. This number accounts for about 10% of the total IHCS users in Hong Kong. Ten of the 15 IHCS service units had implemented the day care program on a regular basis. To gather information to inform possible enhancement of the day care program, we conducted site visits and content review to better understand its content and delivery model. Subsequently we conducted focus groups with day care program participants and staff to collect their views on the program.

Our research team visited 4 day care programs between June and November of 2013. These programs were provided in IHCS units across the urban areas and outlying islands. The program content and operation were different in different geographical locations and there was no standardized protocol on how the program should be implemented.

Apart from performing site visits, we sent a data collection form to IHCS units to collect data on the detailed content of their day care programs. The day care program mainly consisted of physical exercises and social activities. All service units offered group exercises covering basic training of upper body muscle and lower body muscle. Depending on the availability of space and manpower, training sessions of cardiopulmonary, dynamic balance, fine motor and flexibility were selectively offered. As for social activities, most of the service units had activities for socialization after the exercise sessions. Besides, half of the units also provided cognitive training for participants.

In October 2013, we conducted two service-users focus groups and two staff focus groups to collect their views on the day care program. The staff focus groups included staff of various backgrounds (social worker, physiotherapist, community worker, personal care worker). A total of 18 service users and 12 staff participated in the focus groups.



### 3. Enhancement of Happy n' Healthy Day Care Program.....

#### ***3.1 Formulation of Program***

Based on the findings from our site visits, content review and focus groups, and after taking into account the space and manpower limitations as well as participants' and staff's expectations, we proposed an enhanced Hn'H day care program that added a home-based exercise component to the current center-based model with the support of volunteers. In the enhanced model, participants are encouraged to do exercises individually at home under the guidance of volunteers. This revision was driven by the aim of preserving the key features of the day care program, including both group physical exercises and social activities, while modifying the content and mode of delivery to minimize operation costs and maximize benefits.

The enhanced model addressed three key challenges in the original model of center-based program. First, the intensity was not enough to maximize the health benefits of participants. To benefit from exercises, elderly people need to do exercise more frequently, more than once a week or once every two weeks under the current center-based model. We believed that this could be achieved by introducing a home-based exercise component to supplement the center-based component in the Hn'H program. A combined center-based and home-based exercise model increased the frequency of exercise while not adding extra burden to space. Elderly people would more likely be able to form a new habit of regular exercise after they experienced the benefits of exercise and their body adjusted to the exercise routine.

Second, there was not enough staff to support older people to increase the frequency of exercise. Older people needed support from staff to follow the exercise routine and to develop their exercise habit, but, at the same time, there was a shortage of staff to supervise and support them. We suggested using trained volunteers, instead of paid staff, to supervise and support them in the exercise component of the day care program. The use of volunteers reduced dependency on paid staff and contributed to program sustainability. As discussed in focus groups, many centers have difficulty in hiring PTs and OTs to design exercise routine and to lead group exercise sessions. The labor shortage is not going to improve in the near future. Therefore, we suggested finding an alternative source of labor to provide the needed supervision and support to participants in the exercise program. We believed that using trained volunteers would be a viable option. Although volunteers were not intended to replace PTs or OTs in designing exercise protocol, with proper training, they could implement those protocols in group exercise in center as well as individual exercise at participants' home.

Third, the exercise routine was individualized for each participant, making the implementation and supervision of group exercise challenging as each participant in the group was following his or her own exercise routine. Also, as discussed above, there were not enough PTs or OTs to design individualized exercise routines for all participants. We suggested using a standardized set of exercise routines for all participants. To differentiate exercise from rehabilitation, we suggested finding an exercise specialist to design those exercise routines, allowing PT/OT to focus their work on rehabilitation.

### ***3.2 Review of Literature on Elderly Exercise***

A substantial body of scientific evidence supports that regular physical activity can bring dramatic health benefits to people of all ages and abilities, and these benefits extend throughout the life course. According to the American College of Sports Medicine (ACSM), older persons are recommended to do moderate exercises three to five times per week for at least 30 minutes each time, in which the training of endurance, strength, balance and flexibility should be covered (Hughes, Seymour, Campbell, Whitelaw, & Bazzarre, 2009; Pollock et al., 1998). Some of the benefits associated with regular exercise include reduction of the risks for coronary heart disease, hypertension, obesity, diabetes, osteoporosis, and mental health disorders (Caspersen, Kriska, & Dearwater, 1994; Elward & Larson, 1992; Pate et al., 1995; Simonsick et al., 1993). With regular exercise, older people may be able to live a higher quality of life and may extend their years of active and independent living.

We believed that the exercise program could also be extended to other frail elders. Between 2015 and 2016, it is estimated that 27,193 and 9,100 people will receive Integrated Home Care Service (IHCS) and Enhanced Home and Community Care Service (EHCCS) respectively and a majority of them are elderly people (figures from Head 170, the budget of year 2015-2016). These service users usually have different levels of dependency in daily living and some of them may have difficulties in going out. Worse still, a proportion of older adults who receive IHCS and EHCCS are “homebound” – which is defined as never or almost never leaving one’s home except for emergencies, not going beyond one’s door without assistance, or going out of one’s home less than once a month. The prevalence rate of being homebound is as high as 50% among people over the age of 85 years. They are more likely living alone and have mobility limitations, incontinence, and a high risk of fall, and fear of falling (Gilbert, Branch, & Orav, 1992). Although these frail elders may not be able to participate in traditional center-based exercise program, they may still benefit from exercise. We believed that they can benefit from a home-based exercise program that increases their strength.

Home-based exercise has recently been described as a means of “pre-rehabilitation” for physically frail and community-living older adults. In general, some often-adopted home-based exercise protocol and programs include the Seattle Protocol (SP), Well-rounded Exercise Program (WREP), Home Support Exercise Program (HSEP) and Strong-For-Life Program (SFLP). These protocols and programs have different characteristics but apply similar principles in the design of exercises and the mode of delivery, with the goal of promoting adherence to physical activities among dependent older adults and “homebound” frail seniors. To increase the likelihood of doing exercises, the in-home exercises are designed to be simple and assessable with no special equipment other than readily available tools such as elastic resistance band and furniture or equipment that can be found in most homes. These exercises address multiple areas of functioning, particularly mobility, balance, ability to transfer and strength; and are progressive in terms of increased time, number of repetitions, or difficulty so as to enhance the effect of doing physical exercises. As for the mode of delivery, since most dependent elders and “homebound” older persons receive home-support services such as home-delivered meals and respite care, the home-based exercises program takes advantage of front-line personal care workers (PCWs) to deliver in-home exercise programs. Prior research has shown that, together with the supervision of PCWs and continued self-report of exercise progress; older adults can gradually develop the habit of doing exercises regularly (Teri et al., 2011). In addition, significant positive changes in older adults’ functional fitness and psychological well-being as a result of doing home-based exercises have been reported (Jette, Harris, Sleeper, & Lachman, 1996; Johnson, Myers, Scholey, Cyarto, & Ecclestone, 2003; Teri et al., 2011; Yamauchi et al., 2005).

