



Appendix B – Embedding wellness and reablement in the CHSP overview

Contents

1. Strategies to embed wellness and reablement	2
2. Why wellness and reablement is important.....	2
2.1 Understanding the ageing journey – the Life Curve.....	2
3. Benefits of a wellness and reablement approach.....	3
3.1 Benefits for clients	3
3.2 Benefits for service provider organisations	4
3.3 Benefits for families and carers.....	4
4. Wellness and reablement initiative.....	4
4.2 Other resources	4
5. Live Up – empowering older people to remain independent for longer	5
6. Wellness and reablement in assessment and support planning	5
7. Care planning.....	6
7.1 Reviewing the Care and Services Plan.....	6
8. Client scenarios	7
8.1 Wellness and reablement-focused assessment with support planning	7
8.2 Supporting greater independence.....	8
8.3 Short-term wellness and reablement, and restorative interventions	9

1. Strategies to embed wellness and reablement

There are a number of strategies that CHSP providers may use to embed wellness and reablement into service delivery. Strategies may include:

- assessing the organisation's maturity and readiness to embed wellness and reablement, prepare for any changes required to develop and continue to develop maturity
- taking a whole-of-organisation approach, including commitment from both management and staff
- reflecting wellness and reablement in organisational policy and procedures, especially in recruitment, employment, orientation, induction practices, position descriptions and performance reviews
- providing and encouraging staff training and education programs that aim to reshape the mindset of management, staff, volunteers, clients and their families and carers
- taking time to work with staff to ensure they understand the benefits and reasons for applying wellness and reablement approaches
- using our collection of [practical guides and tools](#) to:
 - embed wellness and reablement approaches into service delivery
 - deliver person-centred, goal-oriented services and conduct regular reviews
 - support staff to apply a person-centred and outcomes-focused approach to work with CHSP clients to achieve their goals
- ensuring communication materials reflect wellness and reablement approaches to set client and staff expectations.

2. Why wellness and reablement is important

Emerging research has demonstrated the benefits of focussing on client independence.

Traditional models of service delivery that focus on what a client can't do, rather than what they can, can lead to over-reliance on services, which has been linked with accelerated functional decline.

2.1 Understanding the ageing journey – the Life Curve

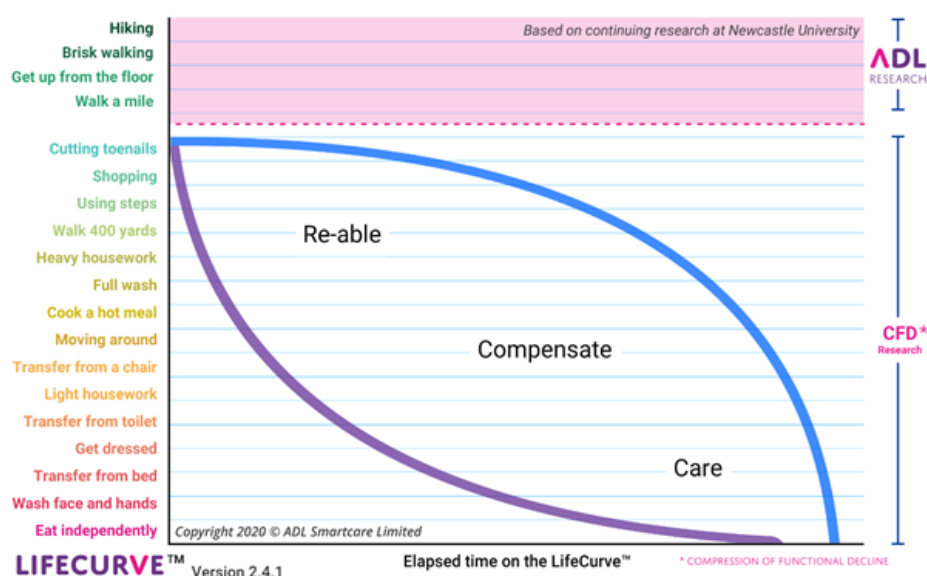
Research suggests the largest influencer in age-related decline is not genetics, but lifestyle choices. Older people who continue to do things for themselves tend to remain independent longer and live better.

Professor Peter Gore, Institute of Aging at Newcastle University in the United Kingdom, developed a framework to understand the age-related decline.

The framework is called the Life Curve (see Figure 1 below), which looks at:

- the impact of maintaining independence on quality of life
- the rate of age-related functional decline.

