UNIVERSITY of TASMANIA

familybasedcare
Association North West Inc.

REABLEMENT IMPLEMENTATION AND EVALUATION AT FAMILY BASED CARE: FINAL REPORT

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Prof. Steven Campbell
School of Nursing
University of Tasmania

A/Prof. Marguerite Bramble
School of Nursing,
Midwifery & Indigenous Health
Charles Sturt University

A/Prof. Annette Marlow
College of Health and Medicine
University of Tasmania

Dr. Hazel Maxwell
School of Health Sciences
University of Tasmania.

Dr. Sarah Prior
School of Medicine
University of Tasmania

Dr. Anne Heath
University College
University of Tasmania

Ms. Nicole Reeves
School of Nursing
University of Tasmania

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Any enquiries about or comments on this publication should be directed to:

Professor Steve Campbell,
School of Nursing,
University of Tasmania.
Newnham Campus, Launceston, Tasmania, 7250
Email: Steven.Campbell@utas.edu.au

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Abbreviations/glossary

Term	Definition
Activities of Daily Living (ADL)	Described as the activities that may require assistance from direct care workers, including walking, breathing, elimination, eat and drink, movement, sleep and rest, select clothes, learning and discovery, body temperature, keep clean, avoid dangers, communicate, worship, work accomplishment and play.
Australian Health System	Two tiered Federal and State system which includes financial and information flows between the Aged Care System and the National Disability Insurance System (NDIS).
Care Coordinator	Staff employed in leadership positions by Family Based Care and who coordinate care through the development of individualised care plans, which in turn are carried out by direct care workers.
Commonwealth Government Home Support and Care Program (CHSP)	One of the changes made by the Australian Government to the aged care system to help older people stay independent and, in their homes, and communities for longer. The CHSP provides entry-level home support for frail older people who need assistance to keep living independently.
Community Services	The provision of respite care, personal care, social support, support with home maintenance and domestic assistance.
Consumer Directed Care	A model of service delivery designed to give more choice and flexibility to consumers.
Direct Care Worker	Responsible for assisting people with daily living activities who cannot perform them independently; this includes encouraging attitudes and behaviours that enhance community inclusion.
Family Based Care (FBC)	Community based organisation providing services to around 3,900 clients in a population of approximately 258,000 in communities across North and North West Tasmania.
National Disability Insurance Scheme (NDIS)	A government scheme that provides funding for support services to Australians who are 65 and under, who have permanent and significant disability.

Reablement (Federal Dept of Health Definition)	A short-term or time-limited intervention that is more targeted towards a person's specific goal or desired outcome to adapt to changed circumstances such as functional loss, or to regain confidence and capacity to resume activities.
Status, Certainty, Autonomy, Relatedness, Fairness (SCARF)	The extent to which participants felt attuned to the reablement project.
Wellness (Federal Dept of Health Definition)	Cultural shift away from 'doing for' to doing with'. Can be applied to all CHSP clients, to assist people to reach their goals and maximise their independence and autonomy.
University of Tasmania (UTAS)	A tertiary education and research institution located in Tasmania, Australia.

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Executive summary

Researchers from the University of Tasmania, led by Professor Steve Campbell, were invited by Douglass Doherty, CEO Family Based Care (FBC) to submit a proposal to teach, implement and evaluate reablement within FBC. A review of the literature, some of which is presented in this report, showed a lack of consensus in defining reablement, and little in behavioural terms to assist in changing the way in which direct care workers carry out their functions. The general approach to the implementation and evaluation of reablement presented in this report has been from the "bottom up", by developing teaching materials and evaluation instruments based on direct input from the direct care workers and others in FBC respecting their expertise. This approach has greatly enhanced the success of the project, as it has assisted in creating teaching materials which relate well to the direct care workers, and similarly the evaluation methods have meaning for Family Based Care.

The leadership team at FBC were asked to find a group of direct care workers and care coordinators who they considered to understand the nature of reablement. Two meetings were held with this group of eight participants. Various tasks were achieved, firstly reviewing the nature of different kinds of "Activities of Daily Living (ADL)" to restrict evaluation to only those ADLs that apply to their roles in support work. Secondly a draft questionnaire to explore reablement and ADLs was piloted and modified by this group. Finally, the participants were encouraged to provide examples of reablement in action. As a result of these discussions, and stories, each of the participants recorded at least one story on video, understanding this would potentially be included in the teaching materials for FBC.

Two teaching sessions of two hours were designed by the research team and approved by the leadership team prior to the teaching sessions. There was a one-month gap between each teaching session. The leadership team at FBC decided to make the teaching sessions compulsory. Feedback from participants concerning the teaching indicated it was considered highly credible, especially supported through the inclusion of colleagues' videos. Participants also appreciated the chance to engage with the material and acknowledged the respect the teachers gave to the participants and their contribution.

From a total of 186 staff, 166 attended the first session, and 93 the second teaching session. The quantitative data showed clearly the range of sympathy the participants displayed for reablement, as did the data for the Status, Certainty, Autonomy, Relatedness and Fairness (SCARF) variables. Both the ADL and the SCARF instrument was found to be reliable and highly valid for internal consistency, in statistical terms.

The qualitative phase of this study involved the identification of direct care workers to interview about their clients and reablement, as well as interviewing clients. These findings can be found later, but key to these is the inter-relationship and inter-dependency of the direct care workers with the clients and their relative isolation when giving and receiving care.

A number of key areas of discussion are highlighted in the report. For instance, care coordinators are at the heart of Family Based Care. They are the ones who meet and set the tone for the relationship with new clients and can make change happen by

supporting their team in a way that promotes reablement. It is therefore not surprising that many of the actions included in the final plan involve the care coordinators taking a different approach.