### ***3.3 Design of Exercises***

Using the existing center-based exercise protocol and programs as a template, the enhanced Hn’H Program added a new in-home exercise component into the existing model. Specifically, the enhanced model adopted the mixed model of home-based and center-based exercises.

#### ***3.3.1 Population Assessment***

In order to develop a set of exercises that could bring the greatest benefits to the elders, we conducted a population assessment to identify the major weaknesses in physical functioning among participants of the day care program. Senior Fitness Test (SFT) was used for this assessment. The SFT is a reliable test battery for examining the physical fitness of adults aged 60 years and older. It is a simple method of assessing the physical attributes that older adults needed to perform daily activities. It consists of six test items, including arm curl test, 30-second chair stand test, back scratch test, chair sit and reach test, 8-foot up and go test, and 2-minute step in place—covering lower- and upper-body strength, lower-

and upper-body flexibility, agility and balance, and aerobic endurance—that can be done with minimal space, equipment, and technical requirements. These tests can assist health practitioners and rehabilitation specialists in identifying weaknesses that cause mobility problems, developing exercise programs that improve functional fitness, prevent future mobility issues, and evaluate progress.

A total of 35 current participants of the day care program attended the SFT. The result was analyzed by a Clinical Exercise Specialist. Compared with the U.S. normative data of males and females aged from 60 years to 94 years, it was found that more than half of the participants scored below the average in all test items except the chair sit and reach test (Table 1). In particular, results of the 8-foot up and go test revealed significant weaknesses in agility and balance.

**Table 1. Results of SFT in Population Assessment**

Test Item	Area of Body Assessed	Gender	Number of People		
			Below Average	Average	Above Average
Arm Curl Test	Upper Body Strength	Male	10	2	1
		Female	16	6	0
30-second Chair Stand Test	Lower Body Strength	Male	9	4	0
		Female	13	7	1
Back Scratch Test	Upper Body Flexibility	Male	6	3	3
		Female	16	5	1
Chair Sit and Reach Test	Lower Body Flexibility	Male	7	3	2
		Female	5	16	1
8-foot Up and Go Test	Agility and Balance	Male	12	1	0
		Female	21	1	0
2-minute Step In Place Test	Aerobic Endurance	Male	11	2	0
		Female	13	6	2

### ***3.3.2 Development of Exercise Protocol***

Based on the findings of the SFT, we decided to focus on improving the agility and balance of the participants. We developed a set of comprehensive exercises that trains the whole body, but with specific focus on strengthening the lower body. The goal was to enhance elderly people's functional ability to deal with their daily living tasks through strengthening muscles, improving balance and promoting flexibility. The set of exercises comprised of (1) warm up exercises, (2) main exercises and (3) cool down exercises, which altogether included 16 training items. These items aimed to exercise the neck, shoulder, trunk, hips, knees and ankles respectively. Specifically, seven out of the 16 training items were designed to train the lower body. They concentrated on strengthening as well as stretching muscles of the hips, thighs and legs so as to improve the balance and extend the range of motion. By improving balance and extending the range of motion of their legs, older adults would have lower risk of falling and be able to better handle the activities of daily living that heavily relied on the lower limbs (such as taking stairs and transfer to toilet). Given that chairs were readily available in most homes, we designed the exercises using chairs as the assisted equipment, supplemented by resistance band and a ball. The photos below show some of the exercises.



Using the ACSM guideline as reference, we increased the frequency of the exercise program to three times per week and 30 minutes each time. Our Clinical Exercise Specialist advised that this pattern of exercises should last for at least three months to provide sufficient time for the positive effects of exercise to emerge. The venues were the HKFWS service units and elderly people's own home. At the early stage of the program, the elders attended center-based group exercises session and volunteers conducted regular home visits to supervise them individually at home. In the middle of the program, both the frequency of center-based exercises and volunteer home visits decreased gradually, but volunteer made phone calls to remind elders to exercise at home. Table 2 illustrates the schedule of program. An exercise manual with pictures was distributed to the elders so that they could follow the exercise routine at home. Also, a record book was given to them to keep track of their progress in doing in-home exercises.

**Table 2. Schedule of Program**

Timeframe	Center-based Sessions	Home-based Exercises			
		Volunteer's Home Visit		Volunteer's Phone Call	
1st week	✓	✓	✓		
2nd week	✓	✓	✓		
3rd week	✓	✓	✓		
4th week	✓	✓		✓	
5th week	✓	✓		✓	
6th week	✓	✓		✓	
7th week	✓			✓	✓
8th week	✓			✓	✓
9th week	✓			✓	✓
10th week				✓	
11th week				✓	
12th week				✓	
13rd week	✓			✓	

“✓” represents one contact



### **3.3.2.1 Center-based Group Exercises**

The enhanced center-based group exercise was led by trained social workers, instead of PTs. Before exercise, the PCWs checked the elders' vital signs to ensure their physical condition was suitable for attending the exercise session. The whole set of exercises lasted for about 30 to 45 minutes. To motivate elders to continue doing exercises, award would be presented periodically as a compliment to those who achieve satisfactory records of both attending center-based and doing home-based exercises.

### **3.3.2.2 Home-based Individual Exercises**

For the home-based exercise component, volunteers visited the elders in their homes to supervise their exercise using the manual. Furthermore, volunteers also called them to remind and encourage them to exercises regularly at home.

## ***3.4 Design of Social Activities***

Apart from doing exercises, in light of the importance of the social element as found in the focus groups, a series of social activities for the elders were organized after every center-based exercise session. Social workers of the HKFWS developed an activity manual for the 10 center-based sessions.

Each session started with vital sign checking to ensure the participants' physical condition was fit for doing exercise. Social worker introduced and re-stated the benefits of regular exercise and elders were given a chance to share their experience of in-home exercise. The sharing was used to develop a sense of belonging among participants and to build peer support which, together with award presentation to their effort in exercise, motivated and reinforced their commitment to exercise. The group then proceeded to social activities. These social activities aimed to enhance the participants' knowledge and skills in building healthy life style to promote positive ageing. It included sharing of childhood memories, introduction of healthy diet and lifestyle, sharing of ageing challenges, management of emotion, developing hobbies, improving sleeping quality and memory skills etc.. Through sharing of their personal lives, elders were able to get to know each other better and develop supportive relationship among them. Besides, elders were encouraged to take an active role in the group sharing. They could build confidence and skills through exchanging experience and wisdom on the topics. For instance, when sharing childhood memories, elders were invited to prepare a traditional snack that they enjoyed the most as a child and shared with other participants in that session. As for the health education, social worker educated elders about healthy lifestyle such as introducing the food pyramid and

teaching diaphragmatic breathing. The health education, together with the practice of exercise protocol, have made the enhanced Hn'H day care Program a health-promoting intervention through increasing the awareness of exercises and changing to a more healthy and active lifestyle.

