



Australian Government  
Department of Social Services

# *Living well at home: CHSP Good Practice Guide*

Commonwealth Home Support Programme (CHSP)



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## Foreword

The Australian Government is currently implementing changes to the aged care system and a key part of this will be the Commonwealth Home Support Programme (CHSP). Commencing on 1 July 2015, the CHSP will support the development of an end-to-end aged care system by providing entry level services.

Key elements of the creation of the CHSP from 1 July 2015 include the following:

- one consolidated program providing entry-level home support;
- a standardised national assessment process that will include the development of goal orientated, person-centred support plans for clients; and
- an increased focus on ways of working aimed at maximising client independence and autonomy (known in the aged care literature as wellness, reablement and restorative care).

A Commonwealth Home Support Programme Manual has been produced to spell out what is required of providers in the delivery and management of the CHSP. The Programme Manual forms part of the grant agreement between a provider and the Department.

This Good Practice Guide is intended to complement the Programme Manual and support the take up of wellness approaches in home care services.

Although wellness, reablement and restorative approaches are emerging as powerful ways to help older people improve their function, independence and quality of life, they are not new concepts in aged care. In Australia, Victoria and Western Australia are already operating with a wellness focus embedded in their programs and services. Other states and territories have also taken significant steps to introduce a wellness approach and some individual organisations in those jurisdictions are using well developed wellness practices. The Good Practice Guide seeks to build on existing examples of good practice and draw on the communications, capacity-building and training products that have been developed over a number of years in all jurisdictions and overseas.

Because this is a 'practice' guide, it is not designed to provide process guidelines for the implementation of the CHSP per se. Nor is the Good Practice Guide prescriptive in the way individuals and organisations should implement wellness approaches. The concepts and principles of wellness, reablement and restorative care will need to be taken and moulded to suit the individual circumstances of clients and service settings.

Although wellness and related concepts are already used widely in the aged care sector, for many providers their adoption will represent a significant change from the way entry level care services have previously been delivered. This involves a shift from a service delivery model that may have fostered dependence to one that actively promotes independence and supports people to remain living in their own homes and the community for as long as they can manage and wish to do so.

From a client's perspective, a wellness approach means the client can expect service providers to offer to do more 'with them' rather than just 'for them'. While a client might be experiencing some challenges in their overall functioning, a wellness approach starts from the point of view that they continue to have goals to achieve, have roles that have meaning, continue to make a contribution to society and have a life to live.

A wellness approach means listening to what the client wants to do, looking at what they can do (their abilities) and focuses on regaining or retaining their level of function and minimising the impact of any functional loss so that they can continue to manage their day to day life. It supports clients to be independent in their homes and to continue to actively participate in their communities for as long as they wish to do so.

The CHSP Programme Manual indicates that service providers will be expected to adopt a wellness approach in their service delivery practices. At the same time, the Department is conscious of the fact that it will take time for this approach to become embedded in service delivery practices. The expectation therefore is that providers will work towards the adoption of a wellness approach as indicated in the Manual, and that they will develop plans to commence this process from 1 July 2015.

An earlier draft of the *Good Practice Guide* was published in March 2015 and comments were invited from the sector. Submissions received were very positive about the adoption of a wellness approach and the *Good Practice Guide* as a resource to support this. The Department has endeavoured to respond to the many thoughtful suggestions in the changes it has made in this version of the Guide. However, the Department remains open to further input, including additional resources that can be cited. The intention is to update the Guide from time to time.

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The Department of Social Services gratefully acknowledges the assistance and expert advice contributed to date by the National Aged Care Alliance, including through the Commonwealth Home Support Programme Expert Advisory Group which has been established to support the overall development of the Commonwealth Home Support Programme. In particular, the Wellness Sub-Group has provided advice about sources of good practice material and about the overall content and structure of the Good Practice Guide.

## Feedback

The Department invites feedback on this document (either through your peak body or else individually) to [chsp@dss.gov.au](mailto:chsp@dss.gov.au). Suggestions for additional resources to include in the Guide are also welcome. It is expected that further editions of the Guide will be published from time to time.

## Disclaimer

This publication is presented for the purpose of disseminating information free of charge for the benefit of the public. The material in this publication includes the views or recommendations of third parties, which do not necessarily reflect the views of the Australian Government, or indicate its commitment to a particular course of action.

Reasonable efforts were made and expert advice was obtained from the Wellness Sub-Group of the Commonwealth Home Support Programme Expert Advisory Group to ensure that the information contained in this publication was correct and reflected good practice at the time of publication. The Commonwealth of Australia and the membership of the Commonwealth Home Support Programme Expert Advisory Group do not guarantee, and accept no legal liability whatsoever arising from or connected to, the accuracy, reliability, currency or completeness of any material contained in this publication.

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This publication is not a substitute for independent professional advice and users should obtain any appropriate professional advice relevant to their particular circumstances.

## Part 1 Introduction

### 1.1 Background

The Australian Government is currently implementing changes to the aged care system. These changes are being made now to ensure the system:

- offers choice and puts control back into the hands of consumers;
- encourages businesses to invest and grow; and
- provides diverse and rewarding career options; and
- is sustainable and affordable.

Moving towards consumer-directed care is a big part of the changes being made to the aged care system. It means people will have greater choice and care will be based on needs. The traditional image of aged care is often associated with residential aged care, but most people want to stay independent, remain in their home and connected to family and community for much longer. Investment in home support and Home Care Packages means that people will have greater choice and flexibility when it comes to home-based care and support.

Commencing on 1 July 2015, the Commonwealth Home Support Programme (CHSP) will be central to the aged care changes, and will support the development of an end-to-end aged care system. The existing Commonwealth Home and Community Care Program, the National Respite for Carers Program, the Day Therapy Centres Program and the Assistance with Care and Housing for the Aged Program will be combined under a single streamlined Commonwealth Home Support Programme to provide entry-level maintenance, care, support and respite services for older people living in the community, and their carers<sup>1</sup>.

A Commonwealth Home Support Programme Manual has been produced to reflect the establishment of the new programme. The manual replaces:

- the Commonwealth Home and Community Care (HACC) Program Manual 2012;
- the National Respite for Carers Program (NRCP) - (for planned respite service providers) - Respite Grant Recipients' Programme Manual 2012;
- the Assistance with Care and Housing for the Aged (ACHA) Program - Programme Manual 2012; and
- the Day Therapy Centre (DTC) Program - Programme Manual 2012.

### 1.2 Purpose of the Good Practice Guide

A key element of aged care changes, and the CHSP in particular, will be a focus on wellness, reablement and restorative care. For many providers, this represents a significant change from the way many entry level care services have previously been delivered. It involves a shift from a model that may have fostered dependence to one that actively promotes independence. This is a cultural shift from 'doing for' to 'doing with'.

The Good Practice Guide has been developed to support wellness, reablement and restorative care approaches in home care services. It is intended to provide information about what good practice looks like in home support services and what organisations and individual workers can do to successfully adopt these approaches. As indicated in the CHSP Programme Manual, service providers will be expected to adopt a wellness approach in their service delivery practices although it is also anticipated that this will take time to achieve and will be supported by additional capacity-building activities.

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<sup>1</sup> NRCP, DTC and ACHA services currently delivered in Victoria and Western Australia will form part of the new CHSP from 1 July 2015.



As the wellness approach becomes embedded in service delivery practices, providers will be expected to:

- interpret the support plan with a wellness approach in mind and in consultation with the client;
- work with individuals and their carers<sup>2</sup>, as they seek to maximise their independence and autonomy;
- build on the strengths, capacity and wishes of individuals, and encourage actions that promote self-sufficiency;
- embed a cultural shift from 'doing for' to 'doing with' across service delivery;
- be alert to changing circumstances and goals of the client and consult with the My Aged Care Regional Assessment Services where appropriate to review the client's support plan; and
- consult the *Living well at home: CHSP Good Practice Guide* to assist in the development of good practices within a wellness approach ([www.dss.gov.au/chsp](http://www.dss.gov.au/chsp)).

It is important to understand this is a 'practice' guide and is not designed to provide process guidelines for the implementation of the CHSP per se. These are found in the Programme Manual for the Commonwealth Home Support Programme. Nor is the Good Practice Guide prescriptive in the way individuals and organisations should implement a wellness and reablement approach. The concepts and principles of wellness and reablement will need to be taken and moulded to suit the individual circumstances of clients and service settings.

The Good Practice Guide is designed primarily for CHSP service providers, both managers and staff, as well as those involved in assessment, particularly the My Aged Care and Regional Assessment Services staff.

### **1.3 Meaning of Wellness, Reablement and Restorative Care in the Commonwealth Home Support Programme**

Although wellness, reablement and restorative approaches are emerging as a powerful way to help older people improve their function, independence and quality of life, they are not new concepts in aged care. Reablement has been used extensively in the United Kingdom and New Zealand. In Australia, Victoria and Western Australia are already operating with a wellness and reablement focus embedded in their programs and services. Other states and territories have also taken steps to introduce a wellness approach and some individual organisations in those jurisdictions are using well developed wellness and reablement practices. The Good Practice Guide seeks to build on existing examples of good practice and draw on the communications, capacity-building and training products that have been developed over a number of years in jurisdictions and overseas.

But, before getting started, what do we mean by wellness, reablement and restorative care?

It is clear from the range of ways wellness and related terms are currently used that there is no one accepted or 'right' definition. Discussion about the different interpretations in Australia and internationally can be found at [Appendix 1](#). The approach adopted here is to develop a set of definitions for wellness, reablement and restorative care in the CHSP that draws on contemporary use in Australia and overseas, and, at the same time, aims to make a distinction between the terms. Wellness and related terms are considered here to refer to different methods of intervention. While wellness is also described as a philosophy, it is a "wellness approach" that is defined here as a particular method of intervention.

The result is three different yet complementary methods of intervention that effectively form a continuum of service intervention. The definitions adopted under the CHSP are contained in the dialogue boxes below. A table summarising the characteristics of the different approaches is included at the end of this section. It is designed to show the similarities and differences of the three approaches.

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<sup>2</sup> At a more general level, the [National Carer Strategy](#) recognises the contribution of carers to the Australian community and outlines how this contribution can be valued, supported and shared.

## Wellness

Wellness is an approach that involves assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, and encourage actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

Wellness as a **philosophy** is based on the premise that, even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and as independently as possible. The wellness philosophy underpins all activities under the Commonwealth Home Support Programme.

A wellness **approach** draws on the wellness philosophy to inform a way of working with people. It therefore involves working with individuals, and their carers, to maximise their independence and autonomy<sup>3</sup>. The approach involves assessment, planning and delivery of supports that build on the strengths, capacity and goals of individuals, creatively addressing problems or barriers and encouraging actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home.

It avoids 'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves, or with less assistance, and to increase satisfaction with any gains made. It underpins all assessment and service provision, whether the need for assistance is episodic, fluctuates in intensity or type over time, or is of an ongoing nature.

It helps to understand the wellness approach if it is contrasted with a traditional approach to home support. The following table is an example of this and comes from Western Australia's *Wellness Approach to Community Home Care*<sup>4</sup>.

Current (Dependency) Approach	Wellness Approach
<ul style="list-style-type: none"> <li>➤ Does for &amp; does to a person</li> <li>➤ Takes over/removes roles</li> <li>➤ Supports declining capacity of person</li> <li>➤ Takes control</li> <li>➤ Focuses on physical and mental decline</li> <li>➤ Can isolate from the community</li> <li>➤ Reduces self-confidence</li> <li>➤ Results in Illness/Dependency cycles</li> </ul>	<ul style="list-style-type: none"> <li>➤ Gets the balance right between "doing with" versus "doing for"</li> <li>➤ Identifies what a client can and wants to do, rather than only what they have difficulty with</li> <li>➤ Gradually encourages clients who are having difficulty with activities of daily living to increase their ability</li> <li>➤ Supports roles [that is, values individuals' roles]</li> <li>➤ Builds capacity, self-management and compensates for decline</li> <li>➤ Increases self-confidence</li> <li>➤ Retains and respects autonomy</li> <li>➤ Focuses on re-enabling and maintaining function , minimising the impact of functional loss</li> <li>➤ Looks at ongoing appropriateness of service</li> <li>➤ Supports connections with the community</li> </ul>

<sup>3</sup> In this context, independence means the ability to self-manage the activities of daily living, including social and community participation, and autonomy means being able to make decisions about one's life.

<sup>4</sup> [Wellness Approach to Community Homecare: Information Booklet July 2008](#), p12

The following case study serves to show how a wellness approach makes a difference.

**Case study: Mrs Rowan**

Mrs Rowan likes to keep busy and tries to do as many jobs around the house as possible. Lately she has been unable to hang up some of her heavier clothing items on the line. The traditional approach would involve support workers coming into Mrs Rowan's home once a week to hang out the clothes for her. The wellness approach would encourage the support worker to work with Mrs Rowan to hang out her bigger, heavier items and encourage her to hang her smaller items by using a laundry trolley and an easy-to-reach drying rack. In this way, Mrs Rowan can continue to do things for herself and can act independently to do all her washing except for those items she needs some support to lift.

Source: Silver Chain

The service provider Silver Chain has identified a number of practical steps associated with a wellness approach (see box below<sup>5</sup>). It has also created some simple examples of how the wellness approach works in practice – such as the following.

**Case study: Mrs Smith**

Mrs Smith had a goal of making her bed. With the help of a support worker she takes the sheets off the bed, lays out new sheets and inserts the pillows in the cases. She has also replaced her old woollen blankets with a light weight doona. This means Mrs Smith is able to have control over making her bed by selecting the bed linen and, once the fitted sheet has been put in place (with the support worker lifting the mattress corners), she is able to complete the task herself.

Source: Silver Chain

**The Wellness Approach**

**A wellness approach:**

**Identifies abilities and potential**

It involves going in with a different mindset to find out what people are able to do and what they may be able to do with the right support.

**Looks at appropriateness of service**

The wellness approach identifies if the client will have better outcomes with a service or whether other things would be more appropriate. For example: family, community resource or equipment.

**Allows for time limited services**

From time to time you may come across a client that appears to not need the services or only need services for a set period of time.

**Assesses and develops goals**

The Wellness Approach gathers all the information required to ensure that clients receive services that meet their needs. By setting realistic goals and time frames where possible, staff, clients and families can work together for good outcomes.

**Doing with not for**

This is about encouragement, support and focusing on abilities rather than taking over.

Source: Self Directed Learning Workbook: Working the Wellness Way, Silver Chain, Western Australia, unpublished

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<sup>5</sup> Self Directed Learning Workbook: Working the Wellness Way, Silver Chain, Western Australia, unpublished

A further feature of the wellness approach is that it involves a holistic or a whole person view. In *Challenging Community Care with Wellness*<sup>6</sup>, this is described as “encompassing physical and psychological wellbeing, individual health, community connections, practical support and whatever gives each individual’s life meaning and purpose”.