The final phase of the study was a set of focus groups with the care coordinators, from which an action plan for reablement was produced, and is contained in this report.

Key findings

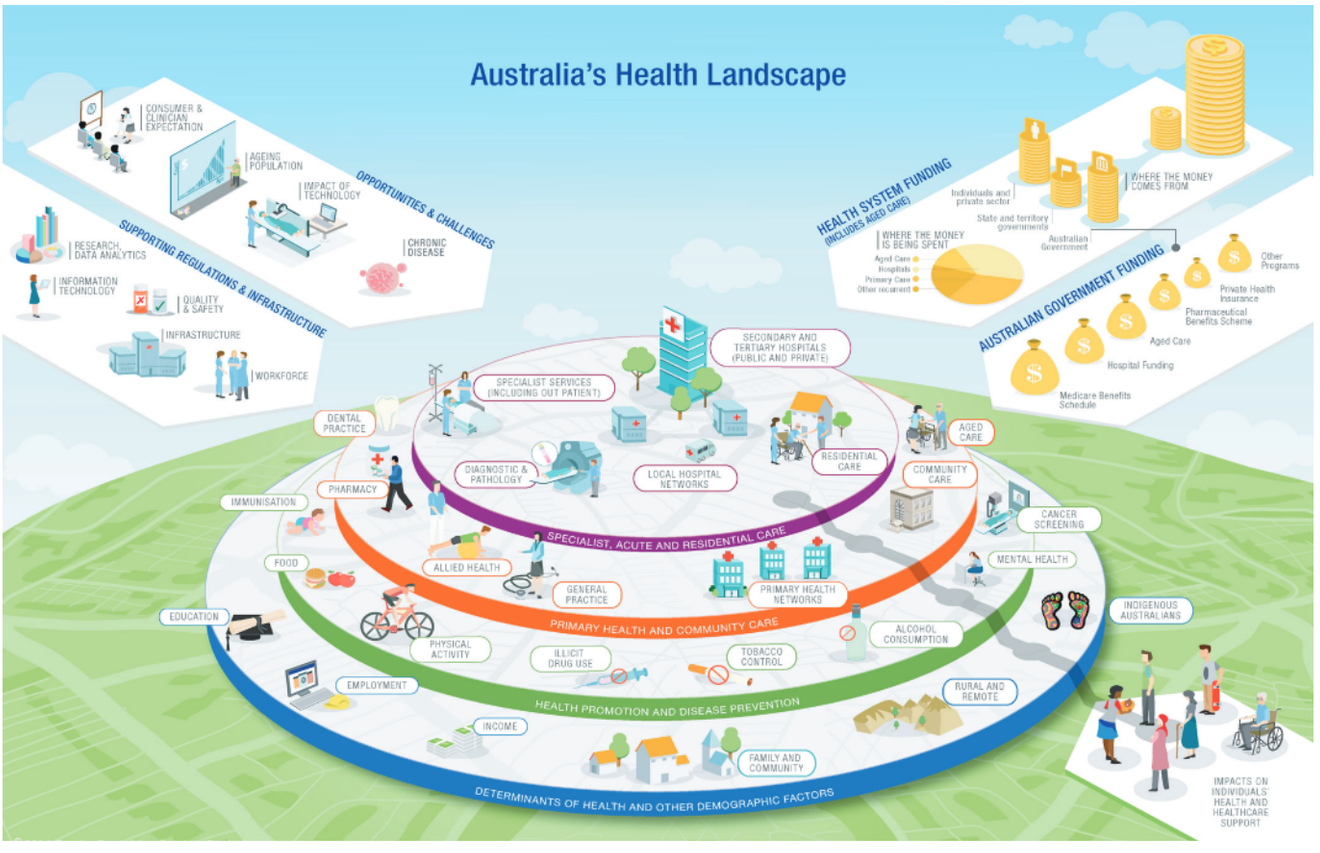
- 95% of participants at FBC are naturally sympathetic to the philosophy of reablement in terms of working with clients.
- It is about releasing this potential and shaping the way the direct care workers feel able to deliver reablement.
- Using videos of specific examples of reablement from colleagues from FBC was a powerful way to get the reablement messages over and promote discussion.
- Direct care workers (and others in the organisation) work with their clients (not for them) to ensure their reablement.
- Reablement is about walking alongside a client, not walking in front or behind.
- While there is reablement, there is also "ablement", which has the same principles but is for clients who have never been abled – that is have never had the ability to perform the activities of daily living that we have focussed on.
- The concept of "use it or lose it" is fundamental to reablement.
- Care Coordinators are key to managing and leading the reablement change.
- Organisational systems and processes need to change to support and embed the reablement direction.

Background

The proportion of the Australian population aged 65 years and over has increased over the last two decades (Australian Bureau of Statistics [ABS], 2016) and is expected to continue to rise with increasing life expectancy. An increasing number of older adults in society creates enormous challenges for the future of health care and associated costs as a result of increased chronic disease and decreased ability to perform activities of daily living (ADL) tasks. These issues place demand on services through hospital and residential aged care admissions as well as a dependence, long term, on community services.

A 2019 review of Australian health services has concluded that whilst our health care systems perform well by international standards, they continue to fall short of providing equitable access to care for all Australians through primary health and community care services (Calder, Dunkin, Rochford & Nichols, 2019). Furthermore, the complexity of the two-tiered Commonwealth and State health systems continues to increase, particularly in relation to financing for services between the Australian government, private health insurers and individuals. As described in Figure 1 (Department of Health [DOH], 2018), these health system challenges, together with changing expectations of clinicians and consumers, technological impacts, the ageing population and people living longer with chronic illness and disability, impact on both introducing and evaluating the impact of new services such as reablement under the umbrella of Consumer Directed Care (CDC).