### ***3.5 Training of Staff and Volunteers***

To equip social workers with the exercise protocol, the HKU team provided a one-day training, led by Clinical Exercise Specialist, to help them familiarize with the exercise protocol. In the workshop, the Clinical Exercise Specialist explained in details the purpose of training items, demonstrated the correct posture of each exercise, and taught effective coaching skills. Based on the manual for group sessions and volunteer management, social workers and community workers were also trained for delivering the new program as well as volunteer management regarding the rationale of the program, the topics on healthy life style and skills in coordinating and supporting volunteers.

We also organized a one day workshop, led by social workers, for volunteers who would be responsible for leading the in-home exercises. The training also included skills to effectively communicate with elderly people and how to handle emergencies. As the program involved a large amount of volunteers from various organizations who played a significant role in motivating and supervising the elders to exercise regularly at home, considerable staff effort was allocated for coordination, offering support and monitoring to volunteers to ensure smooth operation.

### ***3.6 Pilot Study***

Between May and August of 2014, we conducted a 3-month pilot study to test the implementation of the enhanced Hn'H day care program. The pilot was conducted in one center with 7 participants. All of them were women and their ages ranged between 66 years and 85 years, with a mean age of 79.1 years. We used SFT and MOS 36-item Short-Form Health Survey (SF-36) to measure change of physical fitness and psychological well-being every month. We found significant improvements in these outcomes after the program. Subsequently, focus groups were conducted with the participants, staff and volunteers separately to obtain their comments and suggestions for the enhanced program. Positive feedbacks were received.



## 4. Evaluation of Enhanced Happy n' Healthy Day Care Program.....

We enhanced the Hn'H day care program based on these findings and the revised version of the new program was implemented in 7 IHCS service units from October 2014 to March 2015 and another 2 units were recruited as the control group to test the effectiveness of the program.

### 4.1 Profile of Participants

#### 4.1.1 Number of Participants

There were 75 participants in the control group and 58 participants in the experimental group at baseline. After a 3-month period, 62 participants remained in the control group and 51 participants in the experimental group. For the experimental group 42 participants attended the one month follow-up assessment. Table 3 shows the number of participants and response rate at each stage.

**Table 3. Number of Participants and Response Rate**

	Control		Experimental	
	N	Response rate (%)	N	Response rate (%)
Baseline (M0)	75	/	58	/
1st month (M1)	/	/	55	94.8
2nd month (M2)	/	/	53	96.4
3rd month (M3)	62	82.7%	51	96.2
Follow-up (M4)	/	/	42	82.4

### 4.1.2 Gender of Participants

Among the participants who completed both baseline and 3rd month assessments, the ratio of male to female in both groups was almost the same and the ratio was 3:7. Table 4 shows the gender distribution of the participants.

**Table 4. Gender Distribution of the Participants**

Gender	Control		Experimental	
	N	%	N	%
Male	17	27.4	15	29.4
Female	45	72.6	36	70.6
Total	62	100.0	51	100.0

### 4.1.3 Age of Participants

Age range of the control group was between 69 and 105 years and the mean age was 82.0 years (s.d.=6.5). For the experimental group, the age range was between 63 and 93 years and the mean age was 81.4 years (s.d.=7.2). Age distribution of the two groups is shown in Table 5. There was no significant age difference between two groups.

**Table 5. Age Distribution of the Participants**

Age group	Control		Experimental	
	N	%	N	%
60 – 69	2	3.2	3	5.9
70 – 79	17	27.4	17	33.3
80 – 89	36	58.1	22	43.1
90 or above	7	11.3	9	17.6
Total	62	100.0	51	100.0

#### ***4.1.4 Frailty***

In order to match the frailty levels of the participants in the two groups, the FRAIL test was used for screening. At baseline, 31 participants in the control group and 32 participants in the experimental group took the FRAIL test. Results revealed no significant difference in their levels of frailty. Table 6 shows the frailty levels of the participants. Majority of the participants in both groups were at the pre-frail level.

***Table 6. Frailty Level of the Participants***

Frailty Level	Control		Experimental	
	N	%	N	%
Robust	4	12.9	8	25.0
Pre-frail	25	80.6	21	65.6
Frail	2	6.5	3	9.4
Total	31	100.0	32	100.0

#### ***4.2 Physical and Psychosocial Status***

Both the control group and experimental group were given the Abbreviated Mental Test (AMT) for assessing cognitive functioning, SFT for physical functioning and SF-36 test for psychosocial status.

In the baseline assessment, there were no significant differences between control group and experimental group in their AMT scores, all test items of SFT and all domains of SF-36. After the 3-month intervention, compared with the control group, the experimental group showed better performance in arm curl test, sit and reach test in both sides (right and left), and the up and go test (Table 7a & 7b). For the SF-36, after 3-month intervention, the experimental group reported higher ratings in the following domains: Physical Role Functioning, General Health Perception, Social Role Functioning, Emotional Role Functioning and Mental Health. Since the program design did not focus on cognitive training, there was no significant difference in AMT score between the experimental group and control group after the intervention (Table 8a & 8b).

**Table 7a. Baseline Measures in Cognitive and Fitness Tests**

	Group	N	Minimum	Maximum	Mean	Std. Deviation
<b>A. Cognitive Test</b>						
AMT	Control	61	4	10	8.8	1.5
	Experimental	49	5	10	8.8	1.4
<b>B. Senior Fitness Test</b>						
Step in place test (steps)	Control	61	0.0	152.0	62.1	34.2
	Experimental	48	4.0	101.0	53.9	23.7
Arm curl test (times)	Control	62	0.0	22.0	11.0	4.3
	Experimental	51	0.0	21.0	11.2	4.8
Chair stand test result (times)	Control	61	0.0	16.0	8.8	3.0
	Experimental	51	3.0	17.0	9.0	3.3
Sit and reach test right (cm)	Control	60	-45.0	25.0	-8.1	12.1
	Experimental	50	-44.0	16.0	-7.1	11.6
Sit and reach test left (cm)	Control	60	-44.0	15.0	-7.8	11.6
	Experimental	49	-44.0	6.0	-8.4	12.0
Back scratch test right (cm)	Control	61	-60.0	18.0	-10.8	14.0
	Experimental	51	-42.0	19.0	-9.7	12.1
Back scratch test left (cm)	Control	61	-50.0	8.0	-14.9	11.6
	Experimental	50	-44.0	9.0	-13.8	11.4
Up and go test (sec)	Control	62	6.9	61.0	15.4	9.1
	Experimental	50	8.5	33.0	14.6	5.5