“It focuses on the dynamic nature of people’s disability experience emphasising activity, participation and retaining/regaining functional and psychosocial independence to maximise wellbeing. It is also about accepting that individuals will have different motivations and goals and the need to look beyond the normal suite of services that the HACC [CHSP] Program or a particular organisation provides”.

The need to take a holistic or whole person view is particularly important in the way assessments are undertaken. In undertaking client assessments, the My Aged Care Regional Assessment Service will therefore aim to have an understanding of the client’s needs, abilities, strengths and areas of concern which will be the basis for the development of the client’s support plan to be actioned by service provider(s).

Services provided using a wellness approach don’t need to be overly complicated or demanding. Some might need to be accessed outside the CHSP through the broader community. They can include activities like exercise groups, falls prevention groups, tai chi, social support groups or walking groups that keep the client connected to the community and more independent.

## Reablement

Reablement involves time-limited interventions that are targeted towards a person’s specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities.

Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. However, reablement involves time-limited interventions that are more targeted towards a person’s specific goal or desired outcome to adapt to some functional loss, or regain confidence and capacity to resume activities. Supports could include training in a new skill or relearning a lost skill, modification to a person’s home environment or having access to equipment or assistive technology.

Reablement is targeted to CHSP clients who are motivated to continue to undertake activities of daily living for whom time-limited supports can achieve an increase in independence.

In the CHSP, reablement is embedded within the assessment, referral and service pathway. It will be overseen by Regional Assessment Services that will identify opportunities for clients to be as independent as is practical, potentially reducing the need for ongoing and/or higher levels of service delivery.

The UK publication *Reablement: a guide for frontline staff* lists what it says are “essential elements that are defining features [of] any reablement service”<sup>7</sup>. They are:

- Reablement is about helping people to do things for themselves, rather than doing things to or doing things for people.
- Reablement is time-limited; the maximum time that the user can receive reablement support is decided at the start. In most reablement services, this is for six or eight weeks.
- Reablement is outcome-focused: the overall goal is to help people back into their own home<sup>8</sup> or community.

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<sup>6</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program’s Wellness Approach, p26

<sup>7</sup> [Reablement: a guide for front line staff](http://www.opm.co.uk/wp-content/uploads/2014/01/NEIEP-reablement-guide.pdf) p5 at: <http://www.opm.co.uk/wp-content/uploads/2014/01/NEIEP-reablement-guide.pdf>

<sup>8</sup> The focus of the CHSP is on people staying in their homes rather than, as expressed in this UK example, people returning to their homes. An objective of the CHSP is to support clients to delay, or avoid altogether, the need to move into more expensive forms of aged care.

- Reablement involves setting and working towards specific goals agreed between the service user and the reablement team.
- Reablement is a very personalised approach – the kinds of supports given are tailored to the individual user's specific goals and needs.
- Reablement often involves providing intensive support to people.
- Reablement treats assessment as something that is dynamic not static. This approach means that you cannot decide a user's care or support package on the basis of a single, one-off assessment, instead you need to observe the user over a defined period of time, during which their needs and abilities may well change, with a reassessment at the end of the period of reablement.
- Reablement approaches assume that something should change by the end of the reablement intervention; you are working towards positive change.
- Reablement builds on what people currently can do, and supports them to regain skills to increase their confidence and independence.
- Reablement may also involve ensuring people are provided with appropriate equipment and/or assistive technology, and understand how to use it.
- Reablement aims to maximise users' long-term independence, choice and quality of life.
- Reablement aims to reduce or minimise the need for ongoing support after the period of reablement.

In practice, reablement can mean different things for different people – it all depends on a person's individual situation. For example, it might mean a service works with a client to:

- practise daily activities like cooking and bathing to help the person regain skills and get their confidence back;
- find new ways to do some things so that they feel safer and more confident;
- look at what else might help (for example, support to go out, personal alarms, home adaptations or other equipment, such as bath rails); and
- involve their relatives and/or carers in helping the person to live more independently – and discuss any support they might need.

The kind of supports reablement might draw on are many and varied but could include the following<sup>9</sup>:

- equipment and technology to help a person live more independently at home;
- skills for independent living provided through intensive, short-term support; and
- outreach - help with transport and getting out and about.

## Restorative Care

Restorative care involves evidence-based interventions led by allied health workers that allow a person to make a functional gain or improvement after a setback, or in order to avoid a preventable injury.

Restorative care involves evidence-based interventions delivered at an early stage that allow a person to make a functional gain or improvement in health after a setback, or in order to avoid a preventable injury. Interventions are provided or are led by allied health clinicians, general practitioners or other health professionals based on clinical assessment of the individual. Restorative care can involve primary health care providers of hearing, vision and dental care, or specialist mental health or disability services. It can require a multi-disciplinary approach and requires CHSP assessors and services to work in an integrated way with other service systems.

Restorative care provided through the CHSP will be coordinated by allied health and therapy services that will help clients set (functional) goals and review their progress after a defined period. There are also evidence-based, non-allied health restorative interventions in the broader community<sup>10</sup>.

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<sup>9</sup> [Reablement, Leeds City Council](#),

<sup>10</sup> See, for example, [What works to promote emotional wellbeing in older people by Beyond Blue](#)

Restorative care is likely to be appropriate for a smaller sub-set of CHSP clients where assessment indicates that a person has potential to make a functional gain.

An illustrative list of the kinds of therapies and services that could be provided under a restorative care approach include:

- physiotherapy;
- podiatry;
- occupational therapy;
- diversional therapy;
- nursing services;
- speech pathology;
- social work;
- dietetics;
- preventative therapies (such as falls prevention);
- exercise physiology;
- orientation and mobility specialists; and
- personal services (such as continence assistance).

### Summary of Wellness and Related Approaches

Characteristics of Approach	Wellness	Reablement	Restorative Care
<b>Aims to maximise independence and autonomy</b>	Yes	Yes	Yes, plus aims to maintain or improve health and wellbeing
<b>Strengths based</b>	Yes	Yes	Yes
<b>Nature of supports</b>	General, across the CHSP service types	Targeted to assist a person adapt to a particular functional loss	Targeted to assist a person address a particular functional deficit  Based on a clinical assessment
<b>Duration of supports</b>	Can be ongoing	Time limited	Time limited
<b>Involves allied health staff</b>	Yes	Yes	Yes
<b>Target group</b>	All CHSP participants	CHSP participants who want to continue to undertake activities of daily living for whom time limited supports can achieve an increase in independence	CHSP participants who can make a functional gain after a setback  Clients are motivated to make functional gains over a time limited period





## 1.4 Vision of Wellness Approach

A drive for change without a clear focus and vision about how things will be different in the future is destined to fail. Consequently, having a clear understanding and appreciation of past service provision models, contemporary practice and the optimal future manner of providing support for HACC eligible clients was essential<sup>11</sup>.

The vision for a wellness approach in the CHSP is that it will become embedded at all levels of the Programme – in the culture of those administering the Programme and those managing CHSP service providers, those involved in the assessment and support planning activities and those involved in service delivery. It is also anticipated that the approach will be embraced by clients of the CHSP and continue to develop and grow in response to feedback from clients.

The vision for implementation of a wellness approach in the CHSP is that it will be undertaken through a partnership between government and the sector. The way this will be achieved is by embedding wellness and reablement in the My Aged Care processes and the My Aged Care National Training Strategy. It will also be an integral part of the Commonwealth Home Support Programme Manual. The Good Practice Guide will help to inform providers about what it looks like and what they can do to implement it. The Department of Social Services established a Wellness Project Sub-Group of the Home Support Advisory Group (National Aged Care Alliance) to contribute to the guide and its implementation.

Further capacity-building activities to support the implementation of the wellness approach will be developed for implementation concurrent with the release of the guide. The Department is also exploring options for additional sector support measures (see later).

The vision for implementation of the wellness approach also includes a role for provider-led adoption of wellness principles and practices. In this regard, the Western Australian experience identifies a number of issues provider organisations might need to consider<sup>12</sup>. They include a claim sometimes made that “we are already doing wellness”. This guide encourages organisations to reflect on their current approaches to service delivery which could include wellness already embedded in their policies/procedures/processes/practices. They can then determine what steps to take to build on this or, for providers who have not yet made the shift to implement a wellness approach, how they will implement this within their organisations. Ultimately, however, it is likely to be client and community expectations that will decide the success of the wellness approach.

## 1.5 Other Important Influences

Key elements of the creation of the CHSP from 1 July 2015 include the following:

- one consolidated program providing entry-level home support;
- a standardised national assessment process that will include the development of goal orientated, person-centred support plans for clients. New assessment processes being introduced through My Aged Care will establish a new level of independence by separating assessment from service provision; and
- an increased focus on wellness and reablement.

These changes will be supported by a number of change management activities including the My Aged Care National Training Strategy for the My Aged Care Contact Centre, Regional Assessment Service and Aged Care Assessment Teams, and development of the Commonwealth Home Support Programme Manual.

This means that an increased focus on wellness and reablement is being progressed in a wider set of changes to the CHSP. Of particular significance to the wellness, reablement and restorative care approaches are:

1. The new standardised assessment process and separation of assessment from service delivery.

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<sup>11</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program’s Wellness Approach, pp 24-25

<sup>12</sup> Ibid, pp48-50



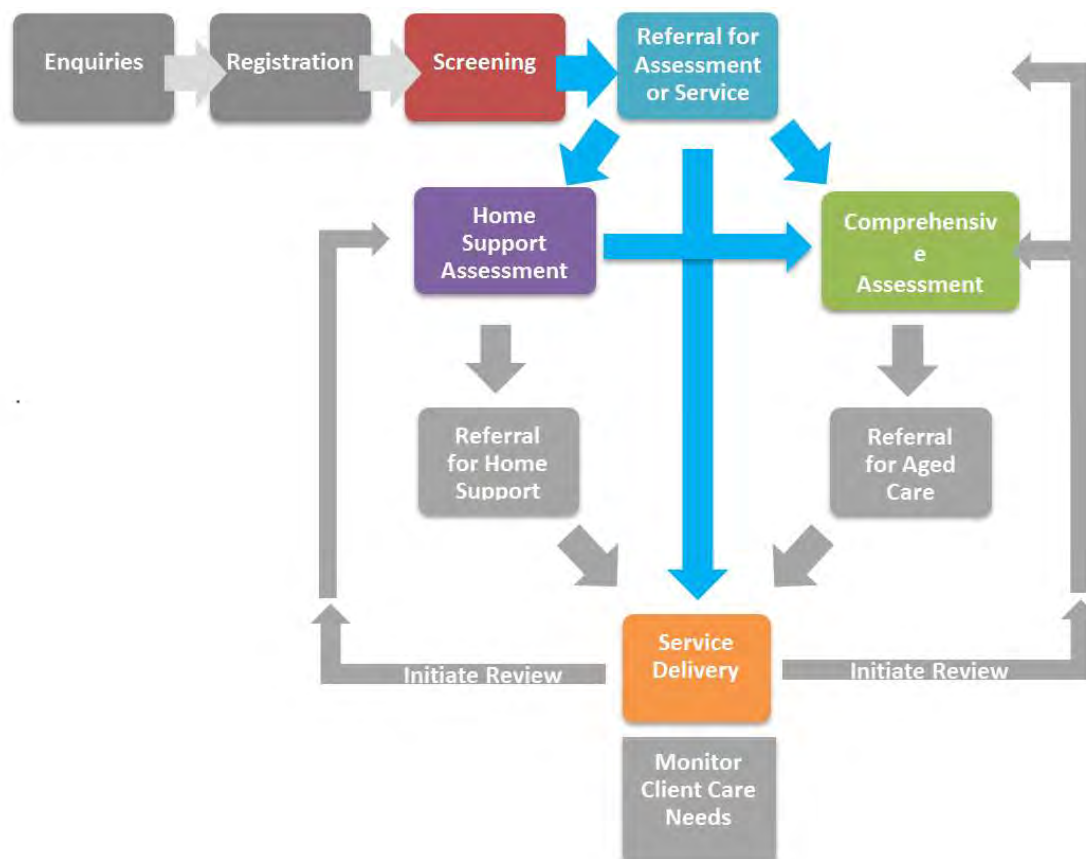
2. Consumer direction. This is an approach that is common to both aged and disability services and is important here. In some of the literature on wellness, consumer direction is seen to be a part of a wellness approach. In this document, consumer direction is described as a separate issue although it will be implemented in the CHSP and therefore something that will guide the assessment, planning and delivery of services alongside a wellness and reablement approach.
3. Sector support. Further support for the implementation of wellness, reablement and restorative care is expected to come from the Commonwealth's current review of sector support more generally.

### New Standardised Assessment Process for the Commonwealth Home Support Programme

A standardised assessment process is being introduced for clients to be able to access services delivered by the CHSP and for services under the Aged Care Act 1997. This is intended to promote equity by ensuring that access to aged care services is based on a consistent assessment of need and to offer clients an increased level of control over the services they receive. In broad terms, the way it will work is as follows (also see the *My Aged Care Pathways* diagram below):

- Screening to be conducted over-the-phone by the My Aged Care Contact Centre. By asking a broad and shallow set of questions, staff will be able to facilitate the appropriate client pathway – to Home Support Assessment, Comprehensive Assessment or direct to services.
- Home Support Assessment to be conducted face-to-face by My Aged Care Regional Assessment Services. This holistic assessment will determine eligibility for the CHSP and will result in the development of a goal-oriented support plan. This will include consideration of both formal and informal services that are most appropriate to provide the client with support.
- Comprehensive Assessment to be conducted face-to-face by Aged Care Assessment Teams. This will also include the development of a goal-oriented support plan and will determine eligibility for services under the *Aged Care Act 1997*.

### My Aged Care Pathways



## Consumer Direction

Consumer directed care, or consumer direction as it is referred to in the CHSP, is an approach to planning and management of care which allows consumers and carers more power to influence the design and delivery of the services they receive, where they want and are able to exercise choice. It seeks to tailor the mix and range of services to a client's preferences, where possible, as well as allow greater flexibility in the timing and scheduling of services and in how care is shared between informal and formal carers.

During 2011-12, Consumer Directed Care (CDC) pilot Home Care Packages were rolled out by some providers and evaluated by the then Department of Health and Ageing and interested stakeholders. An evaluation of the pilot found that there were benefits for older Australians and their carers in terms of increased satisfaction with their package of care and improved communication with providers<sup>13</sup>.