Figure 1. *Australia's Health Landscape (DOH, 2018)*



Consumer Directed Care (CDC) first developed during the disability rights movement in the 1980s, where consumers of all ages called for greater choice and control in service provision (Doty, Mahoney & Simon-Rusinowitz, 2007). CDC is about providing more effective self-management support, to maximise people's motivation and engagement in their own health care and their reablement, and to maximise their independence in the community (Lawn, Westwood, Jordans, Zabeen & O'Connor, 2017).

Reablement is an approach mainly focussed on offering older adults the opportunity to improve their independence through goal oriented targeted interventions. However, one of the major issues facing reablement programs of care and service progression today is the lack of a concrete definition. Reablement has been described as a relatively new approach to supporting people to regain (or maintain) independence and resume the activities which make up their daily lives (Mann, et al. 2016). The primary aim of reablement programs is to achieve sufficient functional skills to allow community-dwelling older adults to remain in their homes with less or no further assistance from the community (Winkel, et al. 2014). This represents a shift from reactive home care services to preventative and proactive models of care (Legg, et al. 2016). Reablement is often seen as a more dynamic process compared with traditional home-care services, as it is intended to offer a short, focused program of support (Rabiee & Glendinning, 2011).

In other countries, such as Netherlands, Scandinavia, US, UK and New Zealand, reablement interventions are delivered as a result of collaborative goal development between the patient and their multidisciplinary reablement team. The focus is on enhancing the performance of daily activities that are important to the client, thus enabling them to age in their own homes and participate socially as desired (Parsons et al, 2019; Tuntland et al, 2015; Tuntland et al, 2019). Interventions are often delivered by occupational therapists and physiotherapists. In a qualitative study in the UK, the ideal reablement worker was described by managers as someone with a good understanding of the concept and practice of reablement, with the skills to stand back, observe and assess users' potential for independence, and work closely with them to provide the support they needed to reach their potential (Rabiee & Glendinning, 2011).

The overall purpose of the study was to deliver, review and evaluate a training program on reablement as a pilot intervention for staff in Family Based Care (FBC) in North West Tasmania. FBC provides services to around 3,900 clients in a population of approximately 258,000 in communities across North West Tasmania. Staff employed by FBC total 223, with 186 direct support staff. FBC's vision and mission are to improve client focused services across aged care, younger persons and their carers (Family Based Care North West Inc, 2017).

Family Based Care context

Family Based Care (FBC) enables the provision of individualised support to people across the life span within the community. With a focus on 'working with' people, FBC staff provide services that are respectful, responsive and person centred. Care Coordinators work with members of the community who are referred to FBC, to develop an individualised plan of care, which in turn is carried out by Direct Care Workers. Services range from the provision of respite care, personal care, social support, support with home maintenance and domestic assistance.

Reablement services can provide economic savings of up to $12,500 per person over 5 years.

Introduction

Literature review

Whilst little evidence is available on the evaluation of reablement services, it has been suggested this is mainly due to reablement being an ill-defined intervention (Legg et al. 2016). It has also been suggested that the wide diversity of intermediate care services has made the systematic evaluation of effectiveness very difficult (Barton et al. 2005). However, qualitative evidence from service users suggests that this intermediate care can make a significant difference to their lives (Godfrey et al. 2005). A number of previous reablement programs have been shown to be successful in delivering client-centred outcomes with benefits for both individuals and healthcare costs, based on various evaluation methods. A randomised controlled trial conducted in Denmark investigating the effectives of reablement showed there were significant improvements in self-perceived activity performance and satisfaction with performance, however no significant improvements were noted in health-related quality of life or physical capacity (Tuntland, 2015).

Another study from the US (Tinetti et al. 2002) found individuals who received restorative home care (reablement programme) were more likely to be living at home and show greater improvement in their self-care, home management, and mobility scores at discharge than those receiving usual home care. The reablement clients also had shorter care episodes and a reduced likelihood of hospital readmission during the care episode (Tinetti, et al. 2012). Economic evaluations of reablement programs showed, when compared to traditional care, cost savings of up to $12,500 AUD per person over a five-year period (Lewin, 2013) and approximately $3000 AUD per person over two years (Lewin, 2014) in separate studies. A further economic evaluation by Kjerstad and Tuntland (2016) found a significant decrease in the need for long-term home-based care services following a time-limited period within a reablement program, thus reducing the long-term expenditure. These studies and this analysis do little to define reablement in behavioural terms with specifics about the interaction between, for instance, direct care worker and client.

Definitions associated with reablement

The major issue facing the development of reablement in Australia's two-tiered system is the development of a consistent, realistic and mainstream approach to care and the lack of a concrete definition in behavioural terms. Table 1 provides a list of currently available definitions considered in this study.

