RESEARCH TO PRACTICE BRIEFING 6

New ways of restoring and supporting the independence of older people

New approaches to community aged care focus on re-establishing daily living skills and community connections of older people, rather than on traditional goals of 'maintenance' and 'support'. Such approaches are goal-oriented, aiming to build on individuals' strengths and goals, with the objective of fostering greater independence and, where possible, less reliance on care services.

This Briefing draws on both Australian and international evidence to provide guidance for community care practitioners in their day-to-day work with older people. It focuses, in particular, on time-limited interventions that help older people 'get back on their feet'.

Research to Practice Briefings

Research to Practice Briefings bring together lessons learned from the literature on a topical issue in community aged care as a resource for those working in this sector. As in most areas of social policy and practice, the research evidence in the literature on community aged care is continually evolving. The Briefings aim to distil key themes and messages from the research and to point to promising and innovative practices.

An advisory group of academics and expert practitioners working in the area of aged care provide advice and peer review.

This briefing has been prepared by the Aged Services Unit, Health and Wellbeing Research Cluster, Southern Cross University, in partnership with The Benevolent Society.

Introduction

Over the last 15 years, a new paradigm for community care services for older people has been emerging, both in Australia and internationally, which challenges the traditional goals of 'maintenance' and 'support' of older people and instead emphasises capacity building and restorative outcomes. Such approaches are known by various terms, including:

- restorative care
- enabling approaches
- reablement
- active service models
- an independence approach
- wellness approaches.

Each approach has a slightly different emphasis. The focus of this paper is reablement of older people in the community, which is one of the strategies within the broader paradigm described above. This briefing summarises the research evidence underpinning reablement.

What is reablement?

Reablement is a planned approach to community care and services for older people that aims to help them re-establish daily living skills and community connections through a time limited, goal-oriented program. It has very specific core features and focuses on helping clients regain skills and increase their independence. Reablement is sometimes described as helping older people to 'get back on their feet'.

In NSW, service providers are being encouraged to adopt 'enabling approaches' to community care. Reablement can be described as an enabling approach, but one with certain features, key being that it is relatively intensive and short term.

A reablement approach would be suitable for older people who, for example:

- need additional support to regain social connections or to regain independence to do such things as their own shopping (for example, a client referred for a Community Aged Care Package or for domestic assistance)
- are living independently but need to rebuild strength in order to remain independent
- have been assessed as needing higher levels of care but who are willing to undertake more intensive therapy to build their physical capacity and become more independent with activities of daily living, after which they would revert to receiving a lower level of care
- have had an episode of ill-health in hospital.

Time-limited reablement approaches will not be appropriate for all older people, for example, those who need ongoing support due to poor and declining health. However, many of the underlying concepts of reablement, such as the focus on assisting each person to build on their individual strengths and goals, have wide applicability irrespective of clients' circumstances or stage of life and underpin wellness or enabling approaches.

A major feature of the reablement approach is the development of an individual plan which is customised to client needs, and is goal-driven by the client and, where appropriate, their carer and/or family. Based on comprehensive targeted assessment, reablement includes both generic interventions and client-specific interventions. Service provision is holistic, drawing on multi-disciplinary approaches to enhance an older person's physical, emotional, social and psychological wellness. On this basis, staff work with clients with a shared understanding that the ultimate purpose of the care program is to achieve client autonomy and discharge from the reablement program to self-care or a lower level of care.

Rationale

The ageing of the Australian population will result in increased demand for care and services. Governments at all levels are seeking new approaches to service provision that are more resource-efficient and promote healthy ageing, resulting in a sustainable older community.

Current government policies and programs have an emphasis on early intervention, client focus, restoration of function and reducing pressure on the service system in the face of growing demand (NSW Government 2008). The most recent Council

[1] In this paper, we use the term 'carer' to mean informal carers such as spouses, other family members and friends.

of Australian Governments (COAG) reform objectives are to promote efficient, cohesive and streamlined approaches to ageing and aged care services (COAG 2010). These objectives are based on recognition of the need for flexibility, collaboration across disciplines and cost-efficiency (National Ageing Research Institute, 2006).