Building on the CDC evaluation, CDC principles<sup>14</sup> have been embedded in all new Home Care Packages and all new Home Care Packages allocated after 1 July 2013 are required to be offered on a consumer directed care basis. From 1 July 2015, all Home Care Packages will be operated on a CDC basis.

The concept of consumer directed care is now being implemented more widely in human services in Australia. In the National Disability Insurance Scheme it is referred to as supporting a participant's choice and control in "pursuit of their goals and the planning and delivery of their supports"<sup>15</sup>. The application of consumer directed care principles is also being investigated in relation to residential aged care.

In the CHSP, consumer direction means that individuals will be empowered to take charge of, and participate in, informed decision-making about the care and services they receive. In particular, clients will be supported to<sup>16</sup>:

- have access to detailed information on aged care options provided through My Aged Care;
- actively participate in assessment of their needs through a two-way conversation with My Aged Care assessors;
- identify any special needs, life goals, strengths and service delivery preferences;
- have their carer's needs recognised and assessed with assessors from My Aged Care;
- have access to free, independent and confidential advocacy services (pending implementation of an expanded aged care advocacy program from 1 July 2016);
- have options on how to select their preferred service providers (if they choose to) from information available through My Aged Care; and
- have access to client feedback mechanisms including the Aged Care Complaints Scheme.

For service providers, consumer direction under the CHSP requires them to:

- establish client consent to receive services as a prerequisite for all service delivery;
- ensure opportunities for client choice and flexibility are provided for each client, their carers and families;
- invite clients to identify their preferences in service delivery and where possible honour that request;
- deliver services tailored to the unique circumstances and cultural preferences identified by each client, their family and carers where possible;
- comply with the Charter of Rights and Responsibilities for Home Care;
- provide clients with a copy of the Charter;
- manage their service information via the My Aged Care web-based provider portal;

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<sup>13</sup> Evaluation of the consumer - directed care initiative: Final Report, Department of Health and Ageing, January 2012

<sup>14</sup> The CDC Principles can be found under Part A, 2.2 of the *Home Care Packages Programme Guidelines 2014*, at: <https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/home-care/home-care-packages-programme-guidelines-july-2014>

<sup>15</sup> National Disability Insurance Scheme Act 2013 (Cth), Objects and principles, section 4(2)

<sup>16</sup> Commonwealth Home Support Programme, Programme Manual 2015

- manage client referrals via the web-based provider portal; and
- update the service plan for the client on My Aged Care where services or client needs have changed.

### **Risk**

Consumer direction has implications for wellness, reablement and restorative care because it will be what a client wants to do and can do that will be the starting point in developing and implementing a support plan that has a wellness, reablement or restorative care focus. While there could be risks associated with what a client wants to do, each individual should be encouraged by the service provider to determine the level of risk he/she wishes to take on, along with appropriate risk mitigation strategies.

### **2015 Budget Changes**

Changes announced in the 2015 Budget<sup>17</sup> will progressively move aged care from a welfare-style system to one that empowers older Australians to choose their own care services, through a market-based system. From February 2017, funding for Home Care Packages will follow the consumer so they are free to select any approved provider to deliver their care. From July 2018, the intention is to combine Home Care Packages and the CHSP into a single integrated care at home programme.

These changes represent a significant shift in how care and support are delivered to older people and will involve consultation with stakeholders on the implementation and transitional arrangements.

The 2015 Budget also provided for additional short-term restorative care places (as a form of Flexible Care) to support older people to improve their capacity to stay independent and living in their homes longer, rather than prematurely entering residential aged care. The new care type will build on the success of the existing Transition Care Programme that assists older people to return home after a hospital stay. However, unlike transition care, short-term restorative care will be available to people before they end up in hospital.

These places will be established under the *Aged Care Act 1997* and further development work will be undertaken to determine issues of eligibility, assessment and service delivery arrangements – as well as their relationship with short-term restorative care assistance provided under the CHSP.

### **Sector Support for Implementing Wellness, Reablement and Restorative Care**

At present, a number of Development Officers and other community support positions are funded by the Commonwealth HACC Program to promote best practice in the development of a strong, cohesive community care system.

Victoria has comparable positions called Active Service Model Industry Consultants who have been employed to support organisations to implement the Active Service Model. They act as key communication points, assist organisations to gain a consistent understanding of the model and provide practical operational support. In Western Australia, CommunityWest provides a similarly supportive role. Staff from the CommunityWest Sector Development area engage with providers to assist with “readiness for wellness, change management strategies, informal sessions on assessment and support [for] planning documentation, planning and implementation advice, review of communication materials, staff information sessions and skill development workshops”<sup>18</sup>.

The Commonwealth is currently reviewing its approach to sector support and this includes consideration of activities that would support the sector to embed a nationally consistent wellness approach into service delivery using Commonwealth supplied resources and tools.

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<sup>17</sup> See More choice and better care for older Australians at: <http://www.myagedcare.gov.au/news/more-choice-and-better-care-older-australians>

<sup>18</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program’s Wellness Approach, p42

## 1.6 Working with Special Needs Groups

The target group for the Commonwealth Home Support Programme is frail, older people (people aged 65 years and over or 50 years and over for Aboriginal and Torres Strait Islander peoples) who need entry level care and support to assist them with daily living to remain living independently at home and in the community.

While assessment, support planning and service delivery will need to be tailored to each individual's circumstances, there are some groups of people within the target population with special needs. When working with people in these groups, to ensure the most appropriate responses are developed, some additional considerations might be necessary, for example: in rural and remote communities where specific support services or allied health professionals may not be available; when working in Indigenous communities where time is needed to develop relationships with people; in working with culturally diverse people where there may be specific cultural considerations and the need for an interpreter or involvement of a bilingual, bicultural worker; and when working with lesbian, gay, bisexual, transgender and intersex people where an understanding of the past experiences and history can impact on the person today.

[Appendix 3](#) provides a list of additional resources for some special needs groups including people who are vision impaired, those living with dementia, people requiring assistive technology, Aboriginal and Torres Strait Islander people, carers, people from CALD (culturally and linguistically diverse communities) and LGBTI (lesbian, gay, bisexual, trans, and/or intersex) backgrounds. It is intended that [Appendix 3](#) will be built up over time with additional material covering further special needs groups.

## 1.7 Role of Carers

In implementing wellness, reablement and restorative care approaches, it will be important to build on the strengths, capacities and goals of carers where they are key supports to clients, and enable carers to choose the extent to which they participate in these approaches<sup>19</sup>. This means engaging with clients and their carers as partners in wellness, reablement and restorative care.

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<sup>19</sup> The *Carer Recognition Act 2010* (Cth) provides a framework for recognising the relationship between carers and the persons for whom they care, and acknowledging the unique knowledge and experience of carers.

## Part 2 Implementing Wellness, Reablement and Restorative Care

### 2.1 Implementing a Wellness Approach

This section of the Good Practice Guide describes what is involved in implementing a wellness approach in home support services. It focuses on four key areas, namely organisational culture, assessment, support planning and service delivery - and explains what a good practice wellness approach looks like and what could be done to achieve this in each area. Provider organisations can use the material contained here to help to inform the way they implement or build on existing wellness approaches. Case studies and links to additional resources are included.

#### Organisational Culture

##### What it looks like

An organisation that has successfully embedded a wellness approach will have reorientated its processes and practices, as well as re-trained people involved in service delivery. This will involve a change in the mind set of stakeholders (management, staff, clients and families) with regard to their perception of the capacity of older people and people with disability to maintain, regain and improve their functioning, independence and autonomy. Successful organisations will demonstrate a focus on outcomes in the supports and services they provide, they will support staff to gain confidence in embedding the wellness approach in their work practices and will emphasise the importance of social connections to link individuals back to their community.

In *Challenging Community Care with Wellness*<sup>20</sup>, a number of attributes of organisational culture appropriate to the wellness approach are contrasted with the kind of attributes found in organisations that adopt a more traditional model. They are:

Traditional Model	Wellness Approach (Organisational culture)
<ul style="list-style-type: none"> <li>Organisational culture, structure processes and practices are service driven and not supportive of a person centred approach to service delivery;</li> <li>Client seen as a passive recipient;</li> <li>Focus is on outputs (such as the number of hours of Domestic Assistance a fortnight);</li> <li>Staff training reflects a dependency style model;</li> <li>Ageist culture - supports concept of older people being dependent on services;</li> <li>Looks to what is currently available from a service;</li> <li>Perception of HACC service for life. Tends to be ongoing until higher level of packaged care required or individual dies; and</li> <li>Uses language such as: can't do, disabled, frail, dependent, unable.</li> </ul>	<ul style="list-style-type: none"> <li>Organisational culture, structure, processes and practices supportive of a person centred approach to service delivery;</li> <li>Client seen as active participant;</li> <li>Focus on outcomes (goals that have been set by and are meaningful to the person receiving the support);</li> <li>Staff trained within a person centred model;</li> <li>Understand the impact of ageism;</li> <li>Offers beyond what is currently available and works towards the future;</li> <li>Recognise potential for HACC services to create dependencies/over service; and</li> <li>Uses language such as ability, can do, capacity, skills, goals, choice, connected, partnership.</li> </ul>

##### How to get there

The Victorian HACC program manual<sup>21</sup> provides a useful guide to understand what needs to be done to embed a wellness approach in provider organisations. Key elements include the following:

<sup>20</sup> *Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach*, p29

<sup>21</sup> [Victorian HACC program manual](#), pages 95-96.

### *Organisation management and leadership to support change*

It will be important for management of an organisation to be engaged and to lead and participate in the change process. Similarly, it will be essential for staff to be engaged, accountable and involved in the change.

### *Workforce development and staff education*

The wellness approach will need to be embedded in organisational policy and procedures, especially in recruitment, employment, orientation and induction practices, such as position descriptions and performance reviews. Equally, it will need to be embedded in staff training and education programs.

When needed, staff should be able to access skilled and knowledgeable staff with expertise, regardless of where the staff member is based. Staff should also be able to draw on multidisciplinary support and use of an interdisciplinary team approach and they should have time and support for case review and reflection, and other professional development strategies. There will also need to be supervision and support practices that reflect and enhance the wellness approach.

### *Changing the conversation and communication*

Communication with a client from the point of intake onwards will need to reflect that services are person-centred and will change according to a person's needs through a process of ongoing review.

Communications material, promotional materials, advertisements, and websites will need to reflect the wellness approach. It is also instructive to draw on the experiences of organisations that have adopted the wellness approach.

The following is a summary of the key findings from the initial planning and implementation stages with lead agencies in Western Australia in 2008<sup>22</sup>.

- The receptive context is very important.
  - Needs support from senior management and key drivers in each organisation to implement and sustain the approach
  - A 'can do' culture needs to be part of an organisation and its leadership
  - A previous history of successful change is beneficial along with ability of an agency to be flexible
- The goals of the change need to be clear and shared.
  - Staff need to believe in the benefits and any concerns discussed
- Communication is essential when implementing a new approach. It requires a change of culture at an organisational and client level.
  - Early and consistent messaging to staff, users and others is vital. Do not forget to include volunteers in this early dissemination of information, they are also pivotal to the success of this change process
- Wellness is a philosophical change and needs to be part of an agency's overall vision and approach to all services. A whole organisation approach.
- Early establishment of a development/steering group that have decision making powers is critical for timely and responsive implementation. This is best led by a senior manager and needs to include a cross section of staff.
- Home Care [Home Support] Managers and Supervisors are critical in persuading care workers of the merits of the approach.
- Time spent working with staff at the beginning is well spent as they gain confidence in this way of working.
- Important to establish a staged implementation rather than a big bang approach as this allows for evolution and safe testing and development.

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<sup>22</sup> [Wellness Approach To Community HomeCare: Information Booklet](#), July 2008, Home and Community Care WA and CommunityWest.



- Policies and procedures need to support the new way of working.
- A strategy for staff to be educated and trained to understand and take the approach forward needs to be developed.
- Mapping the processes and having action items helps to resolve any issues.
- Implementing the approach with new clients has proved easier than existing clients as you can start as you mean to go on. However, the approach has been successful with longer term clients by slowly introducing changes in work practices and encouraging and supporting clients to increase their capabilities over time.

In addition, organisations planning to adopt a wellness approach will be able to draw on the supports available in the sector. Furthermore, as noted earlier, the Commonwealth is currently reviewing its approach to sector support. An extensive range of wellness resources and tools is also available for organisations to use (see below).

### Case Examples/Other Resources

#### Case Example: Provider in Small Town in Western Australia

##### Transcript Submitted by Service Provider in Towards Excellence in Wellness Project, Western Australia<sup>23</sup>

###### *Prior to introducing the Wellness Approach:*

Prior to introducing the Wellness Approach we provided services to clients based on identified needs and the HACC guidelines. These were open to interpretation, however, so we were quite flexible about adapting services to meet needs. Often we did extras such as run to the shop or brush the veranda. Consequently, staff were often stretched to the limit.

We found that staff did not have much personal time with clients as they considered themselves there to 'do for' the clients. Some of the clients' attitude to the staff was that of 'servant/master'. We did not usually involve the client in the required service as it was usually quicker to do everything ourselves. It was quite a change for our clients when we introduced tea pots for the clients to serve themselves rather than us serving them.

###### *To implement the Wellness Approach our organisation had to change:*

We had to adopt a whole new way of working with clients. We had to identify individual needs, requirements, wants, likes and dislikes and how we as a service could help them meet their needs. In order to do this we had to provide staff with a range of training and support, provide up to date information for clients, carers and workers and ensure a good information flow across our services.

The relationship between client and worker is now that of a team with the worker assisting the client to maintain and enhance their capability.

Through talking with clients we now have a good idea of what's important to them and we try to make some of their wishes become reality. For example, we discussed with some of our clients their memories of growing up down South so we worked with them to arrange for a short holiday in Busselton to revisit their past. This we did with the help of Transport Passes.

On a more practical note, we had to change our documentation; website, training resources etc. and we also applied for and received funding to employ an extra Social Activities Officer to push the Wellness Approach.

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<sup>23</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach, p94

*To implement the Wellness Approach our staff had to change:*

- The way we speak to and about clients.
- Breaking tasks down to component parts.
- Doing with rather than to clients.
- Our training. All of our staff had to be up-skilled to work in partnership with clients.
- All of our documentation e.g. Day Care Centre became Activity Club.
- More regular client follow ups.
- In some cases our mind set.
- We now know of and recommend more aids and equipment to help clients remain independent.
- Many of the staff had to relinquish some of their previous roles and ways of doing things to make time for wellness supporting activities.