Table 1. *Definitions of Reablement.*

Author	Definition
Rabiee & Glendinning (2011): p.495	"Services for people with poor physical or mental health to help them accommodate their illness by re-learning the skills necessary for daily living."
Tuntland et al. (2014): p.4	"Focuses on early, time-intensive, multidisciplinary, multi-component and individualised home-based rehabilitation for older adults with functional decline."
	"A goal-directed and intensive intervention, which takes place in the person's home and local surroundings with a focus on enhancing performance of everyday activities defined as important by the person."
Winkel et al. (2015): p.1	"An approach focused on offering the individual citizen the opportunity to regain independence and thus stay longer in their own homes. The focus is to re-learn skills and find new ways to perform ADL tasks by introducing adaptive equipment and assistive technology."
Mann et al. (2016): p.1	"Reablement is a time-limited intervention that aims to support people to regain independence and enable them to resume their daily activities after they return home from an in-patient care setting, or to maintain independence to enable them to remain at home."
Hjelle et al. (2017): p. 1581	"Reablement is an early and time-limited home-based intervention with emphasis on intensive, goal-oriented and interdisciplinary rehabilitation for older adults in need of rehabilitation or at risk of functional decline."
Legg et al. (2016): p.742	"Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living."
Department of Health. (2016): p.12	"Time-limited interventions that target a person's specific goal or desired outcome to adapt to some functional loss or regain confidence to resume activities."
Tuntland et al., (2019): p.1	"Reablement is a person-centred, holistic approach that aims to enhance an individual's physical functioning, to increase or maintain their independence in meaningful activities of daily living (at their place of residence or in the community) and to reduce their need for long-term services…"

International context

Internationally the concept of reablement as a solution-driven global public health agenda has been gaining prominence as an aide to addressing long term funding for those who require ongoing services. However, while Australians have been international leaders in research into the effectiveness of reablement to maximise independence across the lifespan, and particularly for our older population, this has not translated into widespread adoption (Smith, 2016). Similarly, a recent review of care integration in the disability sector found a lack of clarity concerning the boundaries of the National Disability Insurance System (NDIS) and how it will work with services such as reablement in the provision of seamless and consumer-directed care (Dickinson & Carey, 2017).

Reablement across the lifespan in Australia

In Australia the Commonwealth Government's Home Support and Care Program (CHSP) manual promotes a wellness and reablement focus and a cultural shift away from 'doing for' to 'doing with'. In the CHSP Program Manual (2018) a distinction between wellness and reablement is made:

> "Like wellness, reablement aims to assist people to reach their goals and maximise their independence and autonomy. Whereas a wellness approach can be applied to all CHSP clients, reablement is a short-term or time-limited intervention that is more targeted towards a person's specific goal or desired outcome to adapt to changed circumstances such as functional loss, or to regain confidence and capacity to resume activities" (DOH, 2018; Tuntland et al, 2015. (p.22)).

Using this overall approach, from 1 July 2018, the Federal Department of Health has been conducting random audits of wellness approaches in CHSP services (DOH, 2018). In addition, service providers are required to submit regular reports on wellness and reablement approaches to service delivery in accordance with the CHSP grant agreement, using a template provided by the Department of Health (2018).

In Australia, currently the key components to reablement are:

1. an emphasis on capacity building or restorative care to maintain or promote a client's capacity to live as independently as possible, with an aim of improving functional independence, quality of life, and social participation (Burton et al, 2013; Lewin et al, 2008); and

2. an emphasis on a holistic, person-centered approach to care, which promotes clients' wellness and active participation in decisions about care (DOH, 2018).

Tuntland's (2015, p.4) definition of reablement is much more informative, although it does not actually define the behaviours of support workers (direct care worker) caring for clients, it is very clear that the activities are defined by the person or the client in this case.

Procter et al.'s (1999) work with uncovering and describing the role of Community Children's nurses has some interesting insights which are useful when applied to reablement. At the time of Procter et al.'s work, Community Children's nurses tended to be services provided from or with acute children's units and hospitals. The nurses would

be asked to visit the children in their own homes, and deal with whatever the problem was. The children tended to be suffering from serious illnesses, such as cancer, or cystic fibrosis, and the goal of the care was to keep the children at home, out of hospital and having as normal a childhood as possible. In Procter et al. (1999) the nurses were characterised roughly into two groups. The first group of nurses came to the child's home, dealt with the issue and left. The second group of nurses worked with the family, in particular the mother, to manage the issue and prevent its reoccurrence. It is of no surprise the families preferred the approach of the second group of nurses. These nurses worked with the family, they did not do the work for the family and child. The former approach might be quicker, and gain direct gratification for the nurses, but the latter is much more useful for the family. This approach has been influential in providing a different context to reablement, but one which was possible to apply clearly with support workers (direct care workers), and both the under 65s and over 65s. (Procter et al.'s (1999) work developed "rather than" statements which described one preferred approach over another. This "rather than" system was applied to the development of the ADL questionnaire within this research project.)

An holistic, person-centered approach to care.

The current definitions above are laudable but lack any real difference from other philosophies of care, they are therefore adequate but insufficient to be able to describe the aims of reablement. However, they do emphasise creating greater independence in the client by enhancing functional skills and being proactive rather than reactive. Reablement is a process which is about regaining control of former activities of daily living. This involves a partnership between direct care worker and client, with the client informing the decisions about what the priorities are for their reablement. This process misses the opportunity to create "ablement" in those that have never been "abled". These clients might be the young disabled, who have never achieved independence across all activities of daily living, but who would benefit from a process of "ablement", based on the philosophy of reablement, and in influencing a change of behaviour.

Research aims

The aim of this research is to work with FBC to develop and incorporate a wellness and reablement focus to service delivery that emphasises client independence, resilience and self-management of chronic illness in the community (Family Based Care North West Inc, 2017).

The specific aims of the project are as follows:

1. To produce a consensus document about the status of "Reablement" including a refined working definition;
2. To produce a teaching program for "Reablement", to be used with the staff of Family Based Care (FBC);
3. To teach the staff of FBC the fundamentals of how to deliver "Reablement" to their clients;
4. To evaluate the impact of "Reablement" on the relevant staff at FBC; and
5. To evaluate the impact of "Reablement" on the relevant clients of FBC.