Figure 1: The Life Curve



The vertical axis lists activities of daily living that older people generally lose over time, in the order in which they tend to be lost, from top to bottom.

The timeframe for this decline varies and can be influenced by behaviour and interventions. For example, difficulty cutting toenails as an early indicator that intervention may be needed.

The graph shows 2 trajectories: 1) a sub-optimal life curve with a fast early decline and 2) an optimal life curve in which the early decline is slowed down to give people more good days before losing the ability to undertake activities, like walking, shopping and personal care.

The Life Curve illustrates that the sooner a person stops performing certain tasks for themselves, the faster they tend to lose their functional ability.

The aim of CHSP services is to assist clients to perform daily tasks independently for as long as possible so they maintain the ability and can maximise autonomy. This means by retaining physical ability, it helps clients to continue to do the things they enjoy for longer.

You can [download the free LifeCurve™ App](#) from Live Up's website.

3. Benefits of a wellness and reablement approach

Older people are not the only ones who benefit from wellness and reablement. Evidence suggests there are also large benefits for service provider organisations, families and carers, and the broader community.

3.1 Benefits for clients

Implementing a wellness and reablement approach at the earliest opportunity can have significant long-term benefits for clients, including:

- improved sense of purpose, autonomy, and self-worth
- improved physical and emotional health and wellbeing
- reduction in service delivery needs
- increased ability to live independently and safely in their own homes for longer
- greater quality of life and retention of pride and dignity
- improved connection with community
- reduced strain on family and carers.

3.2 Benefits for service provider organisations

CHSP providers that have embedded wellness and reablement identified significant benefits for their staff, business model, organisational processes and their clients. These include:

- greater job satisfaction from actively helping clients achieve their goals and become more independent
- better use of resources, as support workers can focus on complicated tasks clients can't perform for them themselves, which means more meaningful and fulfilling work for staff
- opportunities to broaden the client base by offering more short-term reablement support services
- improved reputation and repeat business based on providing person-centred care, focused on client goals
- better alignment to aged care reform initiatives, improving preparedness to respond to changes in aged care policy
- supporting compliance with meeting CHSP requirements and [Aged Care Quality Standards](#).

3.3 Benefits for families and carers

Wellness and reablement approaches can have significant benefits for family members and carers, including:

- opportunities to be involved in supporting their loved one to meet their goals
- peace of mind in knowing their loved one is retaining or regaining their independence, improving their wellbeing and quality of life
- reduced worry and concern over their loved ones along with reduced strain and pressure due to a decrease in caring requirements.

4. Wellness and reablement initiative

We have developed a range of online [Wellness and reablement resources](#) to support CHSP providers to embed wellness and reablement approaches into their organisational practices and service delivery.

4.2 Other resources

[Wellness and reablement initiative page](#)

[Living well at home: CHSP Good Practice Guide](#) provides practical guidance in how to adopt a wellness and reablement approach into service delivery.

5. Live Up – empowering older people to remain independent for longer

The [LiveUp website](#) enables people to check their health and find personalised suggestions for products and services that promote healthy ageing.

For example, LiveUp can suggest low-cost assistive products and equipment to help with everyday living, as well as personalised exercises and services for age-related wellbeing.

You can download the free LifeCurve™ App, which can track a client's health and give them easy to understand, long term advice tailored to their needs.

To learn about LiveUp's products and services, visit [Live Up's website](#) or call 1800 951 971.

6. Wellness and reablement in assessment and support planning

Assessment and support planning conducted by aged care assessors also adopt a wellness and reablement approach to assessment.

The role of the assessor is to work with the client to identify their needs and concerns, as well as their goals and aspirations.

A Home Support Assessment includes an assessment of 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.

The assessor then works with the client to develop a support plan, which focuses the support needed to assist them to achieve their goals.

In developing a support plan with a client, the assessor should:

- Focus on what a client can do and discuss what they need to complete more difficult tasks.
- Discuss strategies to manage day-to-day tasks. For example, transport planning to meet goals around the use of public transport to maintain usual activities.
- Explore opportunities for supporting independence through wellness and reablement approaches. For example, the client may benefit from time-limited support and/or the use of specific equipment and products or home modifications, such as installing shower rails to build confidence and independence.

Developing a support plan with the client will ensure services accurately reflect their needs and goals. This will help make the client more motivated to work towards their identified goals, including ongoing independence using wellness and reablement approaches.

