Bite Sized Professional Development

Stepping back from stepping in

Session title

Support Planning and Delivering Reablement – Part 2

Facilitators Guide

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Contents

Acknowledgements

This resource was developed by Independent Living Assessment Inc with the support of Laura Coleman – AVIVO, Alison Vella – Aspire4Life and Belinda Robinson – WA Country Health Services who have provided valuable feedback to enhance the information and resources for the series of Bite Size Professional Development sessions. Their understanding and insight into the experiences and challenges of organisations and their staff while working with clients to achieve their goals has enriched these learning resources.

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Support Planning and Delivering Reablement – Part 2

Training Overview

This bite sized session Support Planning and Delivering Reablement Part 2 is the fourth in a series of professional development sessions developed to assist organisations working in the aged care sector to enhance the knowledge and skills of staff when working with clients to achieve their goals. The approach known as Wellness and Reablement aims to build on people's strengths and promotes independence and autonomy.

Structure

The bite size sessions have been designed for organisations to present face to face in team meetings and/or dedicated professional development workshops.

Target Audience

Staff of aged care organisations working with clients in their home and community.

Purpose

There have been many changes over recent years within the sector, a significant one for all staff has been the philosophical cultural shift in how we support older people who are experiencing difficulties with everyday activities. Instead of the traditional hands-on approach of stepping in and doing things for people, support organisation and staff are now expected to assist people to explore ways to maximise their independence and empower people to have a sense of choice and control. The Wellness and Reablement approach has been shown to have positive outcomes for older people as it acknowledges and builds on their abilities and skills, so they remain more independent, with an improved wellbeing, within the community they wish to live.

Good practice support planning is seen as a fundamental element of successful reablement; therefore, to apply the amount of time required for this topic it will be presented in two parts.

Support Planning while Delivering Reablement – Part 1: aims to raise awareness of the importance and elements of good practice support planning while working with clients to achieve their goals. Through reflection of current practices and identification of improvement activities, participants will develop a plan to incorporate good practice support planning into their role and/or the organisation in which they work.

Support Planning while Delivering Reablement – Part 2: this session aims to provide a summary of Part 1 above and an opportunity for staff who are responsible to develop support plans, to apply good practice elements and practice when developing support plans based on case scenarios.

Session title

Support Planning and Delivering Reablement – Part 2

Training Overview – *cont.*

Participants of Support Planning – Part 2 will:

- Revisit the elements of good practice support planning from Part 1
- Apply learning from Support Planning and Delivering Reablement – Part 1 into practice when developing support plans
- Identify any gaps in knowledge and skills when developing good practice support plans and how to address them.

Resources

- Facilitator's Guide *(this document)*
- PowerPoint Presentation
- Planning Template
- Case Scenarios
- Evaluation Questionnaire

Optional **Resources**

- Download our 'How to Write Support Plans' guide on the KeepAble web hub go to: **keepable.com.au/for-homecare-providers/plans-guides-and-roadmaps/guide-to-writing-support-plans/** and download the PDF or review online as an eBook.

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Support Planning and Delivering Reablement – Part 2

Lesson Plan

Time	Content	Resource
2 minutes	Welcome (introductions if required) Session objectives.	PPP (slide 2)
2 minutes	Why is good practice support planning important? *If conducting Part 1 & 2 consecutively this slide can be hidden*	PPP (slide 3)
3 minutes	Activity – What role do you currently play in developing or delivering a support plan? *If conducting Part 1 & 2 consecutively this slide can be hidden*	PPP (slide 4)
20 minutes	Putting Learning into Practice Activity – Applying good practice support planning.	PPP (slide 5) Activity - Planning Template - Case scenarios
5 minutes	Questions and feedback	PPP (slide 6) Evaluation questionnaire

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Support Planning and Delivering Reablement – Part 2

Slide 1 – Welcome and Introduction

Acknowledgement of Country

We pay our respect to Aboriginal and Torres Strait Islander cultures, to Elders past, present and emerging, and to all Aboriginal and Torres Strait Islander peoples including members of the Stolen Generation.

Welcome

Introductions (if required)

About the session

This bite sized session Support Planning and Delivering Reablement Part 2 is the fourth in a series of professional development sessions developed to assist organisations working in the aged care sector to enhance the knowledge and skills of staff when working with clients to achieve their goals.

Good practice support planning is seen as a fundamental element of successful reablement; therefore, to apply the amount of time required for this topic is presented in two parts. When appropriate they can be presented in one session, with duplicated information removed.

Support Planning and Delivering Reablement – Part 1 aims to raise awareness of the importance and elements of good practice support planning while working with clients to achieve their goals. Through reflection of current practices and identification of improvement activities, participants will develop a plan to incorporate good practice support planning into their role and/or the organisation in which they work.

Support Planning and Delivering Reablement – Part 2 – for staff who develop support plans, this session aims to provide a summary of – Part 1 and provide an opportunity to put the learning of Part 1 into practice by developing a support plan based on a case scenario within the responsibilities of their role.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 2 – Session Objectives

Participants of Support Planning – Part 2 will:

- Revisit the elements of good practice support planning from Part 1

  Provide an overview of why good practice support planning is important when supporting clients to achieve their goals. The session also revisits the elements of good practice support planning guiding the staff who develop support plans to ensure these features are included in the client plans.

- Apply learning from Support Planning and Delivering Reablement – Part 1 into practice when developing support plans

  Provides an opportunity for the participants to apply the learning from Part 1 and practice developing a support plan based on good practice elements.