Research methods

This mixed methods study took place at Family Based Care (FBC) in North West Tasmania, where staff and clients participated in training activities related to including and developing reablement within their scope of practice. Two ethical approvals were obtained from the Tasmanian Social Sciences Research Ethics Committee (Reference H0017264 and H0017139) for the three phases of the study.

Phase 1: Reablement training and development

Developing the training materials

The leadership team at FBC formed a group comprising direct care workers and care coordinators who they considered to understand the nature of reablement. Two workshops were held with this group of eight participants. During the workshops a review of the nature of different kinds of "Activities of Daily Living (ADL)" was undertaken to restrict evaluation to only those ADLs that apply to direct care work. A draft questionnaire to explore reablement and ADLs was piloted and modified by this group and participants were encouraged to give examples of reablement in action. As a result of these discussions, and stories, each of the participants recorded at least one story on video, understanding this would potentially be included in the teaching materials for FBC.

The final Activities of Daily Living questionnaire (Appendix A) assesses changes in knowledge and attitude to reablement following training, and subsequent inclusions of new learnings into practice, using a framework of activities of daily living. The questionnaire consists of statements which are either sympathetic or non-sympathetic to reablement. Using a 6-point Likert scale (strongly agree, agree, not sure, disagree, strongly disagree and not applicable) participants were asked to select the answer that best fits their view of reablement with respect to each activity of daily living (e.g. breathing, elimination, movement). The statements were designed so that the expected results for a very pro reablement population would be predominantly at either the strongly agree end or the strongly disagree end. During development and piloting of the questionnaire, items were tested for internal statistical reliability and the sample size of 166 staff ensured a medium effect size and an alpha level of 0.05.

The SCARF Questionnaire (Appendix B) based on the SCARF approach (Rock and Cox, 2012) assesses the extent to which each member of staff feels attuned or not with the reablement initiative. Using a 6-point Likert scale (strongly agree, agree, not sure, disagree, strongly disagree and not applicable) participants were asked to read the statements within the five SCARF domains (Status, Certainty, Autonomy, Relatedness and Fairness) and select the answer that best fit how they feel about the reablement project.

Delivering the Training Programme

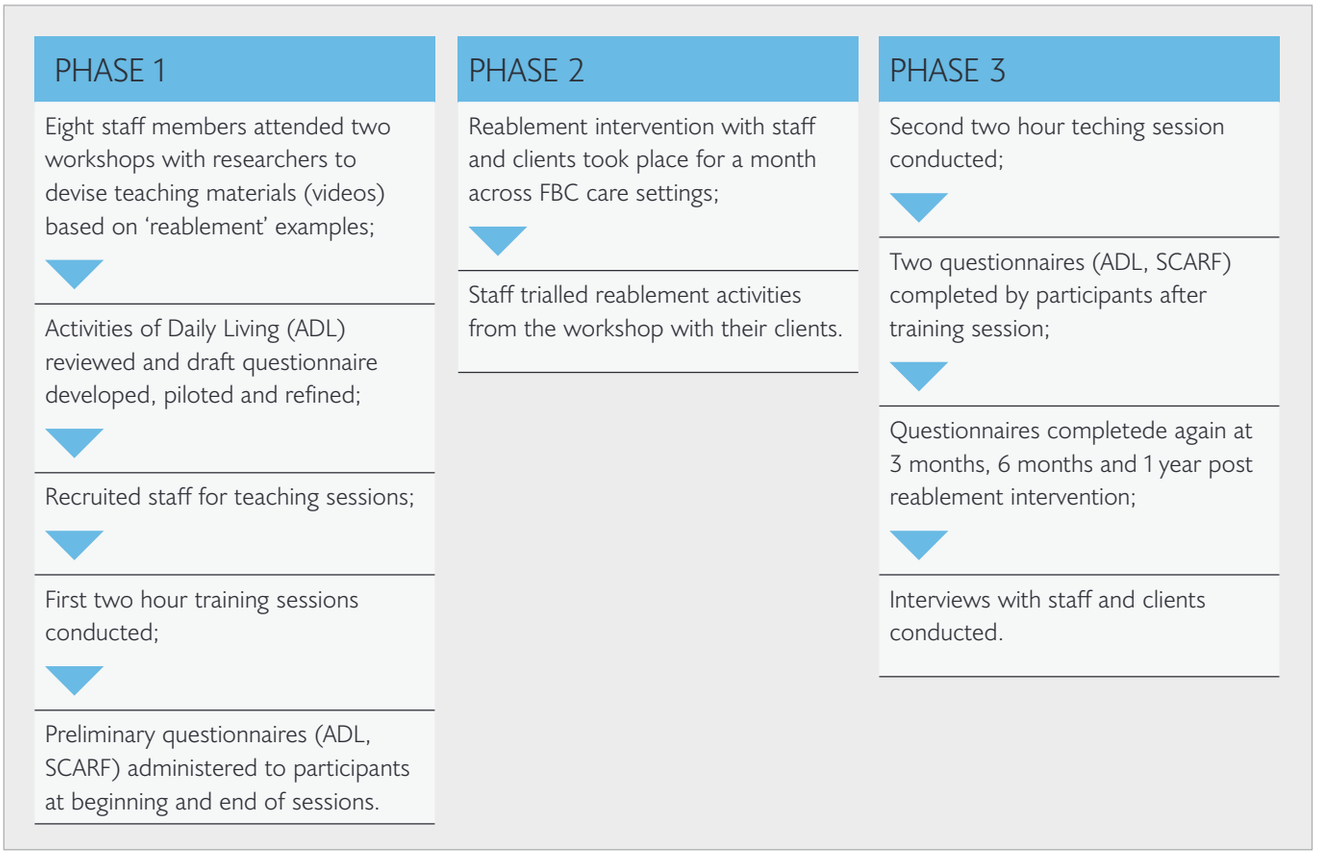
To deliver, review and evaluate the effects of reablement training, a compulsory training programme was conducted for all staff at FBC. Family Based Care staff attended two, 2-hour reablement training sessions (approximately 2 months apart, starting in March 2018) at FBC premises in Burnie. The training sessions were scheduled for March