**Table 7b. Three-month Measures in Cognitive and Fitness Tests**

	Group	N	Minimum	Maximum	Mean	Std. Deviation
<b>A. Cognitive Test</b>						
AMT	Control	61	5	10	9.0	1.3
	Experimental	49	4	10	8.8	1.4
<b>B. Senior Fitness Test</b>						
Step in place test (steps)	Control	61	0.0	160.0	66.2	30.1
	Experimental	48	18.0	161.0	72.3	30.2
Arm curl test (times) ***	Control	62	0.0	21.0	11.7	4.5
	Experimental	51	6.0	30.0	15.3	5.9
Chair stand test result (times)	Control	61	3.0	16.0	8.8	3.1
	Experimental	51	0.0	21.0	10.1	4.2
Sit and reach test right (cm) ***	Control	60	-30.0	13.0	-6.4	9.1
	Experimental	50	-21.0	20.0	-0.3	8.2
Sit and reach test left (cm) **	Control	60	-40.0	12.0	-6.4	10.0
	Experimental	49	-23.0	18.0	-0.8	7.5
Back scratch test right (cm)	Control	61	-42.0	26.0	-9.7	13.7
	Experimental	51	-37.0	7.0	-9.5	11.2
Back scratch test left (cm)	Control	61	-38.0	34.0	-14.3	14.8
	Experimental	50	-40.0	3.0	-13.8	10.6
Up and go test (sec) *	Control	62	9.0	45.0	17.4	8.3
	Experimental	50	5.0	78.0	13.5	10.6



**Table 8a. Baseline Measures in SF-36**

		N	Minimum	Maximum	Mean	Std. Deviation
Physical Functioning	Control	56	15.0	95.0	55.8	20.2
	Experimental	46	10.0	95.0	55.8	24.9
Physical Role Functioning	Control	61	0.0	100.0	48.8	44.4
	Experimental	50	0.0	100.0	58.0	45.3
Bodily Pain	Control	62	0.0	100.0	65.0	25.1
	Experimental	50	10.0	100.0	66.1	29.5
General Health Perceptions	Control	57	0.0	100.0	55.6	23.1
	Experimental	50	10.0	92.0	55.5	19.0
Vitality	Control	61	10.0	100.0	56.4	20.2
	Experimental	48	15.0	95.0	57.3	21.4
Social Role Functioning	Control	58	12.5	100.0	78.0	25.9
	Experimental	50	25.0	100.0	84.0	21.1
Emotional Role Functioning	Control	61	0.0	100.0	59.0	45.3
	Experimental	50	0.0	100.0	70.0	42.2
Mental Health	Control	59	24.0	100.0	72.1	19.0
	Experimental	48	24.0	100.0	72.2	19.9

**Table 8b. Three-month Measures in SF-36**

		N	Minimum	Maximum	Mean	Std. Deviation
Physical Functioning	Control	56	15.0	95.0	53.0	21.4
	Experimental	46	20.0	90.0	61.1	22.2
Physical Role Functioning **	Control	61	0.0	100.0	43.0	42.6
	Experimental	50	0.0	100.0	69.0	42.4
Bodily Pain	Control	62	0.0	100.0	64.2	26.8
	Experimental	50	22.0	100.0	71.2	25.6
General Health Perceptions **	Control	57	0.0	92.0	49.9	22.5
	Experimental	50	20.0	97.0	61.6	19.5
Vitality	Control	61	10.0	95.0	55.1	22.1
	Experimental	48	15.0	100.0	62.8	21.2
Social Role Functioning **	Control	58	12.5	100.0	73.3	25.2
	Experimental	50	37.5	100.0	88.0	19.1
Emotional Role Functioning **	Control	61	0.0	100.0	54.1	45.2
	Experimental	50	0.0	100.0	78.0	37.9
Mental Health *	Control	59	16.0	100.0	68.6	21.9
	Experimental	48	36.0	100.0	76.8	17.1

In order to determine when the participants would start showing positive changes in their functioning during the 3-month intervention, the experimental group participants took the SFT monthly to measure their physical changes. Participants who participated for the whole experimental period were selected for analysis.

For the SFT, results of some test items showed changes either after the first month or second month into the intervention, but other items did not show any changes. Table 9 briefly shows the changes of performance in each test item and Table 11 shows the detailed findings of the SFT. Table 9 shows that after one month of exercises, there was an improvement in the Step-in-place test, Arm-curl test and Sit-and-reach test for both sides (right and left sides). Apart from these tests, the Chair-stand test and the Up-and-go test also showed improvement after two months of exercises. For the Arm-curl test, there was continuous improvement after three months of exercises. For the Back-scratch test for both sides (right and left), no improvements were observed throughout the three-month intervention. However, after two months of exercises, except for the Arm-curl test, no further improvements were observed for all test items.

**Table 9. Performance in Test Item**

Test Item	M0 and M1	M1 and M2	M2 and M3
Step in place test (steps)	✓	✓	
Arm curl test (times)	✓	✓	✓
Chair stand test (times)		✓	
Sit and reach test right (cm)	✓	✓	
Sit and reach test left (cm)	✓	✓	
Back scratch test right (cm)			
Back scratch test left (cm)			
Up and go test (sec)		✓	

M0 = baseline measure

M1 = 1st month measure

M2 = 2nd month measure

M3 = 3rd month measure

“✓” = statistically significant changes

Furthermore, there was a two-month follow-up assessment to examine the sustainability of improvements resulting from doing exercises after the intervention. Table 10 shows the changes of performance in each test item between the baseline and follow-up measures and Table 11 shows the detailed findings of the tests. Table 10 shows that, at the two-month follow-up assessment, there was no significant change in all the test items of SFT. There was neither improvement nor deterioration in the performance. Compared with the baseline results, the Back-scratch test for both sides (right and left) did not show any improvement throughout the intervention period whereas other tests showed improvement between the baseline and follow-up measures. The Up-and-go test showed no difference between these two time points.