## Resources

- *Challenging Community Care with Wellness – An implementation overview of the WA HACC Program’s Wellness Approach* [101 pages] at: [https://www.communitywest.com.au/news/newsletters/cat\\_view/74-wellness/206-wellness-publications](https://www.communitywest.com.au/news/newsletters/cat_view/74-wellness/206-wellness-publications) [This paper provides an overview of wellness and what is required to implement a shift in focus in the delivery of support services from a traditional model]
- *Pathway to WA HACC Wellness Approach – Stage 1: Planning* [33 pages] at: [https://www.communitywest.com.au/news/newsletters/cat\\_view/74-wellness/219-wellness-tools-guides-useful-resources](https://www.communitywest.com.au/news/newsletters/cat_view/74-wellness/219-wellness-tools-guides-useful-resources) [This is a tool developed in Western Australia to assist provider organisations to work their way through the various steps needed to prepare to implement a change in focus to a wellness approach to service delivery]
- *Pathway to WA HACC Wellness Approach – Stage 2: Implementing Wellness* [25 pages] at: [https://www.communitywest.com.au/news/newsletters/cat\\_view/74-wellness/219-wellness-tools-guides-useful-resources](https://www.communitywest.com.au/news/newsletters/cat_view/74-wellness/219-wellness-tools-guides-useful-resources) [This is a tool developed in Western Australia to assist provider organisations to work their way through the various steps needed to implement a change in focus to a wellness approach to service delivery]
- *ASM [Active Service Model] Implementation Plan Template*, at: [http://docs.health.vic.gov.au/docs/doc/BECAB48ECE202383CA257CA7000F1BD2/\\$FILE/ASM%20Implementation%20plan%20template%202014-15.docx](http://docs.health.vic.gov.au/docs/doc/BECAB48ECE202383CA257CA7000F1BD2/$FILE/ASM%20Implementation%20plan%20template%202014-15.docx) [This template is used in Victoria for providers to develop their individual provider-level plans for implementing the active service model]
- *Towards an enabling approach in community care*, October 2010, [NSW document] at: [http://www.adhc.nsw.gov.au/\\_data/assets/file/0010/233965/Better\\_Practice\\_Project\\_-\\_Discussion.pdf](http://www.adhc.nsw.gov.au/_data/assets/file/0010/233965/Better_Practice_Project_-_Discussion.pdf) [An introduction to New South Wales’ equivalent of the wellness approach, called “enabling approach”]
- *Victorian HACC Active Service Model Implementation Plan, 2009—2011*, at: [http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.health.vic.gov.au%2Fhacc%2Fdownloads%2Fpdf%2Fasm\\_plan.pdf&ei=g-yEVPScC8LI8AXX6YLACA&usq=AFQjCNG-Isd3X4adDU\\_AHmffmHxrd-2WBw](http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.health.vic.gov.au%2Fhacc%2Fdownloads%2Fpdf%2Fasm_plan.pdf&ei=g-yEVPScC8LI8AXX6YLACA&usq=AFQjCNG-Isd3X4adDU_AHmffmHxrd-2WBw) [Implementation plan for the HACC Active Service Model in Victoria for the period 1 July 2009 to 30 June 2011]
- Training material:
  - In Victoria, the Department has created a Statement of HACC Education and Training Priorities Consultation Paper, at: [http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.chisholm.edu.au%2F~%2Fmedia%2Ffiles%2Fmarketing%2Fstatementoftrainingpriorities&ei=Rcx7VLHlPOPvmAXB7IC4CQ&usq=AFQjCNHTM\\_EiNYu9vFXM5r5CG8SequtYBA](http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CB0QFjAA&url=http%3A%2F%2Fwww.chisholm.edu.au%2F~%2Fmedia%2Ffiles%2Fmarketing%2Fstatementoftrainingpriorities&ei=Rcx7VLHlPOPvmAXB7IC4CQ&usq=AFQjCNHTM_EiNYu9vFXM5r5CG8SequtYBA) [This document specifies a range of elective and core units that, in general terms, focus on knowledge of the client group and/or practical skills required to deliver services with an Active Service Model perspective. The provider of training in Victoria is the Chisholm Institute]



- In Western Australia the HACC program has partnered with CommunityWest, a not-for-profit organisation, to design and develop the wellness approach and to mentor and support WA service providers to implement it.
- [HACC – Active Service Model: communications toolkit handbook](#) [The toolkit is designed “to communicate the move to the ASM approach to clients, carers, non-HACC funded service providers and the community” (p2)]
- [WA HACC Program Communications Kit – Talking about Wellness](#) at: [Provides Western Australian HACC service providers with tools, information and guidance to use when talking to clients, carers, staff and volunteers about the wellness approach]
- [Supporting Volunteers to take an Active Service Approach - A Resource Kit for Victorian Home and Community Care services](#), 2013 [Victorian kit designed to assist HACC-funded organisations in supporting volunteers to take an Active Service approach]

## Assessment

### What it looks like

This section is particularly relevant for My Aged Care Regional Assessment Services and Aged Care Assessment Teams. Assessment is a process of engaging with a client to be able to understand the needs they have. In the CHSP this process will be undertaken by the My Aged Care Contact Centre and Regional Assessment Services – as described earlier.

A National Screening and Assessment Form has been developed to facilitate the collection of information about a client’s needs and areas of support. It will be used to document a client’s current level of support (formal and informal) and engagement; carer availability and sustainability; health concerns and priorities; functional status; psychosocial and psychological concerns; home and personal safety considerations; and decision making capabilities. It also allows for the identification of any complexities a client may have that indicate a level of vulnerability. This allows the Regional Assessment Service to have an understanding of the client’s needs, abilities, strengths and areas of concern which will be the basis for the development of the client’s support plan to be actioned by service provider(s).

While the assessment process will be undertaken by the My Aged Care Contact Centre and Regional Assessment Services, it will be important for service providers to understand how this process works, the information that has been collected about the client’s needs, and the support plan that has been developed based on the client’s goals. Service providers will have a responsibility to work with clients to achieve their goals through innovative service delivery, and to update a client’s information should their needs change. This functionality will be available through the Service Provider Portal in My Aged Care<sup>24</sup>.

Furthermore, as noted in a Victorian guide to assessment and care planning, “assessment is usually not a one-off event, but an ongoing process of building trust and understanding”<sup>25</sup>. In this regard, it might be the service provider who will come to understand that a client’s needs have changed or that the services built into the support plan are not achieving the desired outcomes.

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24 The My Aged Care Service Provider Portal is a web-based link through which service providers will be able to:

- accept a referral;
- view client details and support plan;
- record service information; and
- submit a request for a client to be re-assessed.

<sup>25</sup> [Strengthening assessment and care planning – A guide for HACC assessment services in Victoria](#), 2011, p15.

Within this wider view of what constitutes assessment, it will therefore be useful for service providers to have knowledge of what is good practice. The Western Australia publication *Challenging Community Care with Wellness*<sup>26</sup> identifies the following elements:

- Assessment is critical to understanding the issues, needs and preferences as well as setting a person's expectations about how the HACC Program [CHSP] might support them. It is an ongoing process that begins at the first point of contact and continues through to service delivery, review and reassessment.
- Within a wellness framework, individual assessments need to incorporate the social, functional, psychological and physical elements of an individual's life as well as what is intrinsically important to each client; what gives their life meaning and purpose. Assessment needs to be strength based and conducted in a way that recognises a person's skills and abilities, what a person can and wants to do, their choices and priorities and promotes their personal independence and autonomy.
- The assessment needs to be a problem solving exercise in which the assessor, client and/or carer together identify a person's difficulties, what factors are potentially limiting independence and agree on solutions to these problems. Solutions may, or may not, include a HACC Program [CHSP] funded service. Nevertheless the assessment establishes goals of support which drive the development of the support plan and any subsequent service delivery or referral.

### **How to get there**

The assessment process to be administered through the My Aged Care Contact Centre and Regional Assessment Services will be supported by the My Aged Care National Training Strategy. For providers who elect to strengthen this aspect of their own services, some additional advice comes from the Western Australian experience. Observations drawn from providing support to providers in Western Australia include the following<sup>27</sup>:

- Emphasis [of support] was focused on building awareness and skill around what constitutes a wellness focused assessment. This incorporated how such an assessment might be conducted including elements such as communication style and approach; use of empowering language to build confidence and capacity; the information required and how to elicit through questioning; and the collaborative process necessary to ensure that goals are clarified and affirmed by the client.
- In the training to support this skills development, various examples were used to demonstrate how a wellness response differs according to the person's needs and goals. These are then contrasted against the more traditional dependency model so that the focus is on supporting a person to adapt to or retain ability levels, learn new skills and stay connected with people, places and pursuits important to them. The key in adopting this focus starts from the premise that it is not about matching available services to a client but rather how the organisation would work with the individual and support them across a range of support needs. The new approach to assessment, support planning and service delivery therefore makes the assumption that a person is capable of being a partner in the process. They are not a passive recipient of services. Instead the focus is on the individual's outcome rather than the service output.

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<sup>26</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach, p32, at: [https://www.communitywest.com.au/news/newsletters/cat\\_view/74-wellness/206-wellness-publications](https://www.communitywest.com.au/news/newsletters/cat_view/74-wellness/206-wellness-publications)

<sup>27</sup> Ibid

## Case Examples/Other Resources

### Case study: Mrs C

Mrs C is 81 years old and lives alone. She had been actively involved in her church and local community before experiencing a stroke earlier in the year. Following the stroke, Mrs C stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she has also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening. The assessor who saw Mrs C focused on her strengths and abilities as well as her needs. Together they discussed what Mrs C would most like to achieve from a support plan. Mrs C's expressed goals were to get stronger, resume her church activities, do more about the house and get back out in the garden.

\*See under Support Planning for more on this case study

Source: Towards an enabling approach in community care<sup>28</sup>

### Resources

- [Challenging Community Care with Wellness – An implementation overview of the WA HACCC Program's Wellness Approach](#) [101 pages] at:
- [Western Australian \(WA\) Home and Community Care \(HACC\) Program Assessment Framework Service Redesign](#), April 2009, [This is the foundation document in Western Australia that underpins the current model of access and assessment in that state]
- [Framework for Assessment in the Home and Community Care Program in Victoria, 2007](#), [This document provides background to establishment of access points and a consistent approach to assessment and client care coordination in Victoria]
- [Strengthening assessment and care planning – A guide for HACC assessment services in Victoria](#) [196 pages. There is also a workbook that accompanies the guide [36 pages].

## Support Planning

### What it looks like

Support planning is a process through which My Aged Care Regional Assessment Services (and Aged Care Assessment Teams) assessors and clients collaborate to set goals, establish priorities and develop strategies to achieve positive and meaningful outcomes. The assessor will record assessment information and create a support plan with the client. The support planning process is underpinned by a wellness approach with the assessor seeking to:

- develop an understanding of the client's (and carer's, if applicable) reason for seeking assistance, the areas of concern the client wishes to address and the outcomes the client is seeking to achieve;
- support the client to live independently, in their own home wherever possible;
- provide support in a respectful manner which upholds the client's rights, dignity and sense of control;
- offer choices and focus on encouraging the client to regain skills and capacities wherever possible; and
- consider solutions and strategies that can be achieved through formal Commonwealth funded and other available services in the client's preferred location as well as informal services such as facilitated by social, community and family connections.

The support plan is a component of the National Screening and Assessment Form that details the outcomes of discussions with the client and is used to decide what support is appropriate. The assessor will also take into account existing services the client is receiving and whether these services are still required.

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<sup>28</sup> *Towards an enabling approach in community care*, October 2010, at:  
[http://www.adhc.nsw.gov.au/\\_data/assets/file/0010/233965/Better\\_Practice\\_Project\\_-\\_Discussion.pdf](http://www.adhc.nsw.gov.au/_data/assets/file/0010/233965/Better_Practice_Project_-_Discussion.pdf)

The assessor and client will work collaboratively to look at areas of priority and concern, identify the client's goals, assess the client's motivation level to meet the goals and, identify the agreed actions to achieve the client's goals. The process is designed to identify:

- scope of the support that is recommended;
- any particular needs or preferences including area of service delivery;
- extent and duration of recommended services;
- scheduled review date for either the service provider or assessor to undertake; and
- other recommendations which may assist with the client's wellbeing.

At this point, clients could be referred to a suitable CHSP service provider. The service provider will receive the referral through the My Aged Care Service Provider Portal where they will be able to access the client's record, assessment information and support plan. If a client would benefit from a short course of targeted interventions, the assessor could refer the person to a CHSP provider as part of a short term reablement service (see section 2.2 Implementing a Reablement Approach). Those with more complex needs could be assisted through short term case management and linked to a range of services.

While the support plan will be developed between the client and the My Aged Care Regional Assessment Service, it will be important for service providers to understand the process and the significance of the support plan to achieving good outcomes for clients in the CHSP. It will give the service provider an insight into the goals of the client and the support they have agreed to receive to meet those goals. Combined with the assessment information, it will give a service provider an indication of the client's needs, the activities the client can complete themselves and the activities they may need further assistance with. It will also give service providers an indication of the client's satisfaction with their level of independence and their motivation to achieve their goal(s) - important considerations when delivering services.

As with assessment, support planning is also a continuous process and needs to be revisited as a person's circumstances and goals change. Providers can become involved in this in their day to day contact with clients and can request a review be undertaken by the My Aged Care Regional Assessment Service based on these interactions.

Experience in this area in Western Australia<sup>29</sup> points to the following good practice findings:

- Goal orientated support planning takes on a much greater focus within a wellness framework. It considers why the person has accessed HACC [CHSP] services, what motivates them and what goals they would like to work towards.
- The support plan is not just a list of the services to be delivered. It links identified needs to planned services with defined goals related to specific functional difficulties, to the particular support to be provided and the desired outcomes. The focus is always on the person/carer and their own goals with the service support contributing to these goals, not as an outcome in themselves.
- Support planning developed in partnership with the client utilises a capacity building approach. This is an approach that clearly identifies the client's goals which in turn enables the client, service provider and support worker to work together to develop the strategies to achieve the stated goals and determine how support can best be provided.
- Determining the best ways to address the person's goals requires critical thinking, dynamic problem solving and development of creative solutions so that options outside of the normal square are explored. Within a wellness framework, support is more likely to involve both formal organisations and informal community resources and networks to support a person to reach their goals.
- Review of support is essential and a proactive process that works with the person to track their progress towards achieving their goals and the support plan adjusted accordingly to reflect the individuality and changing needs of the client.

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<sup>29</sup> *Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach*, p33

- The success of a wellness assessment and goal based support plan can become just an exercise if support is not delivered in a manner that builds on the capacity of the individual at all times.