and April 2018. The two training sessions were designed by the research team and approved by the leadership team prior to commencement. Importantly, each teaching session contained two video reablement examples from their colleagues. These videos prompted in-depth reablement discussion by the participants. Two hundred and twenty-three staff at FBC attended the first reablement training session. These training sessions were conducted by the UTAS research team. The materials used in the training were based on Activities for Daily Living (ADL) questionnaire with examples developed and used in consultation with staff at FBC to ensure the case studies used were appropriate and relevant.

Staff attending the training sessions provided written consent for their involvement and were requested to complete the ADL questionnaire and SCARF questionnaire at the following intervals to assess the extent to which reablement was being utilised as part of staff routine practice:

1. At the beginning of Training Session 1 (T1B)
2. At the end of Training Sessions 1 (T1E)
3. At the end of Training sessions 2 (T2E)
4. Three months post training session 2 (3-Month)
5. Six months post training sessions 2 (6-Month)
6. Twelve months post training sessions 2 (END)

Figure 2. *Methodology Outline.*



Phase 2: Interviews

Parallel to the quantitative data collection through questionnaires, qualitative semi-structured interviews were conducted with four FBC staff and three FBC clients. The administration team from FBC forwarded an email to staff requesting their participation in an interview with the research team. The details for the research team were provided and staff were asked to contact a member of the research team if they wished to participate or required further information.

Staff members who expressed an interest in participating in the interviews were sent a further email from the research team explaining the process. To be included, staff needed to be actively involved in the care of clients who were less than 65 years of age with a functional disability.

Staff

A purposive sample of four FBC staff were asked to reflect on their experiences of reablement in an interview approximately two months post intervention. Interviews went for approximately 25 minutes to 1-hour duration, were conducted in a place of the participant's choosing. The interviews were recorded via an audio recorder and thematic analysis was performed. The interview questions (see Appendix C) were designed to explore attitudes and knowledge around reablement and its delivery through FBC.

Clients

Three FBC clients participated in semi-structured interviews in the place of their choosing. These clients were recruited through the FBC staff who were interviewed. The staff member was asked to consider if any of their current clients would be interested in being involved in the research study and if so, request them to contact the research team for further information. The clients who contacted the research team were provided with an information sheet and consent form prior to being interviewed. The interview questions were designed to explore the thoughts and feelings about reablement from a client perspective. The interviews ranged from 30 - 45minutes in length.

Phase 3: Focus groups

Our original project involved interviewing direct care workers for the purposes of identifying the enablers and barriers to reablement, but it was learned during our training sessions that care coordinators play a major role in the development of the initial care plans for new clients and working with their families and direct care workers to develop and implement these. This is the point at which reablement can be introduced as a standard process of delivering care as part of Family Based Care's service. Four, two-hour focus groups were held at Family Based Care involving the care coordinators and at least two members of the research team to moderate the conversations (see Table 2). Care coordinators were invited to attend via an email from FBC administration. An information sheet was distributed, and each participant completed and signed a consent form. The discussions were audio recorded and notes were also taken. The audio recordings were transcribed professionally, and thematic analysis was performed to determine the main themes around barriers and enablers to delivering a reablement style of care to clients.

Table 2. *Focus Group Attendance.*

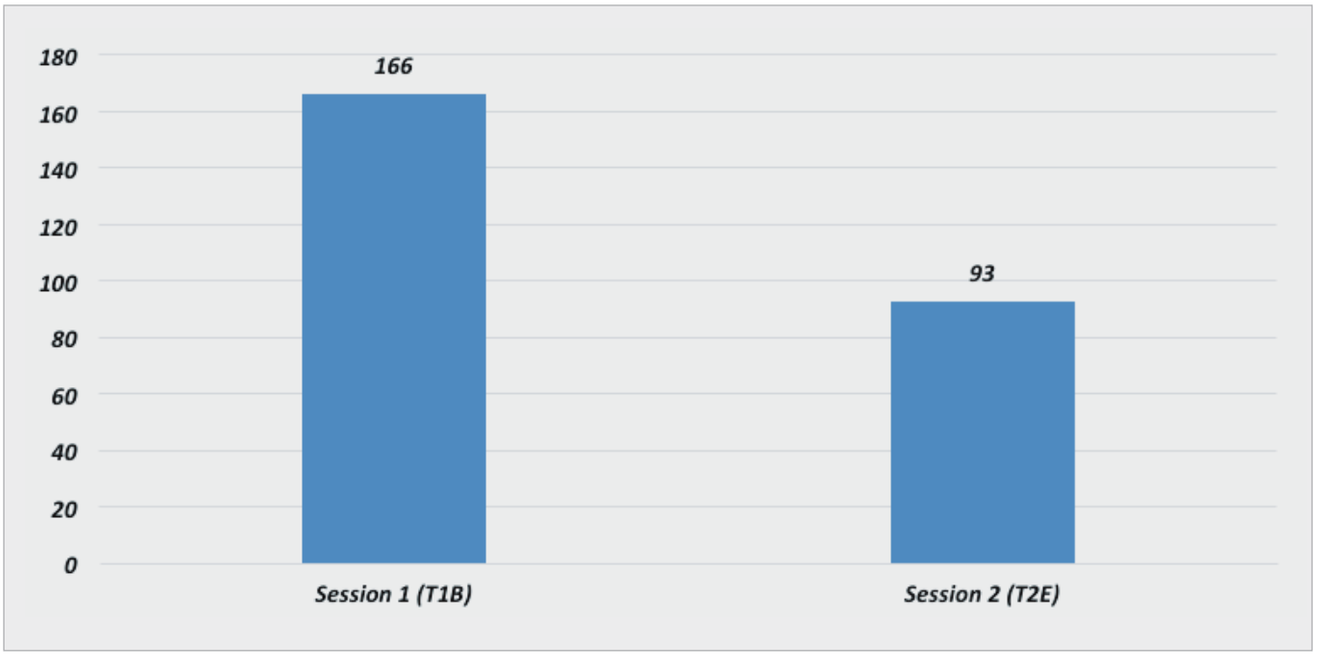
Focus group and date		Number of care coordinators attending	Research team members
FG 1	8 November 2018	14	2
FG 2	22 November 2018	12	2
FG 3	6 December 2018	13	2
FG 4	20 December 2018	11	3