Core elements

Five elements have emerged from the research literature as core to reablement:

- goal-oriented care planning
- multi-dimensional assessment
- multi-disciplinary involvement
- evidence-based generic interventions
- time-limited programs.

Goal-oriented care planning

A goal-setting and care-planning process is used to assist older people to identify what they are currently unable to do and any concerns that they have. The identified issues are then ranked by the person in terms of importance to them. Clients select their long-term goals (appropriate to the expected length of the reablement program), and staff and family members (where relevant) then support the client to set intermediate goals that will assist them to achieve their long-term goals.

Practice Example

A client who has recently been discharged from hospital and needs to regain mobility may set a long-term goal of being able to do her own shopping (e.g. "in 12 weeks time"). Her intermediate goals, perhaps with a target of 1-2 weeks for each, could include:

1. get out of bed unaided
2. goal 1 plus dress herself
3. goal 2 plus walk to the front door
4. goal 3 plus walk to the letterbox and so on, with additional goals added to culminate in her being able to get to the shops and do her own shopping.

This approach of listing and ranking issues assists older people to set long-term goals and combines care planning and goal setting into one meaningful activity.

Services using this approach find that it assists staff to develop measurable, finite and realistic goals (a requirement for reablement). Training staff in goal-oriented care planning is important.

Multi-dimensional assessment

Comprehensive multi-dimensional assessment is used to determine client needs and is a pre and post measure of the success of the program. It covers physical and cognitive domains while also identifying the social and emotional supports required. Staff should have a range of assessment tools they can draw on to meet the individual needs of clients.

Multi-disciplinary involvement

Ideally, reablement teams are multi-disciplinary and include a registered nurse, physiotherapist and occupational therapist so that their skills are readily available and they are involved in the initial assessment of all clients. Evidence from the research is that the skills of these practitioners are particularly important. In areas where there is a shortage of allied health staff other approaches, such as brokered services or partnerships, can be used (ASLaRC and DADHC 2009). Another is training other staff in some of these skills (Francis et al, SCIE, 2011).

Evidence-based generic interventions

Research evidence has demonstrated that a core set of evidence-based generic interventions can be developed that most or all clients would receive and which any member of the community care team could apply. This allows for flexibility in allocating care coordinators, and facilitates timely assessments and service delivery. Generic interventions need to be based on common issues and concerns identified by older people entering reablement programs, generally focussing on:

- mobility
- personal care
- Instrumental Activities of Daily Living (IADL)
- falls prevention
- medication management.

Generic interventions should optimise functioning, promote healthy ageing and encourage self-management. In addition to generic interventions, specific client-centred interventions may be developed for each client.

Time-limited programs

Australian and international evidence suggests that the most successful reablement programs range from 6 to 12 weeks, allowing for shorter or longer programs as indicated by early achievements.

Clients' progress towards achieving short and longer-term goals should be monitored throughout the duration of the program as this is integral to timely completion of the program (ASLaRC and DADHC 2009).

National & international experiences

The literature identifies a number of national and international reablement projects.

Australian developments

A number of initiatives in Australia are using reablement and/or enabling approaches. Some examples from New South Wales, Victoria and Western Australia are discussed below.

New South Wales

NSW IMPACT is a sector group which comprises representatives from key players in aged and disability services including consumer groups, providers, government agencies and industry groups. The IMPACT working party has helped to focus discussion on the emerging strengths-based approach to service provision and has established a set of five principles relevant to all enabling approaches to community care, including strategies such as reablement. Community care services should be:

1 Person-centred to enable each consumer to explore individual strengths and goals and work towards achieving the outcomes they desire, with the security of support for those who need it.

2 Culturally appropriate, socially inclusive and sensitive to individual circumstances, social context and relationships, enabling the consumer to continue with what is important to them.