**Table 10. Performance in Test Items at the Follow-Up Measures**

	<b>M3 and M4</b>	<b>M0 and M3</b>	<b>M0 and M4</b>
Step in place test (steps)		✓	✓
Arm curl test (times)		✓	✓
Chair stand test (times)		✓	✓
Sit and reach test right (cm)		✓	✓
Sit and reach test left (cm)		✓	✓
Back scratch test right (cm)			
Back scratch test left (cm)			
Up and go test (sec)			

M0 = baseline measure

M3 = 3rd month measure

M4 = follow-up measure

“✓” = statistically significant changes

**Table 11. Fitness Test Comparison for Experimental Group**

	Period	N	Minimum	Maximum	Mean	Std. Deviation
Step in place test (steps)	Baseline	48	4.0	101.0	53.9	23.7
	1st month	48	10.0	134.0	61.7	26.8
	2nd month	48	23.0	146.0	70.9	26.9
	3rd month	48	18.0	161.0	72.3	30.2
	Follow-up	39	15.0	157.0	71.4	30.9
Arm curl test (times)	Baseline	50	0.0	21.0	11.2	4.9
	1st month	50	6.0	24.0	12.8	4.5
	2nd month	50	3.0	31.0	14.2	6.0
	3rd month	50	6.0	30.0	15.4	5.9
	Follow-up	41	7.0	35.0	15.2	6.1
Chair stand test (times)	Baseline	50	3.0	17.0	9.1	3.4
	1st month	50	0.0	18.0	9.0	3.4
	2nd month	50	0.0	23.0	10.4	3.8
	3rd month	50	0.0	21.0	10.2	4.2
	Follow-up	41	4.0	19.0	10.6	3.6
Sit and reach test right (cm)	Baseline	48	-44.0	6.0	-8.4	12.1
	1st month	48	-25.0	14.0	-3.3	7.4
	2nd month	48	-14.0	14.0	-0.2	6.8
	3rd month	48	-23.0	18.0	-0.8	7.6
	Follow-up	40	-17.0	15.0	-0.6	7.3

**Table 11. Fitness Test Comparison for Experimental Group (con't)**

	Period	N	Minimum	Maximum	Mean	Std. Deviation
Sit and reach test left (cm)	Baseline	49	-44.0	16.0	-7.1	11.8
	1st month	49	-20.0	10.5	-3.1	6.7
	2nd month	49	-11.0	12.5	0.0	6.4
	3rd month	49	-21.0	20.0	-0.3	8.2
	Follow-up	40	-17.0	14.0	-0.48	6.5
Back scratch test right (cm)	Baseline	50	-42.0	19.0	-9.4	12.1
	1st month	50	-39.0	4.0	-9.9	50
	2nd month	50	-44.0	22.0	-7.1	50
	3rd month	50	-37.0	7.0	-9.2	50
	Follow-up	40	-39.0	7.0	-10.3	12.1
Back scratch test left (cm)	Baseline	49	-44.0	9.0	-13.7	11.5
	1st month	49	-45.0	1.0	-14.1	10.6
	2nd month	49	-55.0	26.0	-12.1	14.1
	3rd month	49	-40.0	3.0	-13.6	10.6
	Follow-up	39	-45.0	21.0	-12.7	13.8
Up and go test (sec)	Baseline	49	8.5	33.0	14.6	5.6
	1st month	49	6.0	67.0	14.3	9.7
	2nd month	49	5.0	55.0	12.7	7.6
	3rd month	49	5.0	78.0	13.3	10.7
	Follow-up	41	5.0	63.0	12.7	9.0

For the psychosocial functioning of the experimental group, SF-36 was administered at the baseline, 3-month and follow-up assessments. After the 3-month intervention, participants reported higher ratings in the domains of Bodily Pain, General Health Perception and Mental Health. At the follow-up assessment, participants continued to show improvements in the domain of Physical Functioning. However, for the Bodily Pain Domain, participants showed negative changes. Table 12 briefly shows the changes of the SF-36 scores in each domain at the follow-up assessments and Table 13 shows the detailed test findings.

**Table 12. Changes in SF-36 Scores**

	<b>M0 and M3</b>	<b>M3 and M4</b>	<b>M0 and M4</b>
Physical Functioning		✓	✓
Physical Role Functioning			
Bodily Pain	✓	✓	
General Health Perceptions	✓		
Vitality			
Social Role Functioning			
Emotional Role Functioning			
Mental Health	✓		

M0 = baseline measure

M3 = 3rd month measure

M4 = follow-up measure

“✓” = statistically significant changes

**Table 13. SF-36 Comparison for Experimental Group**

	Period	N	Minimum	Maximum	Mean	Std. Deviation
Physical Functioning	Baseline	46	10.0	95.0	55.8	24.9
	3-month	46	20.0	90.0	61.1	22.2
	Follow-up	38	10.0	100.0	66.7	23.3
Physical Role Functioning	Baseline	50	0.0	100.0	58.0	45.3
	3-month	50	0.0	100.0	69.0	42.4
	Follow-up	41	0.0	100.0	64.6	46.4
Bodily Pain	Baseline	50	10.0	100.0	66.1	29.5
	3-month	50	22.0	100.0	71.2	25.6
	Follow-up	42	10.0	100.0	65.0	26.5
General Health Perceptions	Baseline	50	10.0	92.0	55.5	19.0
	3-month	50	20.0	97.0	61.6	19.5
	Follow-up	41	20.0	92.0	61.1	18.8
Vitality	Baseline	48	15.0	95.0	57.3	21.4
	3-month	48	15.0	100.0	62.8	21.2
	Follow-up	42	15.0	95.0	61.8	18.5
Social Role Functioning	Baseline	50	25.0	100.0	84.0	21.1
	3-month	50	37.5	100.0	88.0	19.1
	Follow-up	42	25.0	100.0	83.0	22.9
Emotional Role Functioning	Baseline	50	0.0	100.0	70.0	42.2
	3-month	50	0.0	100.0	78.0	37.9



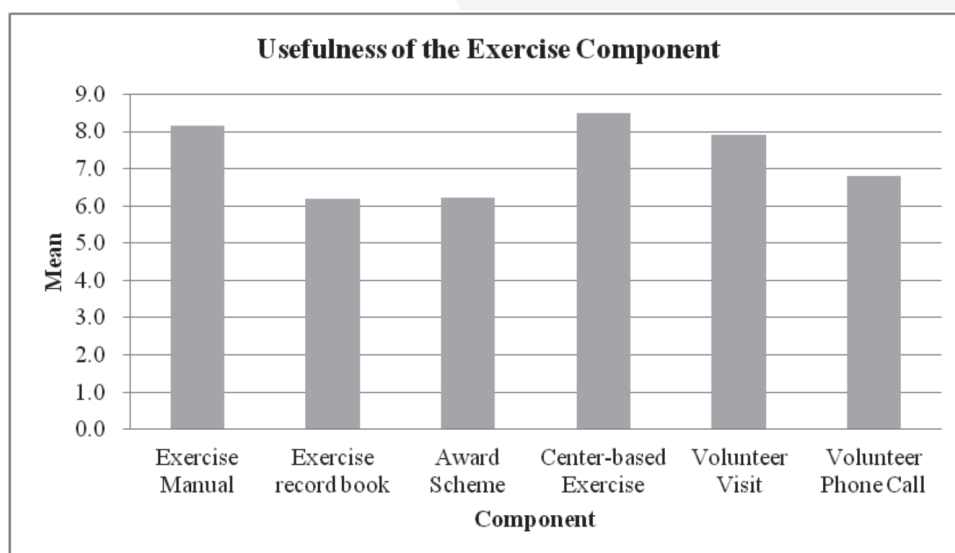
**Table 15. SF-36 Comparison for Experimental Group (con't)**