### How to get there

As indicated, My Aged Care Regional Assessment Services will develop a support plan with clients and recommend support in line with the client's goals. Service providers will have a role in implementing a client's support plan and in advising My Aged Care on any changes in the client's circumstances. It is therefore useful to understand what might trigger a review of a person's support plan. Triggers, most commonly arising from a change in a person's circumstances or functional ability, might include:

- a review date set at the time of assessment;
- additional home support services are required;
- an extension of existing home support services is required;
- the client is no longer in need of the service (eg. they have reached their goal); or
- the client requires a Comprehensive Assessment for services under the *Aged Care Act 1997*.

Should the service provider identify the need to reassess a person's support plan, they can complete a 'request for reassessment' through the Service Provider Portal or contact the My Aged Care Regional Assessment Service directly.

Should a client require an increase in the intensity of service provision or a change to the schedule of service delivery, service providers will be able to enter this information into the client's record via the Service Provider Portal.

In this context, it will also be useful for providers to understand what goes into the support planning process. Some insight is provided by Victoria's assessment and care planning guide<sup>30</sup>. The Victorian model starts with 'Where the person is now' (Assessment stage), leads to 'Where the person wants to be' (Goal setting) and ends with 'How the person will get there' (the 'Care plan' or support plan). The guide also provides a number of 'tips' for engaging with a client when talking about goals, as reproduced here.

Prompts to identify a person's goals could include:

- Ask the person if there is something they have not done for a while that they would like to do again.
- Pick a cue from the conversation, for example they might mention that they normally go to a club or meeting but have stopped this for some reason.
- Ask the person if they have a special family event coming up that they would like to attend.
- Discuss activities that the person used to do but now finds difficult.
- Encourage the person to take time to think about their goals. This may mean you have to return at a later date to continue with goal setting (with the person's permission you might like to arrange a family member to help with the goal setting exercise).

The guide also explains how to respond when a client is not being specific about their goals. It is suggested that, for each main goal a person has, there may be a series of smaller steps that can be identified and made achievable. For example, a person might say "I want to remain at home". Suggested prompts include:

- What do you need to do to stay at home? (It could be that the steps required are to shower independently, make my own meals, get in and out of bed, get to the toilet in the middle of the night safely).
- What is it about being at home that is important to you? (It could be that they need to be able to look after their cat, that this is where they have lived for 60 years and they love walking around the garden).

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<sup>30</sup> Strengthening assessment and care planning; A guide for HACC assessment services in Victoria, Department of Health (Victoria), 2011, p146

## Case Examples/Other Resources

### Case study: Mrs C (continued – the earlier part of this case study shows the assessment phase)

Mrs C's support plan was centred on her achieving her own goals. To help her do this, she agreed to:

- consult her GP and undertake a light home exercise program designed with an allied health worker
- when stronger, join a twice weekly exercise program at a local neighbourhood centre
- work with a domestic assistance service and divide housekeeping tasks into the following categories: 'too heavy for now' (to be done by the service); 'I can do with help' (to be shared with the service); 'I will do' (to be done by Mrs C)
- review and renegotiate these housekeeping tasks at least every three months
- receive assistance to identify and make contact with a person, eg a pastoral care team member, to discuss her continued interest in participating in church activities
- accept referral to an easycare gardening service for discussion and planning on converting her garden to become low maintenance.

### Outcomes

After mastering basic strength and balance exercises through the home exercise program, Mrs C was eventually able to walk unaided inside her home. A more confident Mrs C then arranged a 'buddy' to drive her to and from church activities in return for a home-cooked meal one night a week. After six months, some housework tasks were moved from the 'I can do with help' to the 'I will do category', meaning that Mrs C needed fewer hours of domestic assistance. She was delighted to find that the new raised garden beds, dry spell planting and better mulching reduced the amount of garden maintenance needed without affecting her enjoyment of the garden.

### Resources

- *Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach* [101 pages] at: [https://www.communitywest.com.au/news/newsletters/cat\\_view/74-wellness/206-wellness-publications](https://www.communitywest.com.au/news/newsletters/cat_view/74-wellness/206-wellness-publications)
- Strengthening assessment and care planning – A guide for HACC assessment services in Victoria [196 pages] at: <http://www.health.vic.gov.au/hacc/assessment.htm>. There is also a workbook that accompanies the guide [36 pages].

## Service Delivery

### What it looks like

Good practice in service delivery that employs a wellness approach will focus on what a person can do and wants to be able to do, not just on what they are unable to do at present. It will offer people the opportunity to be actively involved in addressing their goals, participating alongside their support workers to achieve them.

There needs to be a clear connection between the assessment, support planning and service delivery to ensure the desired individual outcomes are achieved. This will be especially important in the CHSP where the assessment/support planning is conducted independent of the service provider. There might need to be some clarifying of the support plan with the client to make sure there is a common understanding of goals and service expectations. How and when the services will be delivered to support a wellness approach will need to be discussed and agreed with the client.

In Western Australia where separation of assessment/planning and service delivery is already in place, the functions of organisations providing the service delivery part of the overall home support process are described as follows:

- work with the client/carer and their support networks to ensure that the personalised goal directed support plan is implemented;



- monitor services to ensure that they are delivered effectively and are achieving the objectives of the support plan;
- ensure the support provided continues to meet client/carer needs;
- initiate contact with HACC Assessment and Coordination Agency [that is, Regional Assessment Services under the CHSP] when a change in need/circumstances has been identified, including attainment of goals; and
- maintain 'availability of service' profile via Access Points.<sup>31</sup>

In practice, the wellness approach in service delivery will look different in each case because of the variety of circumstances in which services are delivered. Some examples<sup>32</sup> are:

- Someone requiring meal assistance might, instead of being provided delivered meals, being taught how to plan simple menus, shop accordingly and then cook.
- Activities such as personal care and housework are done with the client doing as much as they can and the support staff doing those activities that the client can no longer manage unassisted. So they work together.
- Social support is delivered in a way that identifies the client's previous social connections and works towards reconnecting back to previous or new activities. Rather than providing an in-home social support service that can, in itself, be isolating.

Contrasting the wellness approach to service delivery with a more traditional approach helps to highlight its good practice characteristics, as shown in the following table<sup>33</sup>.

Traditional Model (Service delivery)	Wellness Approach (Service delivery)
<ul style="list-style-type: none"> <li>• Current service delivery does not actively work with the service recipient towards preventing loss of independence/wellbeing;</li> <li>• Emphasis on maintenance of older person/no emphasis on reskilling of clients – focus is on outputs such as the number of hours of personal care per week;</li> <li>• Services provided to substitute for clients own efforts to look after themselves;</li> <li>• Quicker to 'do for'; and</li> <li>• Reviews occur when the situation or client's needs change.</li> </ul>	<ul style="list-style-type: none"> <li>• Recognises client abilities and need to regain/retain;</li> <li>• Recognises that service support needs to enable the person and provide opportunities to build capacity – focus is on achieving outcomes;</li> <li>• Service support provided for those activities that the individual cannot do without assistance;</li> <li>• Supports 'to do' or 'do with'; and</li> <li>• Regular review is built into the care plan.</li> </ul>

<sup>31</sup> Western Australia (WA) Home and Community Care Program, Assessment Framework – Service Redesign, Implementation Plan – Phase 1, at: <http://www.health.wa.gov.au/HACC/assessment/index.cfm>

<sup>32</sup> *Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach*, p34

<sup>33</sup> *Ibid*, p31 and *Towards an enabling approach in community care*, p7

Kiama Meals on Wheels service (see example in box below) shows how a traditional service can be provided in a way that adopts a wellness approach.

### **Case Example: Kiama Meals on Wheels**

The concept that a meals service might just be an interim measure has been quite well received in the Kiama community. Kiama Meals on Wheels has been able to achieve this by taking a wellness approach and working with people to define their individual goals. “We try to look at where people are now, where they were before they came to us and what they need to get back there” (Coordinator, Kiama Meals on Wheels Inc). The meals service might be used to complement a person’s skills or as a stepping stone to rebuilding skills. This has meant that while the service is supporting an increased number of people, the number of meals being delivered has declined for some individuals.

Source: *A handbook for community care services: Empowering people, enhancing independence, enriching lives*, p39

### **How to get there**

For organisations to be able to deliver services using a wellness approach, service delivery will need to be embedded in a supportive culture, as described earlier. Staff will need to have been involved in training that shows how the wellness approach can be applied in various settings, and staff will need to be able to draw on support from their supervisors for guidance in working with individual clients. In New South Wales, a number of lessons for service delivery were reported from providers based on their experiences in introducing what are described as “enabling practices”<sup>34</sup>. They include the following:

- Focus on achieving the goals of each person. This will promote their engagement and the likelihood of success.
- Build on the interests, skills, history and culture of each person.
- Integrate support into everyday home and community activities.
- There are people to help within the HACC [CHSP] community. This includes allied health staff, dietitians, HACC development officers and Multicultural Access Project (MAPS) workers.
- Don't reinvent the wheel. Find out how others have dealt with the same issues you are facing.
- Staff and volunteers can be inspired by the results an enabling approach achieves with individuals.
- Training of staff and volunteers is vital.
- ‘Doing with’ rather than ‘doing for’. Enabling practices may initially require more direct support time. However, this may be outweighed by the benefits for the older person in restored independence, for the support worker in witnessing the older person’s improved quality of life and for the system in delaying or avoiding hospital and residential care admissions.
- Cultural competence is important. Recognising the cultural and linguistic diversity of the person is fundamental to enabling approaches. People from diverse backgrounds will not gain confidence in or use available services without such recognition.
- Bilingual, culturally competent workers are needed to support people to engage in culturally appropriate activities at valued and culturally safe venues and to connect with their community. Workers need training and support to understand how a key part of a person’s identity is their culture and language and their engagement with their community.
- Older people may think their physical or social capability is limited. Consistent with experience elsewhere, older people may need information and education to understand that their current situation may improve - “Often the older people we support think they are too old to plan, to dream and to set goals. We show they are not. The 76 year old man is back on his bike – albeit a tandem – after a stroke and the 93 year old with dementia dresses up every Wednesday night for dinner with friends” (General Manager, Health and Community Services, ACH Group, South Australia).

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<sup>34</sup> A handbook for community care services: Empowering people, enhancing independence, enriching lives, pp 7-9



- Partnerships with other HACC service providers [CHSP providers] and with other parts of the broader health and community care sectors are needed. Providing support which is person-centred and enabling will often require working beyond a single service type and involve collaboration with other HACC providers and tapping into skills held by other agencies.
- Initiatives should be informed by evidence. For example, research findings are clear about the benefits of a minimum of 30 minutes of appropriate, daily exercise. There are many clinically tested exercise programs relevant to the older population.
- Staff need to check service progress and results, and if necessary refine the approach. Mechanisms need to be put in place to check changes with the person receiving support, their carers and families, workers and other stakeholders. HACC service providers can learn from what does not seem to work, while celebrating successes.

These lessons from New South Wales are supported by additional findings from implementation in Western Australia<sup>35</sup>. This suggests that, when implementing a wellness approach at the service delivery level, providers should be aware that:

- It is easier to implement a wellness approach with new HACC [CHSP] clients enabling more positive expectations to be set from the start of service engagement.
- Because it is more difficult to engage people who are already in receipt of community care services, in these instances changes need to be implemented more slowly.
- Engaging and gaining the support of individuals/families will impact positively on adoption and make a difference to the outcome.
- Time needs to be spent messaging the value of wellness to individuals, families and the community.

Blue Care, Queensland offers a practical example of what a shift in service delivery to a wellness approach might involve. It has developed a new service model based on wellness principles called *Tailor Made* and the new service model is described in various publications for clients<sup>36</sup> and staff. Blue Care has defined the 'approach' and a number of service characteristics for staff and clients as a guide to the way services will be provided within the Blue Care network (see box below).

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<sup>35</sup> Challenging Community Care with Wellness – An implementation overview of the WA HACC Program's Wellness Approach, p52

<sup>36</sup> See, for example, [Blue Care – Client Information Book](#)

### **Case Example: Tailor Made - Blue Care's approach and services for the future**

#### **Our Approach**

It is the person who comes first and is at the centre of all we do. Each individual's uniqueness is appreciated. It is an equal partnership. The role of family and friends is also recognised and is an important part of the partnership.

Actively listening, we hear the needs and wants of the individual. We recognise the focus of their skills and capabilities. This guides the design and delivery of service and accommodation solutions that are individually 'tailor made'. Services are then delivered in such a way that the person is in control rather than controlled.

#### **Characteristics**

- Doing with not doing for
- Flexible and proactive
- Partnerships and working together
- Being sustainable
- Building from strengths
- Seamless and inclusive
- Appropriate and accessible
- Local solutions

### **Case Examples/Other Resources**

#### **Case study: Mrs Smith**

Mrs Smith is a 72 year old woman with osteoarthritis who has been receiving domestic assistance once weekly for 1.50 hours for general housework and laundry. She requires no other assistance. Mrs Smith was reviewed from a wellness perspective.

This concluded that Mrs Smith can do light dusting, wipe over surfaces, do her own dishes, use a light weight carpet sweeper and put laundry on, during/prior to domestic assistance visits. Over a two month period Mrs Smith has been encouraged to do all of the above activities. A domestic assistance service now goes in once fortnightly only and Mrs Smith is now more involved and has increased activity levels.

#### **Case study: Rose**

Rose is an 87 year old woman who, as a day centre client, had become very dependent on support staff. Her confidence had declined to the point where she was not confident in tending to her own toileting without assistance to and from the toilet at the centre. After much discussion between centre staff and Rose, it was agreed that she was perhaps well enough to do more for herself in the centre and over time was encouraged to do so. Staff were advised to enable her to tackle her toileting independently rather than attempt to assist as previously.

Over time Rose has become more confident and is independent at the centre. This confidence has extended to transport arrangements to and from the day centre. Rose does not like to travel on the centre bus, so has arranged her own transport on the days she attends. She has commented on how proud she feels of herself and her achievements and is now more actively involved with the centre, rather than being a passive recipient.

Source: Wellness Approach to Community Homecare, Community West, July 2008

**Case study: Robert**

Robert is a 67 year old man with cerebral palsy who found that he could no longer take care of his garden. In the past, his wife, who also has cerebral palsy, had been able to provide him with support with garden tasks. However, when her health deteriorated to a point where she could no longer help him, Robert had to give up this work.

Robert mentioned to his assessment officer how much he missed mowing the lawn and tending the garden. He was fiercely independent and wanted to continue doing these tasks—all he needed was help. The assessment officer arranged for a home maintenance officer to come on a fortnightly basis to help him put his 'wellies' on, get the mower safely out of the garage and provide general oversight.

The home maintenance officer really enjoyed the experience of working with Robert, commenting, 'He's quite a character.' As for Robert, he has felt a return of his self-confidence and the pleasure of 'feeling normal'.