If the assessment identifies that a short-term intervention is appropriate, in some circumstances, the assessor may take on a coordination role to ensure all referrals in the support plan are linked to one or more CHSP providers and are delivered within the agreed time frame.

For clients receiving wellness and reablement support, assessors should include review dates on the client's support plan to monitor the client's progress towards their goals and desired outcomes. They will also assess the need for ongoing or any adjustment in services.

The client's support plan is saved to the client record on My Aged Care and can be viewed by their CHSP provider. CHSP providers are required to provide time limited services in line with a client's support plan.

7. Care planning

A wellness and reablement approach requires you to understand your client, their strengths and capabilities and what wellness means to them. The information collected at the time of assessment and included in the client's support plan, provides valuable insights into the client, their current situation and requirements.

In developing the Care and Services Plan, providers should ensure it is aligned to the client's support plan, and developed with the client to support them to achieve more good days.

Developing a Care and Services Plan which is person-centred and outcomes-focused is critical to the success of implementing wellness and reablement and achieving high-quality outcomes for clients.

Care planning involves working with your client to develop and document the approach to support the client achieve their goals.

The Care and Services Plan should outline the wellness and reablement strategies that the support worker will undertake with the client to help them maximise on outcomes that improve their overall wellbeing and maintain/regain their independence and autonomy.

7.1 Reviewing the Care and Services Plan

Clients and their situations are dynamic. Circumstances can change quickly. This means it is extremely important providers are conducting regular reviews on how the client is progressing in terms of their Care and Services Plan.

Reviews are a requirement outlined in the CHSP manual and should be regular and ongoing. This assists in understanding how the client's needs have changed, and if adjustments are required to the referral.

Ongoing reviews are a great opportunity to engage in consistent evaluation of how the Care and Services Plan is currently meeting the client's needs. If any improvements/changes should be made to help clients reach their goals and greater independence and confidence.

8. Client scenarios

8.1 Wellness and reablement-focused assessment with support planning

Scenario 1: Cecelia

Cecelia is an 81-year-old woman who lives alone. Before experiencing a stroke earlier in the year, Cecelia had been actively involved in her church and local community. However, following the stroke, Cecelia stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she had also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.

Cecelia was referred to My Aged Care by her doctor. Following the initial registration process, they organised an assessment. Cecelia's aged care assessment helped to identify her strengths and capabilities, as well as her needs. The resulting support plan was centred around Cecelia's own goals. Her goals included getting stronger, resuming her church activities, doing more about the house and getting back out in the garden.

Cecelia's support plan included:

- referral to an allied health professional to assist with her goal of getting stronger
- referral to a CHSP domestic assistance service provider to provide assistance with the more difficult household chores and to help Cecelia to identify which chores she could still manage to do on her own
- assistance to identify and make contact with a pastoral care team member to discuss her continued interest in participating in church activities
- referral to a home maintenance and repairs service for discussion and planning to convert her garden to be safer and more accessible, and lower maintenance.

After mastering basic strength and balance exercises through a home exercise program designed by the allied health professional, Cecelia was eventually able to walk unaided inside her home. A more confident Cecelia then arranged a 'buddy' to drive her to and from church activities. At the same time, the CHSP domestic assistance service provider worked with Cecelia to assist her to take on some of the easier housekeeping chores enabling her to remain more active and independent.

8.2 Supporting greater independence

Scenario 1: Adelina

Adelina is a 77-year-old woman who had a stroke that affected her left side. Her speech was unaffected, but her movement was restricted. She has little function in her left arm, and her left leg is slightly affected although she is able to walk with a stick.

Adelina felt she was unable to do very much for herself. She really wanted to be able to make her own cup of tea. However, due to the lack of function in her left arm, she felt she was dependent on carers and unable to make a cup of tea between carer visits, unless a friend or neighbour came by. Adelina had reconciled that this was how her life would be. She was dispirited and resistant to her son's suggestion that she could do a bit more for herself.

At the request of her son, Adelina's support plan was reviewed by the aged care assessor and they recommended a referral to an occupational therapist under the CHSP. The occupational therapist suggested that she be assisted to learn to use the microwave and a kettle fitted onto a tipper so that she could make her own cup of tea.