Results

Phase 1: Reablement training and development

One hundred and sixty-six staff members participated in the initial training session at Family Based Care. This number decreased to ninety-three for the second training session (Figure 3), possibly due to the number of staff who felt that they were already delivering reablement focussed care.

Figure 3. *Numbers at Teaching Sessions.*



The roles of the staff members who attended the initial teaching session varied, suggesting reablement plays a part in all roles, not only those directly involved in client care. The demographic details are shown in Table 3.

Table 3. *Demographics of FBC Staff participants.*

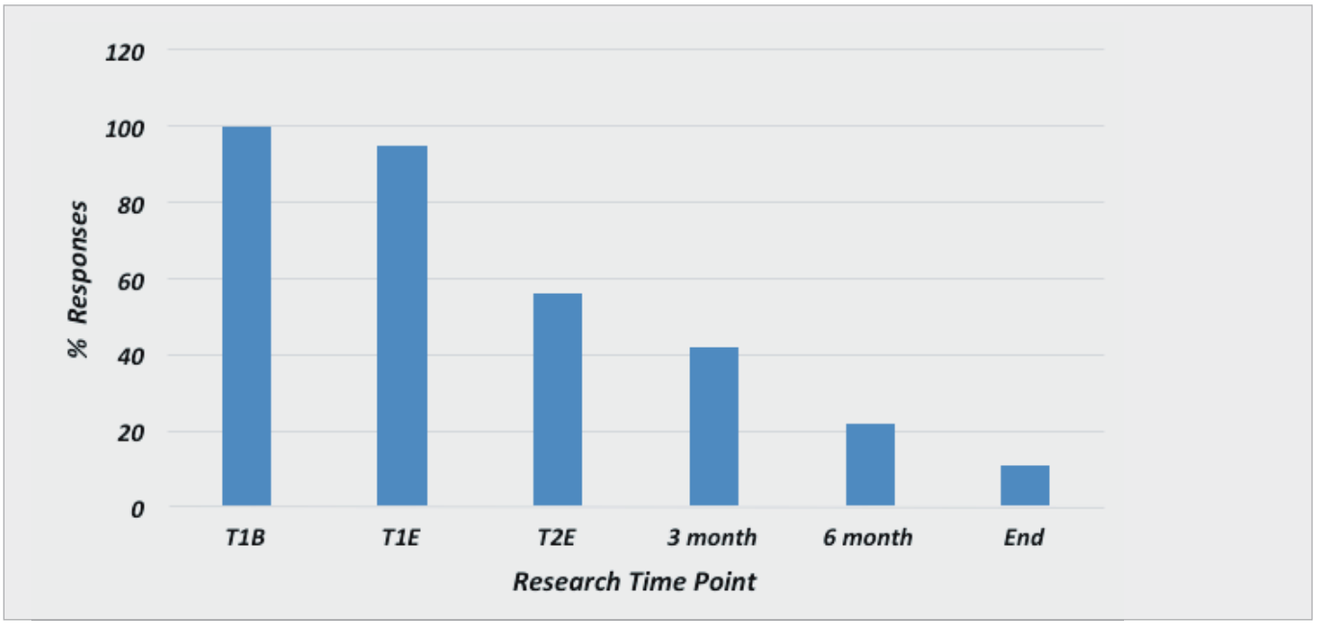
Variable	n Training Session 1	n Training Session 2
	N = 161	N = 93
Role at FBC		
Administration (Inc. Management)	16	7
Program Coordinator	17	9
Direct Care Worker	126	73
Other	7	4
Gender		
Male	22	12
Female	137	79
Unknown	7	2

Training materials – ADL and SCARF

Activities of Daily Living questionnaire

The ADL questionnaire return rate was highest at T1B (97%) and decreased over time, with the final return being 19 (12%). Figure 4 shows the numbers of ADL questionnaires received by the research team at each research time point.