Source: Leading Age Services Australia (LASA)

**Case study: Ahmed**

Ahmed is a 75 year old Lebanese man who was finding it difficult to cook because he could not stand for long periods of time. Rather than enrolling him in a meals program, the assessor organised an Arabic speaking community care worker to provide assistance with meal preparation twice a week and arranged for the purchase of a stool to be used at the kitchen bench.

Ahmed selects meals from a Lebanese cookbook, and the two prepare the food together. This provides an opportunity for socialising for the client, whose English skills are poor, learning food preparation skills he can apply himself at other times, as well as enabling him to enjoy his preferred food.

Source: Leading Age Services Australia (LASA)

**Resources**

- [A handbook for community care services: Empowering people, enhancing independence, enriching lives](#) [NSW document]
- Self Directed Learning Workbook: Working the Wellness Way, Silver Chain, Western Australia [This is a 39 page document that is made up of short statements about wellness and activities for the worker to figure out – typically a scenario with multiple choice questions] [Not available online]
- [Aged Care Professionals Toolkit](#) I-Phone App.
- Introduction to the Active Service Model: A Learning Resource for Home Support Workers, Municipal Association of Victoria, 2010 [Powerpoint introduction to the Active Service Model with case studies and notes for presenter] [To be made available through the [Municipal Association of Victoria website](#)]
- Introduction to the Active Service Model: Why Active Service is Good Idea: A Learning Resource for Home Support Workers, Municipal Association of Victoria [Powerpoint introduction to the Active Service Model] [To be made available through the [Municipal Association of Victoria website](#)]
- DVD demonstrating the benefits of the [Active Service Model in Victorian HACC services](#).
- [Imagining a better life for older people - Co-ordinator's Handbook, Aged & Community Services SA & NT](#), [Described as a "tool to open up the world of possibilities for creatively meeting people's needs, and helping them to continue a meaningful lifestyle in the community"]

## 2.2 Implementing a Reablement Approach

A reablement approach has the same aims and adopts the same strengths-based approach as does a wellness approach. What distinguishes it is that it involves specific, time limited interventions targeted towards a person adapting to some functional loss. However, because it draws on a wellness philosophy, reablement will be part of the same cultural shift required to introduce a wellness approach (as described under section 2.1). The cultural change material under the section Implementing a Wellness Approach will therefore not be repeated here. The focus in this section will be on good practice issues that relate specifically to assessment and support planning, and service delivery. Additional resources organisations might choose to consult include the following:

- [A new reablement journey](#) by Pitts, J et al, p7.

### Assessment and Support Planning

#### What it looks like

Assessment of clients for assistance through a reablement approach is undertaken by the My Aged Care Regional Assessment Service where staff will have a responsibility to work with clients to achieve their goals. Reablement will be an integral part of the overall assessment process, as described under section 2.1 rather than a separate, reablement-specific assessment. The My Aged Care Regional Assessment Service will apply additional criteria to determine whether a person could be suitable for reablement. The assumption is that reablement could be a useful intervention for a smaller sub-group of the overall CHSP client group. The additional criteria are as follows:

- a person would benefit from a short course of targeted interventions to maximise their independence, choice, and quality of life;
- the priority and nature of the person's goal of care and whether this can be addressed through a reablement approach;
- the person's level of motivation to achieve their goal; and
- service availability and client priority.

In summary, the assessment process involves collecting evidence of a person's current circumstances and capabilities (using the National Screening and Assessment Form) and then making an assessment about whether these circumstances, the person's goals and motivation, indicate that a reablement approach will be effective. This is consistent with the guidance provided by the Social Care Institute for Excellence in the UK<sup>37</sup> which proposes that assessment for reablement services be based on what it refers to as the four 'Ps'; that is, Previous, Present, Predict and Prevention. The check list of questions is included below<sup>38</sup>:

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<sup>37</sup> [Reablement, Module 2: Reablement for care workers](#), Social Care Institute for Excellence, UK.

<sup>38</sup> Additional questions could be developed depending on the client's circumstances. These might include questions about communication, transfer/sit to stand ability (movement), the impact on an individual's ability to engage in activities of daily living (for people with disability) and other issues.

<p><b>Previous</b></p> <ul style="list-style-type: none"> <li>• Do they live alone?</li> <li>• How is their mobility?</li> <li>• Do they sleep upstairs?</li> <li>• Do they need grab rails or adaptations?</li> <li>• Is there a toilet downstairs – if not, what are the options?</li> <li>• Do they self-medicate?</li> <li>• Can they prepare food?</li> <li>• Is their ability and safety awareness consistent?</li> <li>• How do they feel they are coping in their usual situation?</li> <li>• Was their admission or illness from a new condition or was it an escalation of a previous condition?</li> </ul>	<p><b>Present</b></p> <ul style="list-style-type: none"> <li>• What is their mobility status?</li> <li>• Do they need help with washing and dressing?</li> <li>• Can they still self-medicate?</li> <li>• Have they fallen, and if yes, why was that?</li> <li>• Has there been a change in mental capacity?</li> <li>• Has their nutritional risk been assessed?</li> <li>• If the person has a long-term condition, is this being jointly managed with secondary care?</li> </ul>
<p><b>Predict</b></p> <ul style="list-style-type: none"> <li>• How will they manage the stairs?</li> <li>• How will they manage shopping?</li> <li>• How will they prepare meals?</li> <li>• Will they need assistance with food preparation and eating?</li> <li>• Will they be able to self-medicate?</li> <li>• What is their expected level of recovery compared to before?</li> <li>• What do they hope to be able to achieve with your support?</li> <li>• Is the support required likely to be for the short term (i.e. the reablement period), or is the person in need of longer-term support?</li> <li>• Is any deterioration in mental capacity due to infection or has it happened over a longer period?</li> </ul>	<p><b>Prevention</b></p> <ul style="list-style-type: none"> <li>• Have appropriate referrals been made?</li> <li>• Has any telecare or assistive technology been considered?</li> <li>• Has equipment been arranged?</li> <li>• Have nutrition goals been met?</li> <li>• Has a support plan been agreed and communicated to all, including the person and their family?</li> </ul>

The My Aged Care Regional Assessment Service will also be responsible for developing support plans with the client that may result in referral to services that will provide a reablement intervention. Such a plan might include some of the following<sup>39</sup>:

- need for assistive devices or equipment;
- in-home or community linked exercise and daily activity program;
- strategies to reduce falls;
- improved awareness and understanding of the use of medication; and
- ways of managing chronic disease, including improved ways of self-management.

Because of the nature of reablement services, it is possible there will be several items in the support plan that need to be delivered in a coordinated way over a limited time period. There are a small number of providers who offer a holistic service where coordination and service delivery would all occur through one organisation. Examples are Blue Care's Tailor Made in Queensland<sup>40</sup> and Silver Chain's Home Independence Program in Western Australia<sup>41</sup>.

More likely, however, the assessor will refer a client to a lead provider, the organisation or individual provider who will deliver the key services in the support plan. The assessor might need to take on a coordination role to

<sup>39</sup> These are services offered by the [Home Independence Program](#), Silver Chain, WA, at: /

<sup>40</sup> A Tailor Made Approach to Future [Blue Care Services](#), Uniting Care, Queensland.

<sup>41</sup> Op. cit.

ensure that all services in the support plan are linked to a provider and that they will all be delivered in the time frame of the overall reablement service.

Referrals could be made to a wide range of CHSP providers depending on the content of a client's support plan. Independent Living Centres<sup>42</sup> (for information and advice on Goods, Equipment and Assistive Technology) and Social Support-Group service types, formerly Centre-based Day Care (for activities designed to develop, maintain and support social interaction), could be considered. Home modification is a further important pathway for referral. In this regard, a KPMG report has found that "home modifications can have positive outcomes for individuals and may reduce the need for downstream care"<sup>43</sup>. Furthermore, the report found that "the likelihood of positive outcomes appears to increase where modifications are not provided in isolation, but instead form part of a holistic, reablement focussed approach.

In some circumstances, where a home modification is required, the assessor might propose an allied health assessment prior to referral to the home modification service. The potential for home modifications to make a significant difference in how well a person might adapt to a functional loss is shown in the case study below.

**Case study: Mr Green**

Mr Green is an 83 year old man who lives with his daughter and her family. He used to be very sociable, enjoyed meeting with friends, going out to lunch occasionally, or just chatting over a cup of tea.

Mr Green now uses a wheelchair, but his daughter's small house has narrow doorways and both front and back doors are several steps above street level. Moving about the house is difficult and leaving it is impossible. Mr Green has not been out for several months and was very depressed when the family was referred to a local Home Modifications Australia provider.

Two internal doors have been widened and Mr Green can now sit on the front verandah and chat with his neighbours. The family is excitedly awaiting the completion of the small ramp that will allow him to go out again. Mr Green's daughter says his life has been "transformed".

Source: MOD.A Home Modifications Australia

In addition, there could be circumstances where providers outside the CHSP (including for assessments) are more appropriate or are more accessible locally than a CHSP provider. For people who are vision impaired, for example, it could be appropriate for the My Aged Care Regional Assessment Service to recommend the client approach a specialist to gauge the kind of supports that would be appropriate within a reablement approach. The examples below demonstrate the kind of supports that could be provided after a specialist assessment.

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<sup>42</sup> The [Independent Living Centre Australia](#) website.

<sup>43</sup> Review of Home Modification and Home Maintenance service types under the Commonwealth HACC Program, KPMG, May 2014, piii at:

### **Case study: Teresa**

Teresa is a 70 year old Italian woman with limited English language skills. She lives alone in her family home. She has diabetic retinopathy and was diagnosed with central vision loss in her right eye and small vessel ischemia in her left eye, a few years ago. She has accessed the Low Vision Clinic and Community Services through the Royal Society for the Blind (RSB) on numerous occasions when she has experienced some vision deterioration. Her husband passed away suddenly 12 months ago. He was her main support – shopping, cleaning, bill paying and social support. She has a daughter who lives interstate.

Teresa recently re-visited the Low Vision Centre and was told she is now legally blind. She has been recently diagnosed with depression, is socially disengaged, and relies on supportive neighbours for shopping and bill paying. She has declined residential care, which has been strongly suggested by her GP and daughter, as well as the option for a home care package as Teresa declined to have the ACAT assessment. Upon her recent visit at the Low Vision Centre there were numerous positive outcomes:

- Teresa was referred to Community Services for Occupational Therapy, where they worked with Teresa to assess her home, applied tactile markings throughout her home and arranged the installation of equipment to maintain her safety.
- The Low Vision Counsellor assisted her with her application for a blind pension and arranged for short term counselling tailored to her recent experiences and change in vision.
- Teresa was also referred to the orientation and mobility specialists to assist with gauging kerb depth and provide strategies so she can confidently cross the road.
- Teresa was also assessed as needing a range of low vision assistive technology services (a magnifier, accessible mobile phone and computer screen reader) which she was able to acquire under the CHSP service type for assistive technology.
- Teresa is now doing her own housework, is confident to walk around her area, enjoys shopping with her neighbour and attends an RSB social group.

Source: Royal Society for the Blind

### **Case study: Rhonda**

Rhonda is 75 years old and lives at home with her husband who cares for her. Rhonda has progressively lost her sight over the past ten years. During this time, services have been provided to Rhonda by a specialist blindness service provider on an annual basis. They include:

- low vision assessment by an orthoptist;
- occupational therapist services provided in her home;
- home modifications to maintain safety and independence in the home;
- monthly respite for carers group activities;
- library services for accessible reading materials; and
- once a fortnight telelink crossword group.

In addition, Rhonda is receiving other CHSP services, namely home maintenance and volunteer transport.

Source: Vision Australia

### **How to get there**

As noted earlier, the assessment process to be administered through the My Aged Care Regional Assessment Services will be supported by the National Training Strategy. This assessment training includes consideration of reablement as an appropriate intervention.

As part of this training, new staff will be invited to watch a short [video](#) about the reablement approach. The video comes from the UK and involves a person leaving hospital who needs some short term intervention to adapt to a functional loss that caused hospitalisation in the first place. In Australia, a person in these circumstances would be expected to be assisted through a Transition Care Program but the principles are the same and the [video](#) gives a good idea of what is involved and what can be achieved through a reablement approach.



The importance of goal-setting in the development of support plans is highlighted by the Social Care Institute for Excellence in the UK. In the training document *Maximising the potential of reablement*, the following observations are made <sup>44</sup>.

“Goal-setting is essential to the success of reablement. There is no single universally accepted tool for goal-setting, although focusing on people’s strengths and what they want to be able to do is a good basis for the process, as follows:

- Having established people’s needs and strengths, goal-setting involves three main steps: identifying an end point (the goal or achievement), working out what steps are needed to reach that end point and, finally, establishing what structures must be in place to facilitate goal attainment.
- The ‘SMART’ principles also provide a useful guide to goal-setting as follows:
  - Specific – it’s easier to accomplish a specific goal than a general one. For example, ‘re-join my old lunch club and attend twice a week’.
  - Measurable – there should be concrete criteria for measuring progress toward the attainment of goals.
  - Attainable – when people identify goals that are really important to them (e.g. ‘be able to cook Sunday lunch for my family again’) they are more likely to develop the attitudes and ability to reach them.
  - Realistic – goals should represent an objective that people are willing and able to work toward. They should also be set at a sufficiently high level that they represent real progress. Of course, progress is relative.
  - Timely – goals should be grounded within a time frame (e.g. ‘by the end of the week I will be able to button my own cardigan’).
- Although the SMART principles provide a good framework, they should be applied in a way that is responsive to each individual’s needs. Above all, goals must be person-centred and developed with as much participation as possible by the individual.
- Goals are a joint undertaking between the individual and the reablement service. Having a written agreement, signed by both parties, is one way of formalising people’s commitment to achieving goals.
- Where appropriate, the individual’s family and friends should also be involved in goal-setting. Any conflicting or opposing views about suitable goals must be negotiated sensitively and with professional judgement.”

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<sup>44</sup> [Maximising the potential of reablement](#), Social Care Institute for Excellence, UK.



## Case Examples/Other Resources

### Case study: Mrs Gandolfo

Mrs Gandolfo resides in her own home. She is 82, has raised two children and worked in a variety of manual labour jobs throughout her life. She has type 2 diabetes, shortness of breath upon exertion, high blood pressure, back and neck pain, and has experienced two falls in the past three months that she is unable to explain.

With Mrs Gandolfo's permission, her daughter rang the local council to refer her for assistance with housework and shopping. The assessment officer suggested a home visit in which Mrs Gandolfo could tell her story in her own way.

