AAG
Australian Association of Gerontology

FACT SHEET 5
CASE STUDIES EXPLORING REABLEMENT APPROACHES

June 2019

To improve the experience of ageing through ***CONNECTING RESEARCH, POLICY*** and ***PRACTICE***

This Fact Sheet has been developed by the Australian Association of Gerontology (AAG) with the support of the Expert Reference Group for the AAG Reablement Project 2017-19[1]. The aim is to provide some case studies that explore different approaches to reablement.

This is one of a series of Fact Sheets exploring reablement that have been developed by AAG with the Expert Reference Group for the AAG Reablement Project:

- AAG Fact Sheet1: Definitions of key aged care terms and acronyms used by the Australian Government
- AAG Fact Sheet 2: Australian approaches to reablement in the Home Support and Care Program
- AAG Fact Sheet 3: Australian approaches to reablement in residential aged care in Australia
- AAG Fact Sheet 4: List of published evidence on reablement approaches
- AAG Fact Sheet 5: Case studies exploring reablement approaches
- AAG Fact Sheet 6: International guidance documents on reablement approaches

AAG has also produced three videos featuring experts speaking about reablement. These can be viewed here

Acknowledgment of Country

Australian Association of Gerontology acknowledges Traditional Owners of Country throughout Australia and recognises the continuing connection to lands, waters and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures, to Elders past, present and emerging, and to all Aboriginal and Torres Strait Islander peoples including members of the Stolen Generations. For further information see AAG's Aboriginal and Torres Strait Islander Ageing Advisory Group (ATSIAAG)

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[1] Australian Association of Gerontology (AAG). Terms of Reference. Expert Reference Group for the AAG Reablement Project 2017-19 [Internet]. 2018 [cited 2018 Aug 31]. Available from: https://www.aag.asn.au/documents/item/2208

David

Source: 1. Department of Health. Commonwealth Home Support Programme. Program Manual 2018 [Internet]. Australian Government; 2018 [cited 2018 May 24]. Available from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2018/chsp_manual_-_effective_as_of_1_july_2018.pdf

David is an 81-year-old man who was referred to My Aged Care following a fall he had had two weeks previously. Although he had sustained no specific injuries, David was pretty shaken up from the fall and was now lacking in confidence to shower himself independently. Following his initial screening process through the My Aged Care contact centre, David was referred to the RAS for an assessment. The assessment identified that David was previously independent and was motivated to regain his independence. The assessor also identified that David was still independent in many daily activities but was struggling with his personal care. Based on the RAS assessment, a support plan was developed with David, which identified his goal of being able to maintain his personal care independently. The support plan provided information on David's strengths and abilities as well as his areas of difficulty and recommendations to achieve his goals, including a referral to a CHSP service provider for an occupational therapy assessment and the delivery of time limited personal care services. The occupational therapist then worked with David and his personal carer to devise a plan to achieve his goals. Initially personal care services were provided to David three times a week to assist him with showering. Over a four-week period, the CHSP service provider worked with David to develop specific strategies such as how to step in and out of the shower safely, to help him to build his capacity and regain confidence in showering. After four weeks of service David was confident to shower independently again and the services were withdrawn.

Fred

Source: Case study provided courtesy of Victorian Department of Health and Human Services.

Fred lives alone and due to a diagnosis of prostate cancer and a lengthy treatment period (which was ultimately successful), he was experiencing high levels of fatigue and reduced motivation for activity. At the Home Support Assessment, Fred requested domestic assistance. The assessment officer determined that Fred's physical condition was supportive of active involvement in domestic assistance, with predominant issues being low motivation, inability to prioritise tasks, limited awareness of endurance levels and management of these, and limited organisational skills. Fred identified that he wanted to "get his home under control." The home was quite cluttered, with piles of paperwork spread over multiple areas, and large piles of clothes in both the lounge and bedroom.

Fred's Support Plan was structured using a wellness and reablement approach. He was referred to occupational therapy to identify strategies to support energy conservation, and to identify modifications and equipment in the home to support easy living. The assessment officer conducted joint visits with the

occupational therapist and provider of domestic assistance to align all support and service plans with an agreement that services would cease within a three month period.