For a number of weeks Adelina was supported to build up her confidence in her ability to use the microwave and the kettle. After a few months, Adelina was able to make meals for herself, her own cup of tea and is living a more independent life. As a result, Adelina has said that she is feeling more hopeful and has started to invite friends over for meals. Adelina's son has been delighted to see his mother's renewed sense of self and independence.

Scenario 2: Rose

Rose is an 87-year-old woman who is a community and centre based respite client and has become very dependent on the 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. The centre staff and Rose had a discussion and agreed that she was 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 toilet independently rather than attempt to assist as previously.

Over time, Rose has become more confident and is more 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. She is also now more actively involved with the centre, rather than being a passive recipient.

Scenario 3: Helen

Helen is a 78-year-old woman with osteoarthritis. Lately, Helen has been experiencing difficulty performing household cleaning duties and doing her laundry. At assessment, the assessor referred Helen for domestic assistance to help her manage around the house.

The CHSP provider receiving Helen's referral for domestic assistance contacted Helen to understand more about her circumstances and what she needs support with. Applying a wellness and reablement approach, the service provider speaks with Helen about what's

happening and what she's having difficulty with. In this conversation, the service provider identifies tasks Helen still can do and the certain tasks that impact her arthritis. Helen shares that she used to enjoy doing the housework to keep her home nice and clean. Helen feels lonely because she hasn't had many visitors lately because she's worried about her house.

The service provider works with Helen to develop a Care and Services Plan focused on her strengths and the things she wants to regain and maintain. The service provider visits Helen once a week for a few hours to help her with cleaning and washing. Over a 2-month period, the service provider supports Helen to continue to do the things she wants and provider does the tasks that put stress on Helen's arthritis, such as vacuuming and mopping.

While Helen still requires ongoing support with harder domestic duties, she has improved on her functional capacity and feels more like herself. Helen has benefited from her service provider taking a strength-based approach to service delivery and focusing on 'doing with' not 'doing for'. Helen has been able to maintain some physical activity and regain some independence, which has helped her feel more fulfilled and capable. Helen has begun engaging with her friends again, which has improved her social connectedness.

8.3 Short-term wellness and reablement, and restorative interventions

Scenario 1: David

David is an 81-year-old man who was referred to My Aged Care after fall he had 2-weeks ago. Although he had sustained no specific injuries, David was pretty shaken up from the fall and was now lacking in confidence to shower himself independently.

Following his initial screening process through the My Aged Care contact centre, David was referred for an aged care assessment. The assessment identified that David was previously independent and he was motivated to regain his independence. David was still independent in many daily activities, but was struggling with his personal care.

Based on the assessment, the assessor developed a support plan with David, which identified his goal of being able to independently maintain his personal care. The support plan provided information on David's strengths and abilities, his areas of difficulty and recommendations to achieve his goals. His plan included a referral to a CHSP provider for an occupational therapy assessment and the delivery of time limited personal care services.

The occupational therapist worked with David and his carer to come up with a plan to achieve his goals. Initially, personal care services were provided to David 3-times a week to assist him with showering. Over a 4-week period, the CHSP provider worked with David to develop specific strategies to help him to build his capacity and regain confidence in showering. For example, how to step in and out of the shower safely. After the 4 weeks, David felt confident to shower independently again and the services were withdrawn.

Scenario 2: Bill

Bill is a 75-year-old man who lives at home with his wife Irene. Bill had not previously received any aged care services since he and Irene had always enjoyed good health.

Recently Bill had an accident and spent time in hospital. Although Bill recovered well from his accident, it left him feeling anxious about leaving the house. His hospital stay and inactivity had also reduced his physical fitness, which has prevented Bill from doing as much around the house and garden as he'd done before.

Irene contacted My Aged Care and Bill was referred for an aged care assessment. Bill's assessor worked with him to identify the things he liked to do and what he no longer felt comfortable doing. They developed a support plan with Bill, which included some time limited interventions with a restorative care focus. These included:

- referral to physiotherapy or exercise physiologist to develop a suitable strength, balance and endurance program
- referral to an occupational therapist to identify energy conservation strategies and/or suitable equipment to promote functional independence
- referral for some time-limited home maintenance and repairs and domestic assistance.

Following this time-limited support, Bill now feels more confident living at home and is able to undertake much of the home maintenance and repairs and domestic chores that he used to do. Applying this short-term restorative care intervention approach enabled Bill to regain his strength and confidence. It also prevented a possible longer-term dependence on ongoing services.