- Identify any gaps in knowledge and skills when developing good practice support plans and how to address them

  Gain a greater understanding of the role you currently play and how essential elements could be incorporated into their role when developing or delivering good practice support planning

- Develop a plan of how to increase elements of good practice support planning into their role

  During this activity additional skills and/or knowledge may be identified by the learner, this is an opportunity to discuss and explore avenues to enhance these in the future.

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Support Planning and Delivering Reablement – Part 2

Slide 3 – Why is good practice support planning important?

NB: this slide can be hidden if presenting Part 1 & 2 consecutively

Good Practice Support Planning

Within the aged care sector, the process of support or care planning is common practice, for service providers, each organisation has adopted their own objectives, processes, and templates but My Aged Care Assessors from both Aged Care Assessment Teams (ACAT) and Regional Assessment Services (RAS) are required to complete a My Aged Care (MAC), National Screening and Assessment Form (NSAF) and support plan as part of the assessment process. The elements of good practice support planning can be applied with both of these different planning processes.

The support or care plans developed and delivered by service providers should build on the information contained in the MAC plan and provide greater detail for the client, families and support workers regarding how and who will support the client to achieve their goals and timeframes for short term support. Short term support for a client who wishes to improve their independence tends to be delivered within a 12-week period (CHSP Manual 2020-2022) with the aim for the client to exit the service when a specific outcome or their goal has been met.

In this session we are going to identify why and what the essential qualities of good practice support planning are, when delivering reablement and supporting a client to achieve their goals.

Support Planning and Delivering Reablement – Part 2

Slide 3 – Why is good practice support planning important? *cont.*

Why is good practice support planning important?

- **Provides guidance for client, carers and staff**

  A comprehensive and complete support plan will assist in guiding the client, their families and staff with the information that was identified and discussed with the client at the time of assessment and service provider planning visits. Good practice support plans will provide an understanding of what the client hopes to achieve, and the steps agreed to get there.

- **Builds on information collected at assessment**

  The support plan written by the assessor will identify the client's strengths, concern/s, goal/s and suggested strategies to assist the client to work towards achieving their goal/s. This information needs to align with the discussion the assessor had with the client and observations identified at the time of assessment; then recorded within the NSAF.

  For service providers when developing support plans which guide staff and clients, they will build on the information within the NSAF and support plan by breaking down the broader goals into achievable steps and strategies which will assist the client to work toward their goal/s.

- **Communication tool for all involved when supporting clients to achieve their goal**

  A good practice support plan assists to provide a shared understanding to all involved about:

  - what is important to the client and what they wish to achieve
  - how this will happen
  - the roles and responsibilities each person plays
  - progress and review of the client in achieving their goals
  - record of changes that may need to happen.

There is more potential for the client to feel supported, motivated and be successful in achieving their goals if everyone involved understands why and what is happening while a client is working towards maintaining or regaining independence within their daily activities. It also helps if the client has a setback with their progress, to get things back on track.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 4 – Essential elements of good practice support planning

NB: this slide can be hidden if presenting Part 1 & 2 consecutively

Involve the client and carer every step of the way

Involvement of the client and their carer when developing and reviewing a support plan is an essential step to ensuring the document genuinely reflects the client goals, abilities, difficulties and agreed strategies. There is more likelihood of success for the client to increase or maintain their independence with activities when every opportunity is taken to consult with them and ensure there is an understanding and agreement with the plan.

Understanding of what the client wants and is motivated to achieve

Gaining an understanding of what the client wants to achieve by undertaking a period of reablement and why it is essential to set the purpose of the plan, if this is communicated clearly it will assist all involved to work together with a shared goal.

Identifies client strengths and abilities and difficulties they are experiencing

Recognising a clients' current abilities to complete activities and understanding where they are having difficulties will assist support to be targeted appropriately and increase opportunities for a client to continue to use and build on their current skills. Acknowledging difficulties and barriers to completing activities is an important part of reablement.

Breaks down goals into smaller steps and tasks

Stepping out goals into smaller achievable steps, provides a pathway for all on how the client intends to achieve their goal/s. It will lessen any feelings of being overwhelmed by the end goal by providing opportunities to acknowledge incremental progress and offers greater clarity of when to review the plan i.e. at each step.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 4 – Essential elements of good practice support planning *cont.*

Identify who is responsible for each task

When all involved have a shared understanding of what the client is trying to achieve and the role each play, support staff and carers are guided to assist only where needed and the client is given opportunities to increase their skills through continuing to complete the tasks, they are able to do or work together completing tasks where they are having difficulties. It also contributes to increase role clarity and boundaries for staff to and a greater understanding for the carer and family about who is responsible for what tasks. Where there is a need for other assessments or strategies to be implemented prior to commencement of support services, the plan can communicate this to all involved in supporting the client to achieve their goals.

Seeks solutions and supports positive risk taking

Central to the success of a client to regain or maintain their abilities is having choice and control when planning and implementing support to achieve their goal/s. When developing support plans is the time to identify any risks or barriers with the client and work together to find solutions how they could be lessened. Positive risk taking can deliver many benefits including a feeling of self-worth and autonomy.

Communicate plan to all involved

It is important for all involved to be given an opportunity to read and understand the role they play when delivering a reablement support plan. If a good practice support plan is provided to all appropriate staff in a timely manner i.e.: prior to commencement of support, it will provide staff with information about the support they are to provide and an opportunity to clarify any queries. It is also good practice for support staff to discuss the plan with the client prior to commencing, so all involved are clear what role they will play.

Regularly review support plan and update

Regular check in with clients and staff will assist with understanding if the plan is still appropriate and any timelines in place are realistic. Any progress the client makes needs to be celebrated and documented and the plan updated accordingly.