	Period	N	Minimum	Maximum	Mean	Std. Deviation
Mental Health	Follow-up	42	0.0	100.0	69.8	42.8
	Baseline	48	24.0	100.0	72.2	19.9
	3-month	48	36.0	100.0	76.8	17.1
	Follow-up	39	36.0	100.0	76.6	16.6

### 4.3 Opinion on the Program from Participants

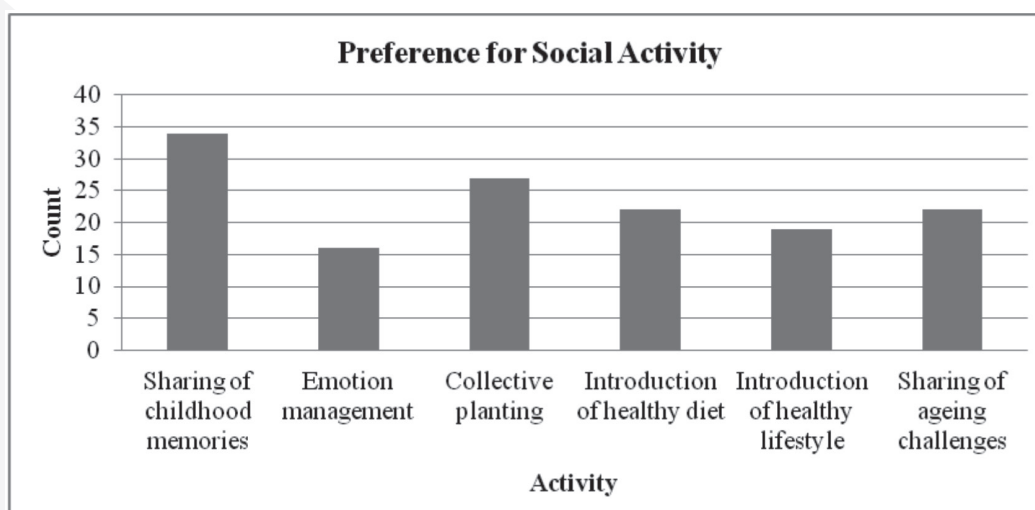
Among the exercise components, center-based exercise, exercise manual and volunteer visit were found to be most useful in motivating the participants to continue doing the exercises. Figure 1 shows the usefulness of each component in facilitating participation in the exercise program.

**Figure 1. Usefulness of the Program Component**



In regard to the social activities held after each center-based exercises session, sharing of childhood memories was the most favorable activity, whereas health education about emotion management was the least favorable. Figure 2 shows the preference of the participants.

*Figure 2. Preference for Social Activity*





## 5. Summary

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We found that the existing model of day care program is very professional-driven and center-based with rehabilitation orientation. Participants meet once a week or biweekly for group exercises and social activities. The current exercise program varies among centers because it is developed by PT for the participants with rehabilitation needs aiming for individualized prescription instead of general health promotion. Under this approach, there is no standardized protocol that it is difficult to evaluate participants' progress, and participants are not expected to do the same exercises at home. The intensity of the group exercises is not high enough to create a significant improvement in participants' physical fitness. The focus on center-based activities, rather than home-based activities, does not promote effectively the adoption of an active lifestyle with regular exercise and does little to enhance participant's independent living. Despite these limitations, participants, in general, like both the group exercises and the social activities of the current day care program. However, such model may create dependency in participants on staff and does not promote formation of exercise habit and independent living.

With the support from the Institute of Human Performance at HKU, the COA research team developed a new exercise program for frail elders and trained a group of care staff and volunteers to implement this new exercise program. The enhanced Hn'H exercise protocol has both center-based and home-based exercises and has increased the intensity from once per week or every other week to three times a week. It is also a time-limited program that lasts for about three months.

We found that the enhanced Hn'H day care program was effective in improving participants' physical fitness and participants were able to show significant improvement after the first month of intervention. We also found that the intervention remained effective for the second month, but the improvement plateaued thereafter. However, even the improvement in physical fitness was plateaued after the first two months, participants were able to sustain the gains after the end of the active intervention.

The program also improved participant's psychological health as measured by the SF36, especially in the areas of self-perceived physical functioning, body pain, general health perception and mental health. However, only the improvement in self-perceived physical functioning was sustained after the end of the active intervention. It seemed that the enhanced Hn'H day care program was not able to create a sustainable improvement in psychological health once the intervention stopped.

Among all exercise components, participants found that the center-based exercise, the exercise

manual, and the volunteer visit were most useful for them. For social activities, they found that activities that involved sharing (e.g. sharing of childhood experience and aging challenges) and group activities (e.g. group gardening) were preferable to educational activities (e.g. emotional management and healthy diet).

Among the social activities, we found that older people enjoyed activities that they were actively participating, such as sharing of childhood memories, collective planting, and sharing of aging challenges. It highlighted the importance of using a participatory approach in organizing social activities for them.

We also did not find much improvement in participants' cognitive functioning. This may be due to the fact that the older people included were not suffering from any cognitive impairment. Also, we did not include much cognitive intervention in the program design. For future program, we suggest that social workers further enhance the social program by adding cognitive stimulating activities into the Hn'H day care program.



## 6. Recommendations

**Empowerment and Independency of IHCS-OC Users:** Currently, there is no official assessment that systematically examines the needs of IHCS-OC users in Hong Kong and agencies often serve a wide spectrum of elders with different levels of impairment. Since physical exercise and rehabilitation are not the components of IHCS ordinary cases, there is no sub-vented resources to help users to improve physical health. To facilitate ageing in place, IHC operators can consider incorporating the exercise program into the current IHCS. It is crucial to educate users, in particular those who are socially inactive, on the importance of doing exercises and encourage them to do exercises on their own regularly. The program serves as a time-limited intervention that promotes healthy lifestyle and habit formation through regular exercise at an intensity that makes a positive change in older people's physical fitness.

**Correct Exercise Types and Intensity:** The day care program should not be seen as a therapeutic intervention, but an exercise program. The exercise intervention should focus on improving participant's general physical fitness so that they can live a relatively independent life. The objectives of the intervention should focus on habit formation that empowers older people to do the correct type of exercise at the right intensity to make a difference, instead of spending time doing exercise under supervision. We recommend the HKFWS to use the exercise protocol in the refined Hn'H day care program as a template to continue the intervention or to further enhance the current program.