At the home visit, they talked about what things Mrs Gandolfo could no longer manage around the house, how much she wanted to get out more and how she viewed using public transport to do this. She showed the assessor the equipment she used and how she would normally clean the house. The assessor advised that a lighter weight vacuum cleaner and different techniques would make it easier for her to manage.

They set three goals she wished to achieve over the next three months:

- **Goal one:** Mrs Gandolfo wanted to be able to manage as much of her own home activities as possible including home maintenance, home care and the garden. To achieve this Mrs Gandolfo decided that she needed to learn simpler ways of doing things, trial some alternative lighter equipment, improve her physical capacity and ask for help on tasks she found too challenging or risky.
- **Goal two:** Mrs Gandolfo wanted to be able to participate in social activities again and resume most of her own shopping. To achieve this Mrs Gandolfo wanted to explore and gain confidence to use community and public transport options and reconnect with the local Italian seniors club.
- **Goal three:** Mrs Gandolfo wanted to have some better understanding and control of her own health.

To achieve these goals a range of options were discussed with Mrs Gandolfo and agreed actions were documented in a support plan as follows.

Mrs Gandolfo agreed to make an appointment with her GP for advice regarding falls, physio assessment and for diabetes management. This was expected also to lead to referral to a diabetes educator and to a physiotherapist at the community health service.

The assessor referred Mrs Gandolfo to Council HACC services for the following:

- Provision of home maintenance for assistance with cleaning the gutters and minor non-trade repairs as required, and some initial help with installing a garden tap timer and castors on the bed to assist with bed-making.
- Provision of a one off spring clean, including bathroom scrub, window clean and removal of some heavy dusty curtains, to bring the house up to a standard where she could maintain it with alternative methods and improved functioning.
- Demonstrate task simplification and energy saving techniques for housework, plus the loan and trial of alternative cleaning equipment.
- Referral for weekly community transport to the shopping centre.
- Provision of maps of local public transport routes/times and Home Support Worker assistance with familiarisation with using public transport.
- Provision of information about the local Italian seniors club.
- Assessor to follow up with referrals and review outcomes and progress with providers and Mrs Gandolfo in 2 months.

Source: Municipal Association of Victoria

### Resources

- [Goal Directed Care Planning Toolkit](#), [This is a project of the Eastern Metropolitan Region in Victoria that has been developed to build care planning capacity of the local HACC sector -91 pages].

- [Home Independence Program](#), Silver Chain, Western Australia [Information about the Home Independence Program, admission criteria etc]
- [Reablement, Module 2: Reablement for care workers](#), Social Care Institute for Excellence, UK [Training material for service providers on reablement in 'flash' and text format]

## Service Delivery

### What it looks like

A study undertaken as part of the Care Services Efficiency Delivery programme in the UK<sup>45</sup> provides an idea of good practice in reablement services. The study defined reablement services as those which “provide personal care, help with activities of daily living and other practical tasks for a time-limited period in such a way as to enable users to develop both the confidence and practical skills to carry out these activities themselves”.

Factors that can impact on success reported in the study include:

- Access to specialist skills and training, including the value of having Occupational Therapists embedded in teams.
- Shared understanding and a strong vision for the service, which includes developing good relationships with Assessment and Care Management and the local hospitals.
- Service user characteristics. That is, that the best results occur for those people who have experienced a fall, or a fracture. Also that better results are achieved with people who have no previous experience of social care, as there is no expectation that support staff will 'do for' the person.
- Importance of flexibility in the duration and frequency of visits.
- Difficulties regarding capacity in the independent sector.
- Commitment, enthusiasm, knowledge and skills of staff. It was also noted that “some staff have found it very challenging to make the transition from 'doing for' to 'supporting to'”.
- Resistance from family members.
- The importance of the initial review being completed in the client's house, particularly in transition from hospital. It was noted that people were able to do more for themselves than they could do in the hospital environment.
- The initial setting of goals with clients should involve one or two senior carers, the service users and occasionally an OT.
- Delays and blockages can occur, if discharges are reliant on referral back to care managers.
- The importance of equipment to the promotion of independence.

A reablement officer in another UK reablement setting provided the following testimony about what it means to be providing services using this approach.

'The service is different because you are not physically doing for the client, you are showing them how to do for themselves so that once we withdraw our service they can carry on. We can demonstrate skills to them and we can source information, enquire about adaptations to their home which would benefit their day-to-day life. We can introduce them to activities and accompany them until they feel confident to go alone.'<sup>46</sup>

### How to get there

The steps service providers can take to be able to work effectively within a reablement setting will be similar to the more general wellness approach described earlier. Additional challenges for service providers engaged to provide services under a reablement approach will be in service coordination and in the time-limited nature of service provision as specified in support plans.

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<sup>45</sup> Reported in [Establishing Best Practice in Reablement](#), Calderdale Council, UK, 2010, p4, p19 at:

<sup>46</sup> [Reablement: a guide for front line staff](#), p24,

Service coordination will require a good relationship between the My Aged Care Regional Assessment Service and service providers, a shared understanding of the goals and services included in support plans, and flexibility to be able to work in with others providing services and be open to adjust the timing when arranging the visits.

The time-limited nature of reablement and the need to plan for ending a period of support, or for transitioning to ongoing services, is a common theme in the literature on reablement. In *A new reablement journey*<sup>47</sup>, it is said that “Reablement services are usually under pressure to meet goals within a set timescale (often 6 - 8 weeks) and need to ‘move people on’ after that time. But, for those who need support beyond that time, there is inadequate preparation for the person to be very involved or to enable that move to be a smooth transition”.

I’ve been told these carers are finishing soon but they don’t know yet what will happen after that. I hope they don’t send a bunch of new folk. I’m sick of all these strangers in my house. [Client]

In the UK publication, *Establishing Best Practice in Reablement*, it was reported that “many frontline staff spoke of their frustration that all of their good work was undone when people went on to receive a long term service from an independent sector homecare provider. There was scepticism that providers would continue to promote independence, as it would not be in their financial interest to minimise a package”<sup>48</sup>.

In *Maximising the potential of reablement*<sup>49</sup>, the UK Social Care Institute of Excellence provides a set of recommendations designed to make this transition a successful one. They are:

- If a person is assessed as having ongoing support needs at the end of reablement, it is crucial that subsequent services continue to provide support in a way that maintains the progress that person had made. The implication of this is that independent sector providers of home care need to adapt their own service to support the aims of reablement.
- There are a number of ways in which independent home care providers can be encouraged to work to sustain people’s independence and any progress they made during their time with the reablement service. One example is a service whose reablement workers mentor home care workers when it appears the person’s support needs have increased following handover. Other local authorities have renegotiated home care contracts to reinforce the reabling ethos.
- It will help to ensure a smooth transition to the ongoing care provider if the reablement service ensures all relevant information about the individual is communicated in a timely manner. It may also be helpful for care workers from the reablement service and from the new provider to work together for the last few reablement visits so that they can share knowledge, understanding and skills. If a person’s ongoing support needs are going to be met by another (home care) provider, relevant family members should be involved in planning that support.
- If at the end of reablement a person does not meet the council’s eligibility criteria for ongoing support, the reablement team and the social worker should consider whether other services such as social clubs or volunteer befriending schemes may still benefit the individual.
- When reablement works well, the ‘reabled’ person will be able to do things for themselves and they will not be referred for ongoing support, such as traditional home care. Commissioners and providers of reablement should be alert to the fact that for some people, particularly those who do not have many visitors or social activities, this may lead to feelings of loneliness and isolation. This is an example of a successful service outcome (no ongoing need for support) not necessarily equating with a successful outcome from the individual’s perspective.

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<sup>47</sup> [A new reablement journey](#) by Pitts, J et al, p7,

<sup>48</sup> *Establishing Best Practice in Reablement*, Calderdale Council, UK, 2010, p7

<sup>49</sup> [Maximising the potential of reablement](#), Social Care Institute for Excellence, UK.

## Case Examples/Other Resources

### Case study: William

William is an 83 year old man who said he needed some home cleaning assistance. In the course of the assessment, he mentioned that he greatly missed no longer being able to walk his dog. He had lost the confidence in his ability to do this safely.

In addition to arranging for the provision of home care, the assessor arranged for a community care worker to accompany William as he walked his dog, using his four-wheeled walking frame. He was eventually able to walk his dog independently and no longer required the community care worker.

Source: Leading Age Services Australia (LASA)

### Case study: Mary

Mary had been extremely isolated during the years she had been caring for her husband – she stopped going to the shops on a regular basis, ceased having daily conversations and generally lost her confidence. This was quite a contrast for Mary who had been active in the Salisbury community for many years and who had been recognised for her volunteer services to the community.

A council member told Mary about the Para Hills Club but because of her diminished confidence she found the idea of attending such a group challenging. With persistent encouragement and support from the Salisbury Home Assist Service staff, Mary joined the Para Hills Club, Friday Group where she has continued to participate for the past four years. Over time, Mary emerged from her isolation supported by members of the group and engaged in activities that she found enjoyable and life-giving.

Source: Engaged in life: Older people and Centre-based Day Care in the City of Salisbury, David Kelly and Associates, 2013, unpublished

## Resources

- [Reablement: a guide for frontline staff](#) [This is an introduction to reablement in the UK, covering what it is, how reablement varies from other services, benefits, what it is like to work in a reablement services and case examples – 49 pages]
- [Establishing Best Practice in Reablement](#), Calderdale Council, UK, 2010, p7 at [Detailed review of best practice in a number of reablement services in the Yorkshire and Humber district of the UK]

## 2.3 Implementing a Restorative Care Approach

As with reablement, the restorative care approach draws on a wellness philosophy. This makes the cultural change material under section 2.1 Implementing a Wellness Approach also relevant here and it will not be repeated. The focus in this section will be on good practice issues that relate specifically to assessment and support planning, and service delivery.

### Assessment and Support Planning

#### What it looks like

Assessment of clients for assistance through a restorative care approach is undertaken initially by the My Aged Care Regional Assessment Service. This will be an integral part of the overall assessment process, as described under section 2.1 rather than a separate, restorative care-specific assessment. The assumption is that, like reablement, restorative care could be a useful intervention for a smaller sub-group of the overall CHSP client group.

It is possible that a client will require a range of supports, one or more of which could have a restorative care focus. Other supports might be more general CHSP services that would fall under the broad wellness approach. The My Aged Care Regional Assessment Service assessor will develop a support plan with the client that reflects the full range of supports (see case study in box below).

Once a support plan has been developed, the My Aged Care Regional Assessment Service assessor will refer a person to a suitable provider. If the support plan contains a single action item that specifically concerns restorative care, the assessor will make a referral to an appropriate CHSP allied health provider, or, potentially, could recommend the client get in touch with a general practitioner, optometrist, dietician or another health professional outside the CHSP depending on the client's circumstances. On the other hand, if the support plan contains several items that need to be delivered, referrals to multiple services may need to be considered.

Where available, this might involve referral to one of the small number of providers that offer a holistic service, where coordination and service delivery could be expected to occur through one organisation. Examples are the Personal Enablement Program run by Silver Chain in Western Australia<sup>50</sup>, the Domiciliary Care Reablement Program in South Australia<sup>51</sup> (see below) and the Care Assess program in Tasmania<sup>52</sup>. Other providers, while not necessarily offering an integrated program, might operate as multi-disciplinary allied health teams providing (through one outlet) services such as dietetics, occupational therapy, podiatry, physiotherapy and speech pathology, and continence nursing. An example in Victoria is the Hume region which supports four multidisciplinary Rural Allied Health Teams<sup>53</sup>. Further examples are Feros Care's Allied Health Services in New South Wales (see details later) and the Healthy Eating Activity and Lifestyle (HEAL™) program also in New South Wales<sup>54</sup>.

Another mechanism designed to coordinate services according to the requirements of individual support plans is through agency partnerships. Partnership arrangements can be formalised at a local or regional level by bringing service providers together to support collaborative planning and development of integrated service responses to support and care for older people in a community. The Central Hume Primary Care Partnership (CHPCP) is an example of this approach<sup>55</sup>.

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<sup>50</sup> [Personal Enablement Program, Silver Chain, Western Australia](#)

<sup>51</sup> Domiciliary Care Reablement Program, 6 Month Interim Evaluation Report, 2013, unpublished

<sup>52</sup> [Home Independence Program, Care Assess](#), Tasmania.

<sup>53</sup> [Review of HACC Allied Health Services](#), Department of Health, Hume Region, 2011, at:

<sup>54</sup> [The Healthy Eating Activity and Lifestyle \(HEAL™\) program](#) is a lifestyle modification program that enables participants to develop lifelong healthy eating and physical activity behaviours.

<sup>55</sup> [See Central Hume Primary Care Partnership](#)



**Case Example: The 'Restorative Care' Program, Domiciliary Care, South Australia**

The program provides 30 places for frail older people living in the community in Metropolitan Adelaide with access to short term (approximately 8 weeks) home based restorative services of personal care, allied health assessment and therapy, basic home modifications and equipment. It aims to enable clients to:

- regain confidence or relearn activities of daily living such as showering, dressing and/or mobility;
- improve their independence; and
- reduce long term need for Home and Community Care services.

The former Day Care Therapy Centres (now within the Allied Health and Therapy Services care type under the CHSP), will also be an option in circumstances where the client can be assisted in an out-of-home setting. Day Therapy Centres have the capacity to provide integrated, short term, therapy-based restorative services. A further pathway is for the assessor to refer a client to a Commonwealth Home Support Programme Allied Health and Therapy Services provider that offers the particular type of therapy relevant to the support plan. In these circumstances, the assessor might need to take on a coordination role to ensure that all services in the support plan are linked to a provider and that they will all be delivered in the time frame of the overall plan.

In some circumstances, the My Aged Care Regional Assessment Service assessor might require a more specialised assessment be undertaken by an allied health provider to confirm the assessment and proposed support plan that has been developed.

**How to get there**

As noted earlier, the assessment process to be administered through the My Aged Care Regional Assessment Services will be supported by the National Training Strategy. This assessment training includes consideration of restorative care as an appropriate intervention.

**Case Examples/Other Resources**

**Case study: Bill**

Bill is a 72 year old man who contacts My Aged Care. The Contact Centre asks Bill a few questions (initial screening) which indicate that Bill has an immediate need for some home help and a referral is generated and sent to a local provider. The assessment also indicates that Bill would benefit from a face-to-face assessment and he agrees. The My Aged Care Regional Assessment Service assessor makes contact with Bill and arranges a home visit for the face-to-face assessment. They review Bill's circumstances and work together to develop a support plan, including actions which support his longer term goals to remain independent and living at home.