3 Flexible and responsive to the range of changing needs, interests and choices of consumers.

4 Supportive, to foster a positive relationship between consumers and carers.

5 Recognised as a fundamental and valued part of society that grows and develops to meet the changing expectations of consumers, carers, funders and the workforce (IMPACT 2009).

The Ageing, Disability and Home Care (ADHC) Better Practice Project is trialling regional demonstration projects focused on functional independence, socialisation and preventative health measures. All programs embrace a person-centred approach, maximising capacity, social participation and connectedness, restorative short-term interventions and preventative approaches. The projects are due for completion in 2011 (ADHC 2009). An education and training program is also planned for 2011.

Victoria

The Victorian Government Active Service Model Program emphasises early intervention, prevention and involvement to assist older people and people with disabilities to maintain or rebuild confidence and stay active and healthy.

Three active service programs in existing HACC services were tested to determine their effectiveness and ease of integration into the whole service system. The projects consisted of single-component restorative approaches, for example:

- Redesign of gardens to allow for low maintenance
- An 8-week health education program covering exercise
- Nutrition and ADLs essential for managing at home
- A social program to enhance community connectedness.

The evaluation report indicated that, whilst the sample groups for these projects were small, there was a measurable increase in client independence, and recommended that the approach be integrated into the service system.

Western Australia

A number of initiatives have been undertaken in WA by different providers and supported by the Department of Health. Silver Chain, one of Australia's largest community service providers, has been trialling a range of approaches to promote independence since 1999.

Models trialled have included the Home Independence Project (HIP) and the Personal Enablement Program (PEP). These programs are short-term interventions directed at optimising functioning and preventing or delaying further decline, promoting healthy ageing and encouraging self-management of chronic disease through goal setting (Lewin et al, 2008).

The evaluation of both programs revealed a marked decrease in dependency levels and high customer satisfaction. They were most successful with new clients (compared to existing home care clients), who were less likely to require ongoing support after involvement in one of the programs. The programs were noted as being cost effective (Lewin, 2010).

HIP is now offered across Perth and in some regional areas of WA by Silver Chain. The organisation also runs a single component program, a Social Enablement pilot based on a volunteer workforce and paid coordinator, which focuses on improving psychological and social wellbeing. Early results are showing a reduction in loneliness and depression and an improvement in wellbeing (Lewin, 2010).

International projects

Meeting the health needs of an ageing population with limited resources is a global challenge and it is useful therefore to identify positive outcomes reported in reablement projects from the US (Tinetti et al, 2002), the UK (Kent et al, 2000) and New Zealand (Parsons and Parson, 2005), especially where coordination across disciplines has been a fundamental aspect of the reablement service. Positive findings include an increase in the number of clients remaining at home with the duration of care shortened significantly; a large proportion of care packages successfully concluded at first interview and reablement clients twice as likely to have their package reduced; and reduced mortality rates and increased independence for daily living activities.

More recently in the UK, the Social Policy Research Unit of the University of York reported on the success and cost-effectiveness of short-term home-care reablement programs (Glendinning et al, 2010). Significant quality of life improvements related to health and social wellbeing were noted, efficiencies were achieved in the decreased subsequent use of social care services, and the project met the National Health and Clinical Excellence cost-effectiveness threshold, although the reduction in social costs was almost entirely offset by the initial cost of the intervention. Significantly, on the basis of these service outcomes and cost analysis, further funding of reablement services has been approved through National Health Service Primary Care Trusts.

A recent research briefing from the Social Care Institute for Excellence (Francis et al, 2011) also noted that a focus on regaining physical ability is central, as is active reassessment. It reported that clients welcomed the emphasis on helping them gain independence and better functioning. Client complaints about reablement mainly related to handover (back to a traditional care provider) and lack of help with domestic tasks.

Practice implications

Given that the key characteristics of reablement include time-limited and goal-oriented care planning, multi-dimensional assessment methods, collaboration across multi-disciplinary teams and the application of generic evidence-based interventions, it is clear that this approach will require some refinement of current internal care systems and processes. Moreover, some capacity-building will be required.