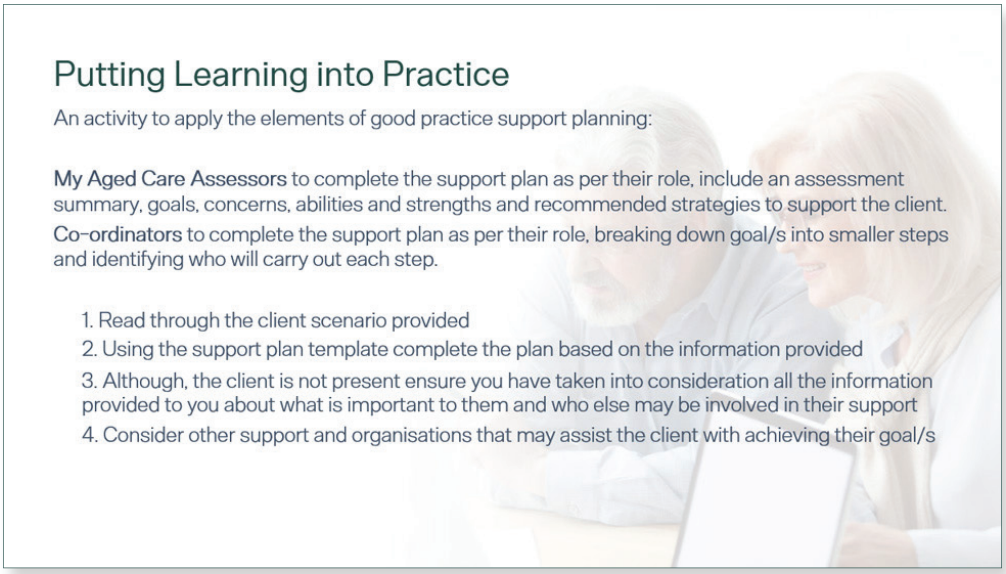
Reassess strategies if the client has a setback

When working with clients to achieve their goal/s the pathway is not always a smooth one, clients can experience setbacks to do with their physical or mental health which can impact their abilities to complete activities in the current plan. Therefore, it is important to work through any challenges with the client and adjust the strategies and /or timelines in the plan. Importantly these updates need to be shared with everyone involved.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice



Putting Learning into Practice

Facilitator to provide each of the participants (individual, pairs or group) an appropriate scenario dependent on their role i.e.: My Aged Care assessor or service provider co-ordinator or similar role.

My Aged Care Assessors

Complete a support plan using the template provided and based on the information given in the case scenario making sure where possible you apply the elements of good practice support planning. Ensure you include an assessment summary and any additional strategies that may assist the client to achieve their goals as they progress through a reablement pathway.

Service Provider – co-ordinator or staff who develop support plans

Complete a support plan using the template provided and based on the information given in the case scenario making sure where possible you apply the elements of good practice support planning. Ensure you break down goals into smaller steps and identify who will carry out each of the steps.

In the following pages are examples of support plans which could be developed based on the scenarios provided. There is an example for each scenario for My Aged Care Assessors and Service Provider co-ordinatiors.

Slide 5 – Putting learning into practice *cont.*

Example only – My Aged Care Assessor Mr G.

Assessment Summary

Introduction

Mr G. was assessed for support with his personal care tasks.

Situation

Mr G. was recently hospitalised after a fall in his backyard. As an outcome of the fall he hit his head, sustained a sprained left wrist and tissue damage to his left shoulder. The wound on the back of his head has healed. Mr. G has stated he has lost confidence with walking inside and outside of his home.

Background

Mr G. spent many years working on a farm, but he and his wife moved to Perth once he retired to be closer to their two daughters. He lives alone since the passing of his wife 10 years ago and is in regular contact with his daughters, although does not see them often due to their busy lives.

Prior to his fall Mr G. enjoyed gardening and going to the bowls club, he has several friends who will assist him with transport since giving up his licence 12 months ago. He stated he is keen to get back to these pastimes but doesn't know if this is possible.

Assessment

During the assessment Mr G. was observed mobilising with a 4 wheeled walker which he has begun using since his fall. He accessed the shower recess safely using the handrail which is already in place. Simple assistive aids such as a long-handled sponge for washing and sock applicator were discussed with Mr G. to assist with his personal care tasks.

Mr G. was observed rocking back and forth to gain momentum when standing up from the shower chair. Mr G. states this caused his shoulder to hurt, and a grimace of pain was observed on Mr. G. face during this movement. Mr G also stated he mobilised independently and without pain prior to his fall and was hoping he could regain this independence.

Recommendations

- Support for 6 weeks, to be reviewed weekly or sooner if required, decreasing support as Mr G's ability and confidence increases.
- Assist Mr G. to regain his independence and confidence when completing his personal care tasks while showering and dressing.
- Mr G. agreed to use a long-handled sponge while showering and trial the use of a sock applicator when putting his socks on.
- Mr G. wishes to recommence activities of interests such as gardening and playing bowls at the local club. Support to be reviewed regularly and adjusted according to Mr G.'s progress.
- At the time of the assessment Mr. G. declined a physiotherapy assessment to assist him with his balance and strength when mobilising.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Goal and steps

Client Concern

Mr G. unable to complete all his personal care tasks due to pain and decreased movement in his left wrist and shoulder, since falling in his backyard.

Client Goal/s

To feel confident and less pain when completing my personal care tasks and be able to return to my interests of gardening and playing bowls.