Bill's particular goal is to maintain his own personal care. The assessor develops a support plan that includes the home help arising from the initial screening as well as a number of short-term interventions with a restorative care focus. This includes: referral to a physiotherapist to develop and supervise a strength and balance programme to increase his endurance levels; and referral to an occupational therapist to identify suitable equipment to promote functional independence, such as a shower stool and grab rail in the toilet.

When accepting the referral via the Service Provider Portal, the service provider will be able to access Bill's client record, support plan and service information. This will give the service providers a more holistic view of Bill's needs and goals, including other services he will be receiving.

Source: Adapted from Key directions for the Commonwealth Home Support Programme, 2014

**Service Delivery**

**What it looks like**

CHSP service providers that operate within a restorative care approach will be a narrow band of all CHSP providers because restorative care interventions are provided or are led by allied health professionals. This also means that services will be provided within the framework of a specific allied health professional service. At the



same time, all CHSP service providers are committed to providing supports aimed at assisting individuals to remain in the community and as independent as possible.

Within this overall objective, the focus of restorative care is on allowing a person to make a functional gain after a setback, or in order to avoid a preventable injury. Furthermore, while some people will need ongoing support to maintain their health, restorative care is intended to be short term. A program that reflects this approach is the Personal Enablement Program in Western Australia, referred to earlier. While the program is designed to support people on discharge from hospital and therefore is more akin to Transition Care, the approach it uses could equally apply to restorative care in circumstances where intervention might prevent a person from having to go to hospital. More details of this program are included in the box below. The multidisciplinary team is constituted for the purposes of the Personal Enablement Program. Multidisciplinary teams in other settings could have a different makeup and include additional services such as speech pathology and dietetics.

#### **Case Example: Personal Enablement Program (PEP)**

PEP is a holistic intervention program which provides continuity of care and encourages long term independence. It is based on a restorative model of care. PEP is able to provide short term occupational therapy and physiotherapy care that will assist the client achieve their functional goals.

The person receiving the care will be involved in all decisions regarding their participation in the program, as will their family and primary carer, if appropriate. Entry to the program will be co-ordinated with the hospital to ensure continuity of care.

PEP is a short term program and is delivered by a multidisciplinary team comprising:

- Occupational therapists
- Physiotherapists
- Registered nurses
- Therapy assistants
- Care aides (personal care)

Once the person is back at home, a member of the multidisciplinary team will work with them, their family or carer, to determine the support and strategies needed to enable them to manage at home and optimise their independence. These may include short term strategies such as:

- task simplification techniques for personal care and domestic tasks; and
- trialling personal and household equipment and aids (costs of non-consumable equipment and aids are not covered by this program).

And long term strategies such as:

- exercises to help them regain their strength and balance;
- increased levels of physical activity;
- education to self-manage chronic diseases; and
- accessing information, community resources and programs.

Source: Personal Enablement Program, Silver Chain, Western Australia

In some states and territories, a focus on short term interventions is already established in the Day Therapy Centre program. In Western Australia, for example, around 80 per cent of clients are defined as short term. In addition, the two highest categories of therapy hours utilised in Western Australian centres were found to be occupational therapy and physiotherapy. In other words, these centres were concentrating on short term therapeutic goals. Activities such as diversional therapy which are associated more with long term or maintenance are not as prominent in Western Australian centres.

#### **How to get there**

Allied health providers funded under the CHSP that intend to offer services using a restorative care focus will need to adopt the shift in service provision represented by wellness – that is, support for a model that actively

promotes independence. This will involve a good working partnership with the My Aged Care Regional Assessment Service and being aligned with the wellness and restorative care thinking that has led to the development of a client's support plan.

Service offerings will also need to be re-thought to emphasise the short term nature of therapies designed to achieve functional goals, and the need to devise long term strategies for individuals who have needs beyond the end of a period of restorative care.

Former Day Therapy Centres will be supported to reposition themselves in this way, which would involve an increase in the ratio of short term and home-based clients and an increase in the number of allied health service types to better support a restorative focus.

### **Case Examples/Resources**

#### **Case Example: Feros Care, Allied Health Services, New South Wales**

Feros Care provides a range of programs, therapies and services to maximise independence and support for individuals to remain active, healthy and socially connected. A mobile service is available in the home, at Feros Care's Wellness Clinics, within residential villages or via video conferencing.

The types of service provided will depend on an individual's needs and healthy living goals. A comprehensive assessment with each individual helps determine what their goals are and how they can achieve a healthier and more active lifestyle. Feros Care's services include Physiotherapy, Podiatry, Exercise Physiology, Occupational Therapy and a range of social, mobility, pain management and falls prevention programs. The aim of the Health and Wellness program is "to assist each individual to remain living independently and confidently in their home, provide rehabilitation and recovery from injury and assist individuals to overcome an illness or learn to live with a disability."

Source: [Feros Care](#) website.

### **Resources**

- [A handbook for community care services: Empowering people, enhancing independence, enriching lives](#) [NSW document; pages 36-41 provide examples of projects with a restorative care focus under the banner Restoring capacity with short-term support]

## Part 3 Appendices

### Appendix 1 Current uses of the terms wellness, reablement and restorative care

The National Aged Care Alliance paper Commonwealth Home Support Program (HSP) Design<sup>56</sup> (September 2013) defines wellness as “a philosophy that focuses on whole of system support to maximise clients’ independence and autonomy”. Furthermore, it is said to be “based on the premise that even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and independently”.

While the paper refers to independence and autonomy it also goes on to talk about achieving gains in capacity in physical, social and emotional wellbeing. It states that wellness “focuses on finding the service solutions to best support each individual’s aspirations to maintain and strengthen their capacity to continue with their activities of daily living, social and community connections”. It also states that reablement services are part of the wellness philosophy. Reablement is said to be “the use of timely assessment and targeted interventions to assist people maximise their independence, choice and quality of life”<sup>57</sup>.

In Victoria, the concept of active service model is used instead of wellness. The active service model is said to be “a quality improvement initiative that explicitly focuses on implementing person and family-centred care, wellness promotion, capacity building and restorative care in service delivery”<sup>58</sup>. The Victorian HACC program manual goes on to say the “goal of the active service model is for people in the HACC target group to live in the community independently, actively and autonomously for as long as possible. In this context, independence refers to the people’s capacity to manage activities of their daily living. Autonomy refers to making decisions about one’s life”.

In Western Australia, The Home and Community Care Program has adopted a wellness approach for the delivery of HACC services in that state. It is said to be based on the assertion that “people who are frail or have a disability have the capacity to make gains in their physical, social and emotional wellbeing and can continue to live independently in the community, if positively supported to do so”<sup>59</sup>. The wellness approach is described in terms of a number of characteristics including: holistic/strengths-based; enables consumer self-direction; places a person’s needs at the centre of planning and support; services to be provided in partnership; works to supplement a person’s ability; highlights social connections; and recognises that people’s needs fluctuate over time. The approach is said to have the potential to “optimise a person’s outcomes with regard to their independence, wellbeing and quality of life”.

Western Australia uses a United Kingdom definition of reablement, stating that “reablement typically refers to intensive and time limited multidisciplinary home care service interventions that have been developed for people with poor physical and/or mental health. Reablement aims to help them accommodate their illness by learning or relearning the skills necessary to manage their illness and to maximise participation in everyday activities”<sup>60</sup>.

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<sup>56</sup> National Aged Care Alliance (2013) [Commonwealth Home Support Program \(HSP\) Design](#), p4

<sup>57</sup> Ibid, p4

<sup>58</sup> [Victorian Home and Community Care program manual](#), part 3, p93, at:

<sup>59</sup>Challenging Community Care with Wellness – An implementation overview of the WA HACC Program’s Wellness Approach, p4

<sup>60</sup> Ibid, p18

## Responses to the Department of Social Services discussion paper Key Directions for the Commonwealth Home Support Programme

In May 2014 the Department released the discussion paper *Key directions for the Commonwealth Home Support Programme*<sup>61</sup> - submissions to the paper closed on 30 June 2014. The paper included a discussion about wellness, reablement and restorative care using definitions that were essentially based on the paper referred to earlier by the National Aged Care Alliance.

Submissions about the paper provided support for these concepts to be embedded and implemented in the CHSP. However, feedback also indicated some overlap in the way different terms are being used. Respondents also offered a range of views about what makes up wellness. In summary, wellness was said to be a consumer directed, person centred, strengths based approach that incorporates prevention with early intervention with the aim to improve/maintain function, health, wellbeing and independence.

### Appendix 2 Additional resources related to wellness, reablement and restorative care (General)

- [The Plan Do Study Act \(PDSA\) Model for Improvement Project](#) – Workbook, Department of Health, Victoria [Provides information about the Plan, Do, Study, Act (PDSA) Model for Improvement Project which involves clients undertaking small, rapid cycles of quality improvement using this approach]
- Enabling the use of easy living equipment in everyday activities - [A guide for Home and Community Care services in Victoria, Municipal Association of Victoria, 2014](#) [Promotes, explains and encourages the use of easy living equipment to support people to be as independent as possible]
- [Well for Life initiatives](#), Well for Life initiatives use health promoting principles and have focused on improving physical activity, nutrition and emotional wellbeing for older people who participate in Home and Community Care (HACC) services in Victoria. There are a number of Well for Life publications some of which are more suitable to service providers whereas other publications are equally valuable to service providers and older people and their carers]
- [The Better Practice Project Handbook](#), Aged and Community Services South Australia & Northern Territory, [The Better Practice Project aims to support those who work with older people to assist them to live full and valued lives. The handbook is one of a number of resources generated by the project]
- Case studies based on [Victoria's Active Service Model](#) [These case studies have been contributed by various HACC service providers, small and large, metropolitan and rural. They cover a variety of circumstances – some could be seen to be examples of wellness, others reablement or restorative care approaches. In a number, a mix of interventions is evident]

### Appendix 3 Additional resources related to wellness, reablement and restorative care (Specific)

#### Resources about people who are blind or vision impaired

- [My Eye Health Program](#), [The My Eye Health Program is designed to educate and create awareness of eye health and prevention of vision loss, eye care services available, referral pathways and management and rehabilitation strategies for chronic vision loss]
- [Vision enhancement and substitution](#),
- [Vision and Ageing](#)
- [Low Vision Primer – A guide to symptoms, diagnosis and treatment](#)
- [Royal Society for the Blind Brochure: Adaptive Technology](#),
- [Royal Society for the Blind Brochure: Counselling and Support](#),
- [Vision Australia](#) provides a range of information and materials on blindness and low vision.

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<sup>61</sup> [Key directions for the Commonwealth Home Support Programme](#)

### Dementia specific resources

- [Strengthening assessment and care planning – Dementia practice guidelines for HACC assessment services](#) [The guidelines provide dementia-specific information and practical guidance for assessors from HACC assessment services in Victoria to improve assessment, care planning and service provision for people with possible dementia and their carers]
- [The Dementia Study Centre](#) aims to improve the quality of care and support provided to people living with dementia and their families through a range of online resources.

### Assistive technology

- [Independent Living Centres Australia \(ILCA\)](#). The ILCA is a collective network with member ILCs from each Australian state and the ACT. It aims to advance assistive technology policy and systems innovation with the Australian Government, and encourage development of evidence for practice in understanding the benefits of assistive technology.

### Aboriginal and Torres Strait Islander specific resources

- The Australian Indigenous [HealthInfoNet](#), aims to inform practice and policy in Indigenous health by making research and other knowledge readily accessible. Examples of resources available include:
  - Information on organisations that are addressing issues related to Aboriginal and Torres Strait Islander older people's health at: [Healthinfonet](#)
  - Workforce resources that include information on training, job opportunities, conferences, and funding in Australia. Specific information is provided on older people's health and related issues at: [healthinfonet](#)
  - Links to electronic networks that enable people with an interest in Indigenous health to share information, knowledge and experience. They are called 'Our yarning places' (formerly called communities of practice) [HealthInfoNet](#)

### Carer resources

- [National Carer Strategy](#) [The strategy recognises the contribution of carers to the Australian community and outlines in six priority areas for action how this contribution can be valued, supported and shared]

### CALD specific resources

- [National Ageing and Aged Care Strategy for People from Culturally and Linguistically Diverse \(CALD\) Backgrounds](#)
- [An investment not an expense: enhancing health literacy in culturally and linguistically diverse communities](#), [This report looks at the available resources, those that are still required and best practice strategies for enhanced health literacy]
- [Partners in Culturally Appropriate Care \(PICAC\)](#) – PICAC, which has a presence in each state and territory, is funded through the Aged Care Service Improvement and Healthy Ageing Grants Fund. It aims to equip aged care providers to deliver culturally appropriate care to older people from culturally and linguistically diverse communities.
- A range of aged care resources can be found at the [Ethnic Community Council Victoria \(ECCV\) website](#).

### Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) specific resources

- [National Lesbian, Gay, Bisexual, Transgender and Intersex \(LGBTI\) Ageing and Aged Care Strategy](#)
- [LGBTI Sensitivity Training](#)

### Appendix 4 Evidence base for wellness, reablement and restorative care

- Domiciliary Care Reablement Program – 6 Month Interim Evaluation Report of the HACC Domiciliary Care Restorative Project, February 2013, Department of Communities and Social Inclusion, South Australia [Unpublished report of an evaluation into a successful restorative care project showing no HACC services required at discharge for 85 per cent of clients]

- [Goal setting as a feature of homecare services for older people: does it make a difference?](#), Parsons J et al, 2011, [A New Zealand study that investigates the impact of a designated goal facilitation tool on health-related quality of life]
- [ASPIRE](#) – Assessment of Services Promoting Independence and Recovery in Elders, University of Auckland, New Zealand, [This study investigated the effectiveness of what is described as ageing-in-place initiatives at several sites in New Zealand and concluded that older people with high and complex needs, who would otherwise be admitted to residential care can remain living at home with no apparent increased risk of harm]
- Home Care Reablement Services: investigating the longer-term impacts, Glendinning, Caroline et al, Social Policy Research Unit, University of York (2010), [Research into the immediate and longer-term benefits of home care reablement]
- A non-randomised controlled trial of the [Home Independence Program](#) (HIP) - an Australian restorative programme for older home care clients, Lewin G and Vandermeulen S, Health & Social Care in the Community Journal, [This study compares the outcomes for individuals who participated in HIP with those individuals who received 'usual' home care services]
- [Evidence for the long term cost effectiveness of home care reablement programs](#), Lewin, G et al, Clinical Interventions in Aging, October 2013, [Study concludes that reablement as the starting point for individuals referred for home care within Australia's reformed aged care system could increase the system's cost effectiveness and ensure that all older Australians have the opportunity to maximize their independence as they age]
- [Care Assess Home Independence \(HHIP\) program evaluation: Final Report – 30 June 2013](#), [The evaluation shows a significant improvement in client independence outcomes]