**Development of A Series of Exercise Protocol:** From the experience of developing the refined exercise protocol, we suggest HKFWS to develop a series of exercise protocol that fits users with different potentials. The refined protocol is designed to target the pre-frail elders and therefore is not suitable for all. For example, for more able users, they may need more progressive exercises to enhance their physical health. HKFWS may consider using the refined protocol as a template to further develop other sets of exercises for its users with different physical levels.

**Use of Volunteers:** The professional-driven model of the current day care program is not sustainable and is creating dependency. We suggest the HKFWS to expand the use of volunteers in their Hn'H Program. The use of volunteer is a community empowerment process to expand the capacity of community to take care of its own elders. This will contribute to the development of community care model where frail elders are cared in the community by the community. In view of the manpower demanded for coordinating volunteers, we suggest the HKFWS actively seeks resources to expand its volunteer program to systematically recruit, train, and provide meaningful engagement activities for their volunteers.

**Optimizing Manpower by Using the Manual:** Insufficient manpower is another issue. It is a general problem rather than a problem specific to the Hn'H Program. Based on our observation, in the pilot and the experimental studies, social workers played a significant role in planning and implementation of group sessions as well as to facilitate the development of the protocol for psychosocial intervention. We believe that, given the development of such a detailed protocol in the refined program, much of the workload can be shifted to the other staff such as program workers if the program will be continued in future. This will not only relieve the burden of social workers, but also reduce staff cost in the long run.

**Participatory Social Activities:** We found that older people enjoyed social activities that they were actively participating, such as sharing of childhood memories, collective planting, and sharing of ageing challenges. It highlighted the importance to involve them in activities. For future activities, we also suggest that the social worker be trained in participating arts or other types of participatory intervention and organize activities using participatory principle.

**Incorporating Cognitive Stimulating Activities:** Although the program does not focus on cognitive frailty, it is valuable to include some cognitive stimulating activities in the future as preventive measure for cognitive frailty. We suggest that social workers include principles of the cognitive stimulating therapy (CST) in designing the social activities. The CST is based on principles of participatory, fun, and cognitively stimulating. CST activities can easily be integrated into the enhanced Hn'H day care program.





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## 小組參加者個案實例

### 個案 1

李女士長期患有腰背痛，日常起身坐下的動作對她來說都十分艱難，加上李女士居於三樓，若要外出時則要視乎當天的身體情況，評估自己能力是否足夠上落樓梯。故上落樓梯對李女士來說是十分困難的。在參加了健樂同行小組後，李女士體會到這套運動帶給她的好處，就是能讓她可以有能力應付上落樓梯。加上義工的家訪及鼓勵，她可以持之以恆，養成做運動的習慣，改善了她的活動能力。此外，李女士亦感受到社區人士對長者們的關懷。

### 個案 2

岑女士身體肥胖，缺乏運動，個性內向，與女兒關係緊張，相處時有較多磨擦。後來經社工鼓勵後參加了此計劃，在小組的第一、二節時，岑女士沉默寡言，表現被動。及後，經義工的探訪及支持鼓勵，她開始做計劃內所教授的運動，也慢慢在日間中心的活動中與其他組員交談及說笑。岑女士在小組中也開始表現得開朗。岑女士也在小組中表示自己瘦了，身體變得輕巧，所以日後會繼續努力做運動。岑女士的心情轉變正面，與女兒的關係也開始緩和及增加了聯絡。

### 個案 3

林婆婆曾因跌倒以致手部活動情況受限制。於小組開始前的能力評估中，多個項目均因手痛及雙腳乏力而不能完成。於小組開始後，她發覺該套運動對其能力有明顯幫助。故此積極地日日做運動。約一星期後，她已清晰記得所有運動的步驟。小組中期，林婆婆更被邀請作客席教練，帶領一班參加者一起做運動。她在後期之能力評估中，更是各參加者中進步最明顯的一位。

### 個案 4

張婆婆第一次參加小組的時候，需要使用輪椅才能到中心，參與計劃後，每天也在家做運動，到最後一節小組時，已經可以不使用輪椅，只須使用拐杖便能來到中心。

## 參加者及職員的意見

- \* 希望再有機會參加同類活動，既鍛鍊了身體，又能增加彼此友誼，及有關老人的保養知識。
- \* 學會後能夠自己在家做，大部份(運動)也是坐著做。
- \* 活動對老人身體有益，讓人更精神及開心。
- \* 工作人員責任心強，對長者關心，我非常感謝。
- \* 有持續性，經過好一段時間在小組中，組員的互相支持及義工的鼓勵下，讓參加者體驗到運動的好處。
- \* 參與活動之長者對小組都很有歸屬感，朋輩間的支持令工作人員和義工在推行計劃期間可以事半功倍。長者對做運動更有推動力，感到做運動是一件有趣的事，在小組活動後期，參與的長者明顯較小組初期時段更主動關心其他組員和積極參與討論。
- \* 運動的設計適合長者在家中練習。義工的參與有助提高長者做運動的動力。小組內容多元化，讓長者多了互動的空間及分享的話題。
- \* 活動包含不同主題及形式，從身心不同方面介入，整體能培養參加者外出的習慣，令他們更積極及更有自信心維持身體健康，亦增強了他們的社交互動。

參考編號：\_\_\_\_\_

香港家庭福利會  
「健樂同行」日間照顧服務計劃

身體狀況申報表

\*如以下其中一項有者，則不適合參與是次計劃：

- 一年內曾進行骨科手術（下肢），例如：全膝或全髖關節置換
- 慢性肺阻病或哮喘患者（需在家長期使用氧氣機 2LO<sub>2</sub> 或以上）  
（不需在家使用氧氣機或氧氣度少於 2LO<sub>2</sub> 除外）
- 心絞痛（需每星期含劑底丸一次者）  
（如超過半年未有使用劑底丸除外）
- 急性缺血性心臟病
- 曾有急性心肌梗塞
- 急性冠心症病人
- 不能控制的高血壓（高血壓的定義為上壓高於 165，下壓高於 90）  
（服藥後，血壓低於上述定義者除外）
- 體位性低血壓
- 曾中風  
（如長者在中風後能自行步行者除外）
- 後期的帕金森症患者
- 癌症患者（癌症有可能轉移至骨）  
（已完成治療或已痊癒者除外）
- 嚴重的骨質疏鬆症（長者需食補骨藥）  
（骨質疏鬆需接受雙能 X 光吸光測定法（DEXA）後才可確診）
- 完全不能接收指示者
- 經常性感到頭暈

本人同意參加「健樂同行」日間照顧服務計劃，確認沒有上述身體情況及願意遵守計劃協議。

簽署：\_\_\_\_\_

(姓名：\_\_\_\_\_)