Client Strengths/abilities

Mr G. is motivated to return to previous level of independence

Mr G. is able to plan and prepare clothes prior to planning

Mr G. is able to mobilise independently with 4 wheeled walker

Mr G. is able to wash and dry most of his body – agreed to use long handled sponge to assist with showering

Mr G. is able to dry most of his upper and lower body, may require some assistance

Mr G. is willing to trial a sock aid applicator to assist with dressing

Client Difficulties

Mr G. has limited movement in left arm due to soft tissue damage from fall

Mr G. experiences pain in his left shoulder and wrist when moving

Mr G. may need some assistance with undressing and dressing himself

Mr G. has agreed to trial a sock applicator to assist him when putting his socks on

Mr G. states he is fearful of falling since he fell in the backyard several weeks ago

Slide 5 – Putting learning into practice *cont.*

Example only – Service Provider Co-ordinator – Client Support Plan Mr G.

Client Goal/s

To feel confident and less pain when completing my personal care, and over time be able to return to my interests of gardening and playing bowls.

Client Strengths/abilities

- Motivated to return to previous level of independence
- Able to choose and locate clothing to be worn each day.
- While sitting on his bed he can remove his pants and underwear.
- Able to mobilise independently to the shower cubicle with four wheeled walker
- Able to regulate the shower independently, does not require supervision while in the shower
- Able to wash himself using a long-handled sponge
- Able to dry most of his body

Client Difficulties

- Mr G may require support to remove his upper body clothing
- May need assistance to remove his shoes and socks
- Mr G. may require supervision while stepping in and out of the shower cubicle
- Mr G may require assistance to dry his back

Steps

Continue to communicate with Mr G. to ensure the support plan is meeting his support needs to achieve his goal.

Visit One –

- Review support plan with Mr G to confirm what he is trying to achieve and the steps in place to assist him to work towards his goal.
- Support Mr G. with the tasks he finds difficult when completing his personal care.
- If necessary, support Mr G. by demonstrating how to use assistive aids i.e.: long handled sponge and sock applicator until he has the confidence to use independently.
- Provide encouragement and allow the time needed for him to complete as much of the tasks as possible, within his range of movement and pain threshold.
- Guide Mr G to remove upper clothing from non-effected side first. Sitting down on bed may assist with confidence to complete this activity.
- If requiring assistance to dry his back suggest he flicks towel over shoulder or putting on a towelling bathrobe to walk to bedroom to get dressed would assist with this activity.

Slide 5 – Putting learning into practice *cont.*

Visit Two –

- Discuss with Mr G. how he feels about his progress, is his pain lessening and does he have increased movement in his left shoulder and arm? Does he feel he can do more for himself each day/week?
- Support Mr G. with the tasks he finds difficult to complete his personal care.
- Continue to provide encouragement and allow the time needed for him to complete as much of the tasks as possible, within his range of movement and pain threshold.
- If he has not already done so, suggest he might like to start walking around the inside of his home without the 4 wheeled walker, if he feels his balance is good enough.
- If he has already commenced walking inside without walker, suggest a short walk out to his backyard while you are there to assist.

Visit Three –

- Follow up with Mr G. about his progress, is his pain lessening and range of movement improving? Has his confidence to mobilise around the house without a walker improved? Does he still require the four visits per week to assist with his personal tasks?
- Support Mr G. with the tasks he finds difficult to complete his personal care
- Continue to provide encouragement and allow the time needed for him to complete as much of the tasks as possible, within his range of movement and pain threshold.
- Commence discussion with Mr G. in regard to a physiotherapy assessment to assist him to increase his range of movement in his shoulder, improve his strength and balance when mobilising, prevent any further falls and increase his confidence to return to his activities like gardening and playing bowls.

Visit Four –

Monitor Mr G.'s progress and adjust plan accordingly, once Mr G is independent with his personal care tasks. Confirm or not agreement to facilitate a referral for a physiotherapy assessment to improve his strength and balance and prevent any further falls. Discuss with Mr G. about exiting the program but reassure him if he requires assistance in the future, he can return.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Example only – My Aged Care Assessor Mr S.

Assessment Summary

Introduction

Mr S. was assessed for support to access transport to visit a friend.

Situation

Mr. S relinquished his driving licence approximately 8 months ago after being involved in a minor accident and experiencing some near misses. He has relied on a neighbour to assist him with transport to the shops and medical appointments and a friend picks him up to attend his club meetings. He has not been able to visit a friend who lives approx. 80kms south of the city since giving up his license. In the past when he was driving, he visited this friend on a monthly basis.

Background

Mr S. lives alone in his unit he has two children, a daughter who lives in Victoria and a son who lives in the southwest WA. He is in regular phone contact with both and in the past has visited and stayed with his son and family. His daughter tries to get home once a year for a visit. Mr S. has interests in rare coins and over the years has becomes friends with several collectors.

Assessment

Mr S. was observed mobilising independently around his home, he is able to transfer from sitting in a dining chair to standing position easily, although, when asked he stated he finds it a little harder from the lounge chair but manages. While out in the community he walks using a walking stick, stating it makes him feel more balanced to as he tires walking greater distances.

Recommendations

- Support to research public transport options to visit his friend
- Support to build confidence to utilise public transport
- Information provided about local strength and balance exercise class (Stay on your Feet), review options for transport to access these classes.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Goal and steps

Client Concern

Mr S. unable to visit his lifetime friend south of the city since relinquishing his driver's licence.

Client Goal/s

To learn how to use public transport and feel confident to use public transport to access places I want to visit.