The domestic assistance worker assigned to Fred had a strong knowledge of wellness and reablement strategies, and both Fred and the worker were provided with flexibility to identify areas of the home that Fred wanted to focus on. Over a period of six visits, they worked together to organise spaces to increase functionality. They completed a "spring clean" of each area, enabling the client to maintain areas independently from then on. The assessment officer followed up with Fred by phone between visits, working with him on motivational strategies, and helping him developing an system to store important paperwork.

At the end of the 12 week reablement period, Fred was maintaining his home environment independently. He had a central organised area for storing documents, enabling him to easily access important information, re-configured the furniture in both his lounge and bedroom to make it easier to maintain the spaces himself, and organised his kitchen to make it easier to prepare meals. All supports ceased at this time.

Important factors that contributed to the success of this story included:

- Team work between client and service providers
- Team work between service providers
  - Assessment officer
  - Domestic assistance provider (administration - to match client/worker, community worker)
  - Occupational therapist provider
- Staff knowledge and skills in applying a wellness and reablement approach
- Coordinated agreement of timeframes (involving the client), to ensure both service plans (across two providers) aligned with the agreed service period.

Whilst service timeframes were limited, flexibility was provided for the client and worker to decide on how the service the was delivered – this meant that ownership remained with the client.

Josie

Source: Case study provided courtesy of Victorian Department of Health and Human Services.

Josie is a spritely 95-year-old lady who lives in an outer area of a medium size country town. Josie referred herself to My Aged Care as she recently failed her driving test and was concerned how she would maintain her level of community access. Josie had always maintained a very active lifestyle. She taught seated tai chi at U3A during the week. She was an active participant and committee member of the local spinners and weaving group. In addition, Josie was a leader in local bushwalking group. Her daughter lived in a nearby town and they would visit each other once or twice a week.

The loss of her licence was devastating to her. She was now relying on her daughter and other friends to get out and about. She was particularly concerned that her daughter would now spend more time "looking after her" than spending the quality time they previously experienced. Josie wanted to explore transport options.

Both Josie and her daughter were part of the assessment process. Josie is independent in most activities of daily living. She maintained a healthy vegetarian diet using fresh vegetables from her garden and bakes her own organic bread. She has some degenerative back pain and accesses domestic assistance from the local service provider each fortnight.

Short term goals included assisting with shopping, managing bill paying, and accessing public transport. Long term goals included to learn how to shop online and to learn to drive a mobility scooter

Josie wanted to continue shopping for herself so short-term shopping assistance was put in place to assist with heavier items. For bill paying, Josie's daughter was able to assist with setting direct debit arrangements for most of Josie's bills. In terms of accessing public transport, Josie wanted to continue to make her own way into town to visit her favourite health food store and her weekly U3A class. Josie suggested accessing public transport as there was bus that passed by the end of her street. The assessment officer spent some time investigating the timetable options. Josie agreed to having a worker assist with a trial run into town as it had been many years since Josie had tried pubic transport. A direct care worker accompanied Josie for the trial. Josie was able to visit her speciality stores and attend her U3A group. Another friend then took her home. After 2 sessions Josie felt confident to do this on her own.

To learn how to access the computer and shop online, Josie's daughter assisted her mother by setting up a computer and showed her how to access on online shopping. A referral was made to the co-located OT to assess Josie's safety for a mobility scooter. The referral was fast tracked as Josie was a My Aged Care reablement client and this was the arrangement that the RAS had set up with the local health service. Josie's progress was monitored each week via the local Care Coordination meeting that involved the assessment team, local service provider and co-located OT.

Josie has continued to catch the bus, now twice a week to access her activities and some shopping. She has learnt to be accepting of her friend's support and accepts lifts to other events. She is using her computer to google healthy living recipes and print thank you card for her friends. She was uncomfortable using online shopping but she shops together with her daughter every fortnight after their lunch date. Josie has realised this was also a meaningful way she could spend time with her daughter and has accepted her daughter's support.

The OT voiced concerns regarding Josie's safety for a scooter due to her vision and reaction times. Josie is waiting on eye test results but may not be safe enough for the scooter. Josie is coming to terms with this but has reported she is satisfied that she can still maintain her social activities.

Managing Josie's high expectations of herself in a sensitive manner was a major part of this plan. Josie needed time to learn and try to manage these new tasks herself. She found it hard to accept help from others. It took approximately 4 months for this outcome to be achieved. The My Aged Care System doesn't allow for any extensions to reablement and a reassessment was conducted to allow extra time for Josie to stay on reablement.