日期：\_\_\_\_\_

## 香港家庭福利會～「健樂同行」日間照顧服務計劃

參考編號：\_\_\_\_\_

## 生命表徵紀錄表

生命表徵	第 1 週 日期：_____	第 2 週 日期：_____	第 3 週 日期：_____	第 4 週 日期：_____	第 5 週 日期：_____	第 6 週 日期：_____	Acceptable range
體溫							36-37.5 degree
血壓							BP: 90-165 / 60-80
含氧量							SO2: 95%-100%

生命表徵	第 7 週 日期：_____	第 8 週 日期：_____	第 9 週 日期：_____	第 13 週 日期：_____	重聚日 日期：_____	Acceptable range
體溫						36-37.5 degree
血壓						BP: 90-165 / 60-80
含氧量						SO2: 95%-100%

## 問卷調查紀錄表

問卷調查	組前評估 日期：_____	第 5 週 日期：_____	第 9 週 日期：_____	第 13 週 日期：_____	重聚日 日期：_____
AMT 分數	_____分	/	/	_____分	_____分
SF-36	_____	/	/	_____	_____
Senior Fitness Test	1. 原地踏步：_____次 2. 啞鈴屈舉：_____次 3. 椅子坐站：_____次 4. 坐下前伸：右腳 _____cm 左腳 _____cm 5. 摸背測試：右手 _____cm 左手 _____cm 6. 計時起立走：_____秒	1. 原地踏步：_____次 2. 啞鈴屈舉：_____次 3. 椅子坐站：_____次 4. 坐下前伸：右腳 _____cm 左腳 _____cm 5. 摸背測試：右手 _____cm 左手 _____cm 6. 計時起立走：_____秒	1. 原地踏步：_____次 2. 啞鈴屈舉：_____次 3. 椅子坐站：_____次 4. 坐下前伸：右腳 _____cm 左腳 _____cm 5. 摸背測試：右手 _____cm 左手 _____cm 6. 計時起立走：_____秒	1. 原地踏步：_____次 2. 啞鈴屈舉：_____次 3. 椅子坐站：_____次 4. 坐下前伸：右腳 _____cm 左腳 _____cm 5. 摸背測試：右手 _____cm 左手 _____cm 6. 計時起立走：_____秒	1. 原地踏步：_____次 2. 啞鈴屈舉：_____次 3. 椅子坐站：_____次 4. 坐下前伸：右腳 _____cm 左腳 _____cm 5. 摸背測試：右手 _____cm 左手 _____cm 6. 計時起立走：_____秒

問卷調查	組前評估	第 13 週	重聚日
目標進度表			
居家安老問題			

負責義工 / 職員 (1)

姓名：\_\_\_\_\_

電話：\_\_\_\_\_

負責義工 / 職員 (2)

姓名：\_\_\_\_\_

電話：\_\_\_\_\_

香港家庭福利會  
「健樂同行」日間照顧服務計劃

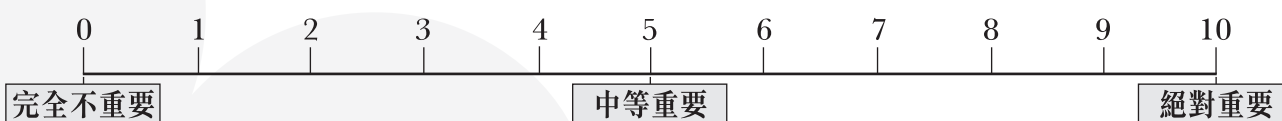
參考編號：\_\_\_\_\_

日期：\_\_\_\_\_

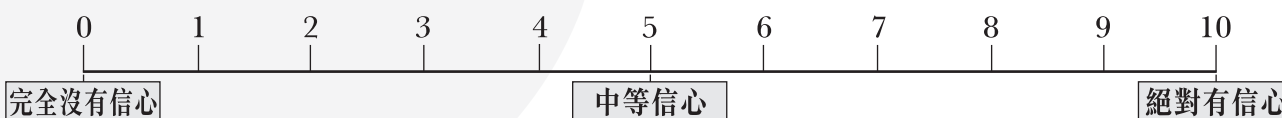
1. 抉擇的考慮

維持現狀的好處	改變 ( 建立運動習慣 ) 的好處
維持現狀的壞處	改變 ( 建立運動習慣 ) 的壞處

2. 改變 ( 建立運動習慣 ) 的重要性

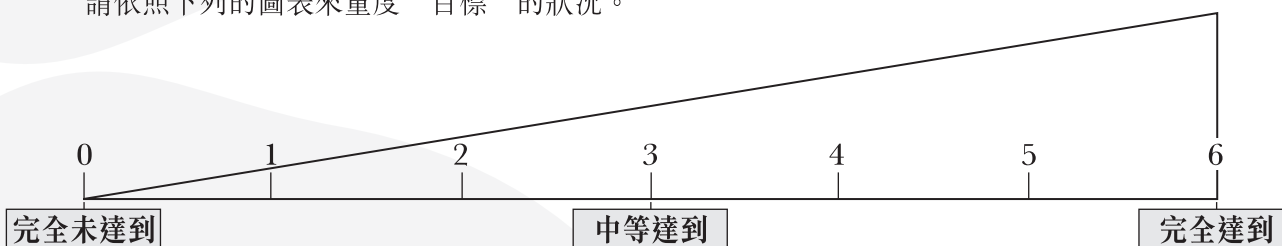


3. 改變 ( 建立運動習慣 ) 的信心



4. 目標進度表

指示：  
請依照下列的圖表來量度“目標”的狀況。



我的目標	簡介	評估
1. 建立運動習慣		
2. 學習建立健康的生活		

5. 你對小組的期望：\_\_\_\_\_



## Research Team

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### **Sau Po Center on Ageing, The University of Hong Kong**

*LUM, Terry Y.S.*

*(Henry G Leong Professor of Social Work and Social Administration*

*Head, Department of Social Work and Social Administration*

*Associate Director, Sau Po Centre on Ageing)*

*LAU, Mandy M.Y. (Research Coordinator)*

*FUNG, Winkie W.Y. (Research Assistant)*

### **Hong Kong Family Welfare Society**

*WONG, Stephanie O.K. (Social Work Consultant)*

*WONG, Estelle K.Y. (Senior Manager, Elderly)*

*MA, Irene W.S. (Manager, Elderly)*

*CHAN, P.K. (Physiotherapist) (until Nov 2015)*

*PUN, Shadow, S.Y. (Social Worker)*

*WONG, Stephen, F. (Social Worker) (until April 2015)*

# Supporting Family to Care for the Elder



香港家庭福利會  
Hong Kong Family Welfare Society



香港大學秀圃老年研究中心  
Sau Po Centre on Ageing  
The University of Hong Kong