Client Strengths/abilities

Mr S is motivated to learn about using public transport and being able to visit his friend who lives south of the city.

Mr S. is able to mobilise with confidence in the community when using his walking stick.

Mr S. is able to understand and follow instructions regarding the use of public transport timetables.

Mr S. is willing to participate in local exercise classes when transport to same has been investigated and confirmed.

Client Difficulties

Mr S. requires assistance to investigate public transport options.

Mr S requires assistance to investigate and access applications to pay for public transport.

Mr S. may require an accompanying person when experiencing the use of public transport until he feels confident to do this on his own.

Mr S. requires assistance to investigate independent transport to local exercise class.

Slide 5 – Putting learning into practice *cont.*

Example only – Service Provider Co-ordinator – Client Support Plan Mr S.

Client Goal/s

To learn how to use public transport and feel confident to use public transport to access places I want to visit.

Client Strengths/abilities

- Mr S is motivated to learn about using public transport and being able to visit his friend who lives south of the city.
- Mr S. is able to mobilise with confidence in the community when using his walking stick
- Mr S. can negotiate steps that may be required when getting on and off public transport
- Mr S. is able to understand and follow instructions regarding the use of public transport timetables.
- Mr S. is willing to participate in local exercise classes when transport to same has been investigated and confirmed.

Client Difficulties

- Mr S. requires assistance to investigate public transport options
- Mr S. is not familiar with using the internet and does not own a computer
- Mr S. requires assistance to investigate and access applications to pay for public transport
- Mr S. may require an accompanying person when experiencing the use of public transport until he feels confident to do this on his own
- Mr S. requires assistance to investigate independent transport to local exercise class.

Steps

Continue to communicate with Mr S. to ensure the support plan is meeting his support needs to achieve his goal.

Visit One –

- Review support plan with Mr S to confirm what he is trying to achieve and the steps in place to assist him to work towards his goal.
- Assist Mr S. to access online information regarding public transport and payment options for seniors from his suburb, you may be required to take Mr S. to the local library to download and print this information as he does not own a digital device.
- If necessary, support Mr S. to complete application for senior transport subsidy
- Suggest to Mr S. he reviews the information and identifies date and time to conduct a trial journey
- Discuss and investigate the need to use any local transport on his arrival to where his friend resides, ask Mr S. to review this information.
- Suggest trialling a local trip on public transport prior to taking the longer trip to visit his friend.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Visit Two –

- With agreement with Mr S. take a short trip using public transport.
- In consultation with Mr S. confirm local trip was successful and continue to plan trip to visit friend or revise longer journey based on feedback from Mr S.
- Discuss and confirm which return travel options i.e.: day, date and time to trial using public transport to meet up with his friend.
- Work with supervisor to ensure you have availability within your schedule.
- Follow up with Mr S. to confirm he has received appropriate seniors travel card to assist with payment of transport costs.

Visit Three –

- Accompany Mr S. on journey to visit friend, assist him to familiarise himself with landmarks and processes required to achieve this trip.
- Support staff to leave Mr S. to catch up with his friend and seek an opportunity to have a lunch break on their own.
- At the end of journey, acknowledge with Mr S. what he has achieved.

Visit Four –

- Follow up with Mr S. regarding his confidence to using public transport both locally and to visit his friend.
- Follow with Mr S. regarding commencement at the local exercise classes and the option to use public transport to attend.
- Let Mr. S. know you will phone him to check in on how his access to the community through public transport has progressed.

Slide 5 – Putting learning into practice *cont.*

Example only – My Aged Care Assessor Mr B.

Assessment Summary

Introduction

Mrs B. was assessed for support to complete her domestic tasks and access a social group within her community.

Situation

Mrs B. lives with a chronic lung condition and has recently been hospitalised for a chest infection. The infection has impacted on her confidence to remain living independently causing her to feel anxious about her future. She has also been experiencing shortness of breath when attempting do her household tasks. Mrs. B was seen by a physiotherapist while in hospital and shown breathing techniques to assist her to improve her lung capacity.

Background

Mrs B. lives alone, she has a daughter and two grandchildren but has limited contact with them. She used to swim regularly with a group but has now stopped and spends much of her time caring for her 3 birds, she has a neighbour who helped when in hospital.

Assessment

Mrs. B was observed mobilising independently around her home, she can transfer from a chair and on and off the toilet without assistance.

She still drives but only to familiar places as she becomes anxious and breathless when travelling outside of her community.

She feels tired and breathless after completing domestic tasks and if finding carrying and hanging her heavier washing items on the clothesline and vacuuming difficult.

Recommendations

- Practice breathing techniques provided by physiotherapist at the hospital.
- Mrs. B has been shown and agreed to implement energy saving techniques when completing her domestic tasks.
- Laundry trolley on wheels has been recommended to assist carrying of heavier items.
- Lowering of clothesline to assist with hanging out of heavier items or trial a clothes airer.
- Relocation of vacuum cleaner to assist with access.
- Local guide to social clubs provided to Mrs B for consideration when ready to increase her social connections.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Goal and steps

Client Concern

Mrs B. is anxious about her capacity to continue living independently as her lung condition is impacting on her ability to complete her daily tasks and socialise.

Client Goal/s

Improve my breathing and feel less anxious so I can complete my domestic tasks and connect with a social group.