For organisations

From an organisational perspective, the literature suggests that visionary leadership needs to be fostered to drive the change towards a reablement culture and to support commitment, enthusiasm, knowledge and skills of front-line staff (Glendinning et al, 2010). To achieve a whole-of-organisation person-centred culture, it is essential that a clear definition (and articulation) of the organisation's model of reablement is provided in which the link between policy, practice, training, supervision and quality is clearly aligned with the agency's mission, vision, values and strategic direction. Organisational policies, procedures, and other core operational systems will also require adaptation to reablement principles and practices.

For service delivery

At the service delivery level, Parsons (2008, podcast 8) emphasised the importance of training in the development of New Zealand's restorative programs, resulting in the development of a number of programs that covered restorative techniques, assessment, treatment and rehabilitation. In the UK, Glendinning et al (2010) suggested that training was particularly important for high-quality assessments, together with rapid assessment and delivery of equipment. To assist staff to adapt to this new model of service provision, staff training also needs to include change management approaches and an understanding of the redefinition of the culture of the organisation.

Wider environmental factors include clarity amongst all relevant staff at various locations regarding the aims, potential and limitations of reablement, together with ready access to specialist training and skills (Glendinning et al, 2010). A staged implementation of reablement processes was also recommended, culminating in the timely monitoring and evaluation of client care against established professional benchmarks (Parsons and Parsons 2005).

Discussion Guide

Based on local and international initiatives, there is growing acknowledgement of the core characteristics of a successful model of person-centred care that achieves specific goals in a nominated time-frame while meeting social inclusion objectives and Australia's care reform agenda.

- The following questions have been formulated to help organisations and practitioners frame and scaffold the transition from research to practice: What do you think about the reablement approach? What do you think are its best elements?
- Could you trial a reablement approach within your own service?
- What elements of reablement would be suitable to introduce into your current program? How would you go about this?
- What would be the barriers in your own team or practice to introducing a reablement approach?
- How would you introduce staff and clients to the concept of 'doing with' rather than 'doing for'?
- How would you adapt your tools, care plans, practices and policies to promote 'doing with' rather than 'doing for' clients?
- How would go about changing the expectations of clients and of other agencies, as to what you provide?
- How would you deal with concerns about risk, or the short term nature of reablement?
- Is your service flexible? How can you make it more so?
- What reablement approaches are being developed or implemented in your state/territory?
- How do you currently promote strengths and capacity building? Can you do more?
- How do you promote preventative and healthy ageing information and activities in your programs?

Helpful resources

NSW
Ageing, Disability and Home Care

The Better Practice Project, Enhancing Independence at home and in the community

Towards an Enabling Approach to Community Care
www.adhc.nsw.gov.au/sp/delivering_hacc_services/the_better_practice_project

NSW IMPACT www.impactnsw.com

VIC
Victorian Govt Health Information, Home and Community Care, Active Service Model Project.
www.health.vic.gov.au/hacc/projects/asm_project.htm

WA
CommunityWest, Wellness Approach
www.communitywest.com.au/wellness

Silver Chain – Enabling Research:
www.silverchain.org.au/research-projects/

Silver Chain (2007). Home Independence Program (HIP) User Manual. www.silverchain.org.au

SA
Aged & Community Services SA & NT Inc - The Better Practice Project
https://www.agedcommunity.asn.au/professional-development/better-practice-project

ECH - enabling older people to enhance their independence and enrich their lives www.ech.asn.au/

NZ
ASPIRE Project www.moh.govt.nz/moh.nsf/indexmh/aspire-factsheet

We welcome feedback on this Briefing.
A full list of references can be accessed on The Benevolent Society's website.

ASLaRC Aged Services Unit
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ASLaRC Aged Services Unit is part of the Health and Wellbeing Research Cluster of Southern Cross University. A primary goal of ASLaRC is to improve the health and well-being of older people through teaching, research, the promotion of evidence-based practice and community engagement.

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