Client Strengths/abilities

Mrs B. is motivated to improve her breathing capacity and lessen her anxiety about her future

Mrs B. is motivated to practice her breathing techniques to improve her lung capacity

Mrs. B. is motivated to implement energy saving techniques to decrease her breathlessness when completing her domestic tasks

Mrs B is independent with her less strenuous domestic tasks

Mrs B. can mobilise inside and outside of her home independently

Mrs B. continues to drive within her local community

Mrs B. is motivated to join a social group when she is feeling less anxious about her breathing

Client Difficulties

Mrs B. experiences anxiety due to her breathlessness on exertion.

Mrs. B. tires quickly when attempting to complete her domestic tasks such as carrying and hanging out of heavier washed items and vacuuming.

Mrs B. experiences anxiety when driving outside of her local area.

Slide 5 – Putting learning into practice *cont.*

Example only – Service Provider Co-ordinator – Client Support Plan Mrs B.

Client Goal/s

Improve my breathing and feel less anxious so I can complete my domestic tasks and connect with a social group.

Client Strengths/abilities

- Mrs B. is motivated to improve her breathing capacity and lessen her anxiety about her future
- Mrs B. is motivated to practice her breathing techniques to improve her lung capacity
- Mrs. B. is motivated to implement energy saving techniques to decrease her breathlessness when completing her domestic tasks
- Mrs B. Is independent with her less strenuous domestic tasks
- Mrs B. can mobilise inside and outside of her home independently
- Mrs B. continues to drive within her local community
- Mrs B. is motivated to join a social group when she is feeling less anxious about her breathing.

Client Difficulties

- Mrs B. experiences anxiety due to her breathlessness on exertion
- Mrs. B. tires quickly when attempting to complete her domestic tasks such as carrying and hanging out of heavier washed items and vacuuming.
- Mrs B. experiences anxiety when driving outside of her local area

Steps

Continue to communicate with Mrs B. to ensure the support plan is meeting her support needs to achieve his goal

Visit One –

- Review support plan with Mrs B. to confirm what she is trying to achieve and the steps in place to assist her to work towards her goal.
- Encourage Mrs B. to practice her breathing techniques as shown by the physiotherapist while in hospital
- Discuss energy saving techniques which the assessor had recommended and how these can be implemented when Mrs B. is doing her domestic tasks e.g.: vacuum one room at a time, then rest, only wash and hang one heavy item at a time then rest.
- Work alongside Mrs. B to complete a domestic task, encouraging her to pace herself and rest once the task is complete. Encourage Mrs B. to continue to complete her domestic tasks spreading them out over the following week and applying the same techniques.
- Follow up with Mrs B. regarding purchasing of a washing trolley with wheels to assist with carrying washing to clothesline.
- Follow up with Mrs B. regarding lowering of clothesline if required, contact assessor for referral for home maintenance to have clothesline lowered.

Slide 5 – Putting learning into practice *cont.*

Visit Two –

- Encourage Mrs B to continue to practice her breathing techniques
- Follow up with Mrs B. regards how she went with doing her domestic tasks using energy saving techniques. If Mrs B reports, there has been no improvement, consult with Mrs B to see if she has suggestions to decrease the impact on her breathlessness and problem solve with Mrs B to plan the following weeks tasks. Report back to supervisor of any changes to support plan if needed.
- Enquire how the carrying and hanging of washing went since implementing changes, feedback outcome to supervisor.

Visit Three –

- Encourage Mrs B. to continue to practice her breathing techniques.
- Follow up with Mrs B. on how she is managing her domestic tasks using energy saving techniques.
- Follow up with Mrs B. to ensure changes to carrying and hanging out her washing has improved.
- Discuss with Mrs. B if she has any interest in the social groups in the local guide given to her by the assessor. Provide any additional information regarding community connection programmes. If appropriate, discuss if she requires assistance to access or commence with one of the groups.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Example only – My Aged Care Assessor Mrs D.

Assessment Summary

Introduction

Mrs D. was assessed for support to complete her meal preparation.

Situation

Mrs D. experiences ongoing pain in her right shoulder and increasing difficulty standing for longer periods of time. This is impacting on her ability to continue to prepare nutritious healthy food of her choice.

Background

Mrs. D. lives alone and has two sons and three grandsons who she is in regular contact by phone and visiting. She enjoys swimming twice weekly and meets with friends on a regular basis.

Assessment

Mrs. D was observed mobilising independently around her home and is independent with showering, dressing, laundry and still drives to access to the community. She is currently receiving assistance with heavier household tasks twice a month from a CHSP service provider. In discussion with Mrs D. regarding her meal preparation she identified she has trialled pre-pared meals from the supermarket and prepared vegetables, but both have not met her expectations.

Recommendations

- Occupational therapist to assess Mrs. D food preparation techniques and kitchen set up
- Sit down while chopping vegetables, modified vegetable peeler or buy pre chopped vegetables.
- Mrs D. to follow up with GP regarding pain management for her shoulder
- Short term support to encourage Mrs D. to implement recommendations from assessor and OT recommendations.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Goal and steps

Client Concern

Mrs D experiences pain in her right shoulder while preparing her meals and is finding increasingly difficult to stand for lengthy periods of time.

Client Goal/s

To be able to continue to prepare and cook the food I enjoy eating.

Client Strengths/abilities

Mrs D. is motivated to continue to prepare her own meals

Mrs D. can plan and shop for food to prepare her meals

Mrs D. can transfer shopping from her vehicle using a trolley and small amounts of goods in each shopping bag.

Client Difficulties

Mrs D. experiences pain when attempting to chop vegetables and prepare her meals

Mrs D. is unable to stand for prolonged period

Mrs D. has difficulty removing heavy cooking pots from her lower cupboards

Slide 5 – Putting learning into practice *cont.*

Example only – Service Provider Co-ordinator – Client Support Plan Mrs D.

Client Goal/s

To be able to continue to prepare and cook the food I enjoy eating.

Client Strengths/abilities

- Mrs D. is motivated to continue to prepare her own meals
- Mrs D. can plan and shop for food to prepare her meals
- Mrs D. can transfer shopping from her vehicle using a trolley and small amounts of goods in each shopping bag.

Client Difficulties

- Mrs D. experiences pain when attempting to chop vegetables and prepare her meals
- Mrs D. is unable to stand for prolonged period
- Mrs D. has difficulty removing heavy cooking pots from her lower cupboards

Steps

Continue to communicate with Mrs D. to ensure the support plan is meeting her support needs to achieve her goal.

Prior to first visit contact Mrs D to confirm she has undergone an OT assessment and is aware of the recommendations the OT has suggested to improve her ability to prepare her meals.

Visit One – (Co-ordination staff)

- Review and discuss OT assessment report with Mrs D. – report includes recommendations for the following:
  - rearranging of kitchen cupboard contents to move heavier cooking utensils where they can be easily accessed by Mrs D.– Support worker to assist Mrs D. with this task
  - use of stool to use at kitchen bench – (Mrs D. already has suitable stool)
  - purchase of jar opener – (Mrs D. has already purchased)
  - purchase of modified chopping board and cutting knife – (Mrs D. has already purchased)
- Discuss with Mrs D. regarding planning of her meals and cooking larger amounts to freeze for use later.
- Provide Mrs D. with other energy saving techniques e.g.: using the stool to sit and prepare her meals or alternating between sitting and standing while preparing her meals.
- Enquire with Mrs D. if she has followed up with her GP regarding review of pain management for her should pain

Slide 5 – Putting learning into practice *cont.*

Visit Two – (support staff)

- In consultation with Mrs D. assist her to rearrange her cooking utensils, for easy access to heavier items
- Discuss with Mrs D. what meal/s she has planned to cook
- Work alongside Mrs D to commence preparation of meal/s
- Encourage Mrs D. to use modified cooking equipment, demonstrate how to use if she requires
- Encourage Mrs D. to use bench stool, ensure stool is set at right height
- Once meal preparation is completed ensure Mrs D. is happy to oversee the cooking of the meal.

Visit Three – (support staff)

- Gain feedback from Mrs D. on any pain she may have experienced from preparing her meals, if this has lessened, continue with steps from visit two. If she has identified what could be improved to lessen the pain or tiredness from standing assist her to implement
- Check with Mrs D. her confidence to use modified kitchen equipment and suitability of rearranged placing of heavy kitchen utensils
- When cooking preparation is complete check with Mrs D. to see if she feels confident to continue her meal preparation on her own. If so, reassure her that she can contact the office at any time to discuss any concerns she may have regarding her meal preparation.

Slide 5 – Putting learning into practice *cont.*

Example only – My Aged Care Assessor Mrs E.

Assessment Summary

Introduction

Mrs E. was assessed for respite support to assist her to connect with her garden and provide a break for Mr E from his caring role.

Situation

Mrs E. has recently been diagnosed with dementia, her husband says it has impacted on her ability to initiate any daily domestic tasks and looking after her plants in the courtyard, which was a favourite pastime. Mrs E. also experiences osteoarthritis in her knees which can cause pain when trying to kneel to tend to her garden pots.

Background

Mrs E. lives with her husband in a townhouse which has a large courtyard garden where Mrs. E until the last six months used to spend much of her time. The recent diagnosis of dementia has caused concern for Mr E. as he has noticed over the last several months Mrs E decreasing interest in her garden and pot plants and is finding it difficult to manage both the domestic and garden chores.

He stated that Mrs E. had been complaining of painful knees and thought this is why she had stopped her upkeep of the garden, until he noticed it was happening with other domestic tasks around the home which she had always carried out. Mrs E. does not have insight into her memory loss and although she does comment on how the garden has become unkept.

Mr and Mrs E. have 2 children who live by and are very supportive but do not always have the time to assist as they have their own families. Mr E. thinks with some modifications to the garden and encouragement that Mrs E would regain her interest, assisting with making the tasks Mr E. needs to complete more manageable.

Assessment

Mrs E. was observed walking inside and outside of her home independently and was keen to show the assessor the garden and pot plants, although, made a comment she needed to get out there again to tidy it up but had been too busy. When observed standing from a sitting position it was with effort and Mrs E. made a groaning noise during this process.

Mrs E. was able to communicate and answer some of the questions asked but relied on her husband to answer queries relating to completing daily activities such as the cooking and cleaning. Mrs E. is independent with her personal care tasks when encouraged by her husband, she does assist with some domestic tasks, but this also requires prompting by her husband.

Slide 5 – Putting learning into practice *cont.*

Recommendations

- In home respite to support Mrs E. to conduct errands within the community and provide a break from his caring role.
- Assistance to work with Mrs E. to reorganise her garden pot plants to be a suitable height to decrease the need to kneel when upkeeping the plants.
- Consider purchasing a kneeling pad to assist.
- Implement visual prompts inside and outside the home to assist Mrs E. with initiation of upkeep of her pot plants.
- Mr E. to follow up with Mrs E GP regarding managing the pain in her knees.
- When time permits and in consultation with Mr E. encourage Mrs E to complete domestic task/s which need doing.
- Information and resources relating to Carers Gateway and Dementia Australia have been provided to Mr E.

Goal and steps

Client Concern

Due to the impact of dementia Mrs E. no longer participates in the upkeep of her pot plants and gardening tasks have increased the pain in her knees.

Client Goal/s

Reignite the interest Mrs E has in her garden by lessening the impact on the pain in her knees and providing visual prompts to encourage her continuation in this activity.

Client Strengths/abilities

Able to mobilise independently inside and outside the home.

Able to bend down to waist height.

Has an in-depth knowledge of plants and remembers this information.

Is willing to participate when accompanied to do so.

Client Difficulties

Requires encouragement and prompting to initiate gardening tasks.

Experiences pain in knees when bending down and getting up from kneeling position.

Does not have insight into short term memory loss and will not acknowledge same.

Slide 5 – Putting learning into practice *cont.*

Example only – Service Provider Co-ordinator – Client Support Plan Mrs E.

Client Goal/s

Reignite the interest Mrs E has in her garden by lessening the impact on the pain in her knees and providing visual prompts to encourage her continuation in this activity.

Client Strengths/abilities

- Able to mobilise independently inside and outside the home
- Able to bend down to waist height
- Has an in-depth knowledge of plants and remembers this information
- Is willing to participate when accompanied to do so.

Client Difficulties

- Requires encouragement and prompting to initiate gardening tasks
- Experiences pain in knees when bending down and getting up from kneeling position
- Does not have insight into short term memory loss and will not acknowledge same

Steps

Continue to communicate with Mrs D. to ensure the support plan is meeting her support needs to achieve her goal.

Visit One – (Co-ordination staff)

- In consultation with Mr and Mrs E. discuss courtyard modifications e.g.: raised pot plant stands. Any modification which will decrease the need for Mrs E. to kneel to complete garden upkeep.
- Ascertain when Mr E. will be able to purchase necessary raised pot plant benches/pot plant holders and garden supplies to commence rearranging of courtyard.
- Discuss commencement day and time that co-ordinates with Mr E availability to take a break from his caring role.
- Discuss option of visual prompts that will assist Mrs E. to initiate garden upkeep tasks.
- Discuss with Mr E. GP follow up regarding pain management for Mrs E.

Session title

Support Planning and Delivering Reablement – Part 2

Slide 5 – Putting learning into practice *cont.*

Visit Two – (support staff)

- Work with Mrs E. to rearrange pot plants on newly acquired benches/stands
- In consultation with Mrs E. discuss which plants require repotting/fertilising or pruning. Work alongside Mrs E. to commence this task
- Encourage Mrs E. to sit when able while completing these tasks

Visit Three – (support staff)

- Reacquaint Mrs E. with the work she has completed on your last visit
- Involve her with decision making about which tasks are to be completed on this visit
- In consultation with Mr E. place visual prompts inside the home to remind Mrs E. to water pot plants and spend time in the courtyard.
- Continue to encourage and work with Mrs E. to upkeep her pot plants.

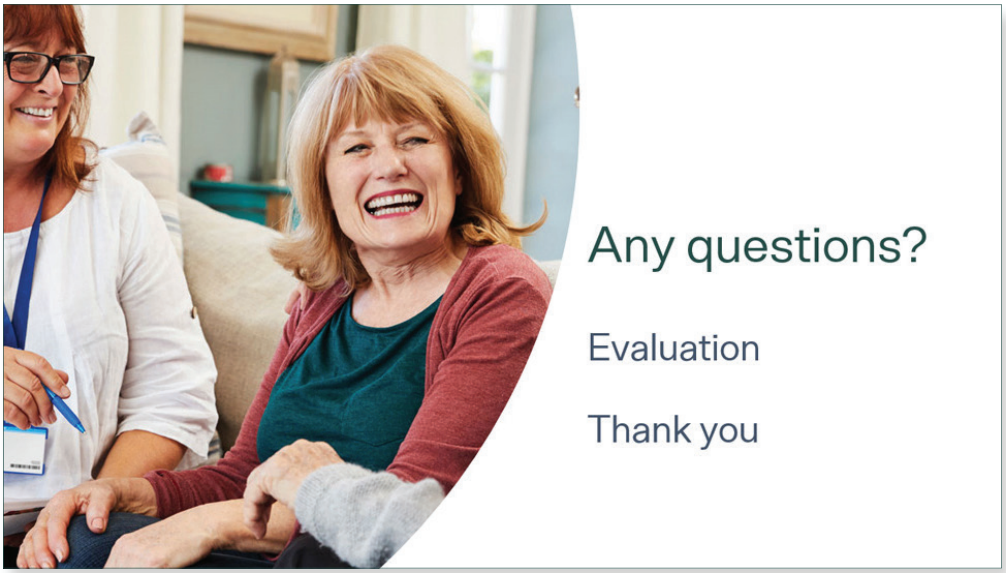
Visit Four

- Consult with Mr E. regarding any improvements or not with Mrs E. initiating access to the courtyard and/or upkeep of plants
- Problem solve with Mr E. if the visual prompts have not increased her engagement with this activity in between support visits
- Continue to work with Mrs E. to increase her participation in the garden
- When time permits and in consultation with Mr E. encourage Mrs E to complete domestic task/s which need doing

Session title

Support Planning and Delivering Reablement – Part 2

Slide 7 – Questions, Evaluation and Thank you



Time permitting answer questions raised or where time does not permit reassure the participants that the questions will be answered and forwarded to them via an appropriate Organisation communication channel.

Feedback Questionnaire

Request that each participant completes a questionnaire, these can be collated and recorded as one to inform your organisational training records. They may assist you to identify individuals who require additional professional development to apply the wellness and reablement knowledge and skills when working with people to achieve their goals.

Thank the participants for their input and making the session a good learning experience.