Figure 4. *Number of questionnaire responses per time point.*



The results show that sympathy to reablement was quite high prior to the training sessions (T1B). However, there were notable increases in this sympathy throughout the 12-month period. Figures 5 and 6 show the differences in sympathy to reablement from the pre-training ADL questionnaires and the END ADL questionnaires for nine statements. The remaining four statements showed little or no increase in reablement sympathy. There was a 34% increase in sympathy for Statement 9 (Avoid Dangers) suggesting an increase in the awareness of using reablement to help clients develop their skills in making judgements about dangerous situations. There was also a 34% increase in sympathy to reablement for Statement 5 (Sleep and Rest) suggesting that direct care workers are working with their clients more to understand their preferences for sleep and rest, rather than taking an authority role.

Figure 5. *Activities of Daily Living: Reablement Sympathy with an Agree Answer.*

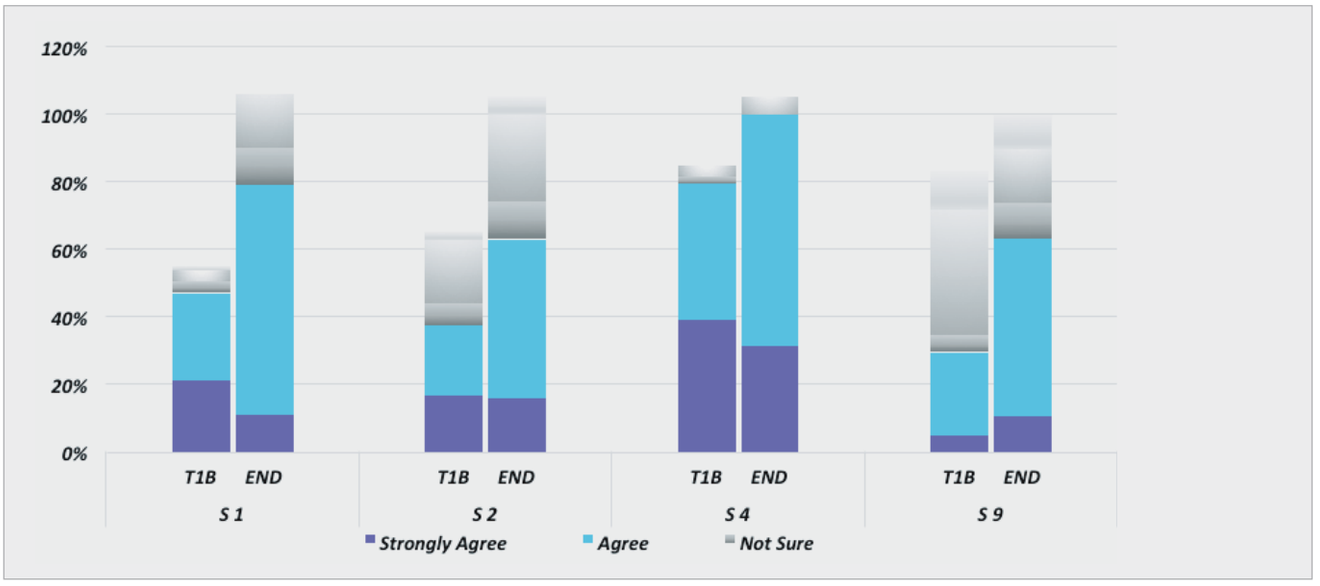
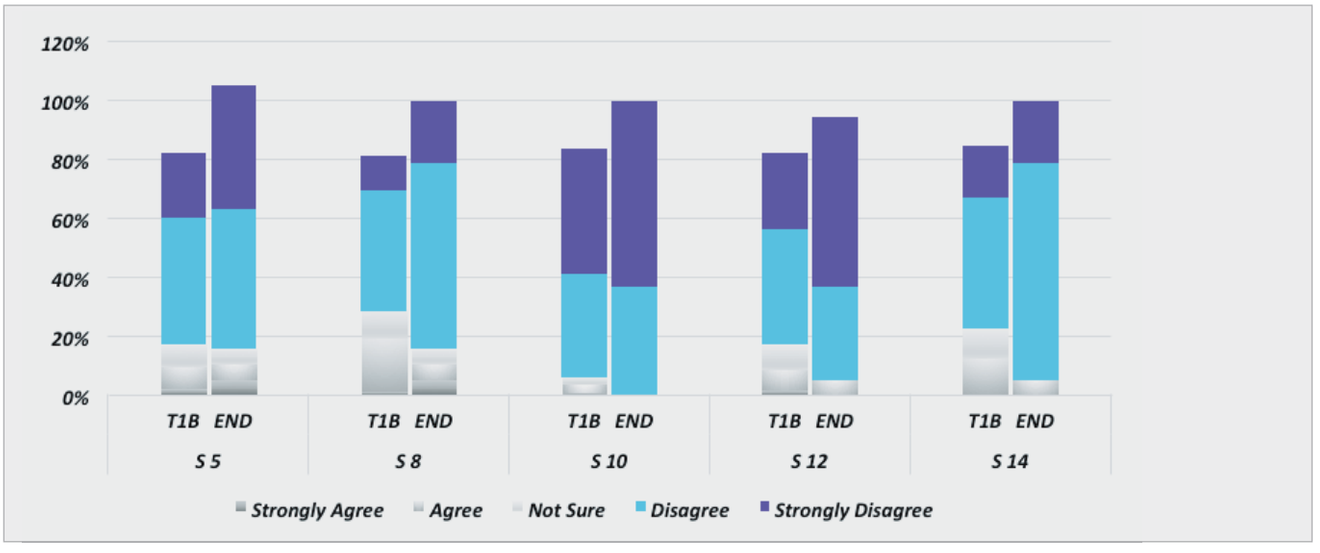


Figure 6. *Activities of Daily Living: Reablement Sympathy with a Disagree Answer.*

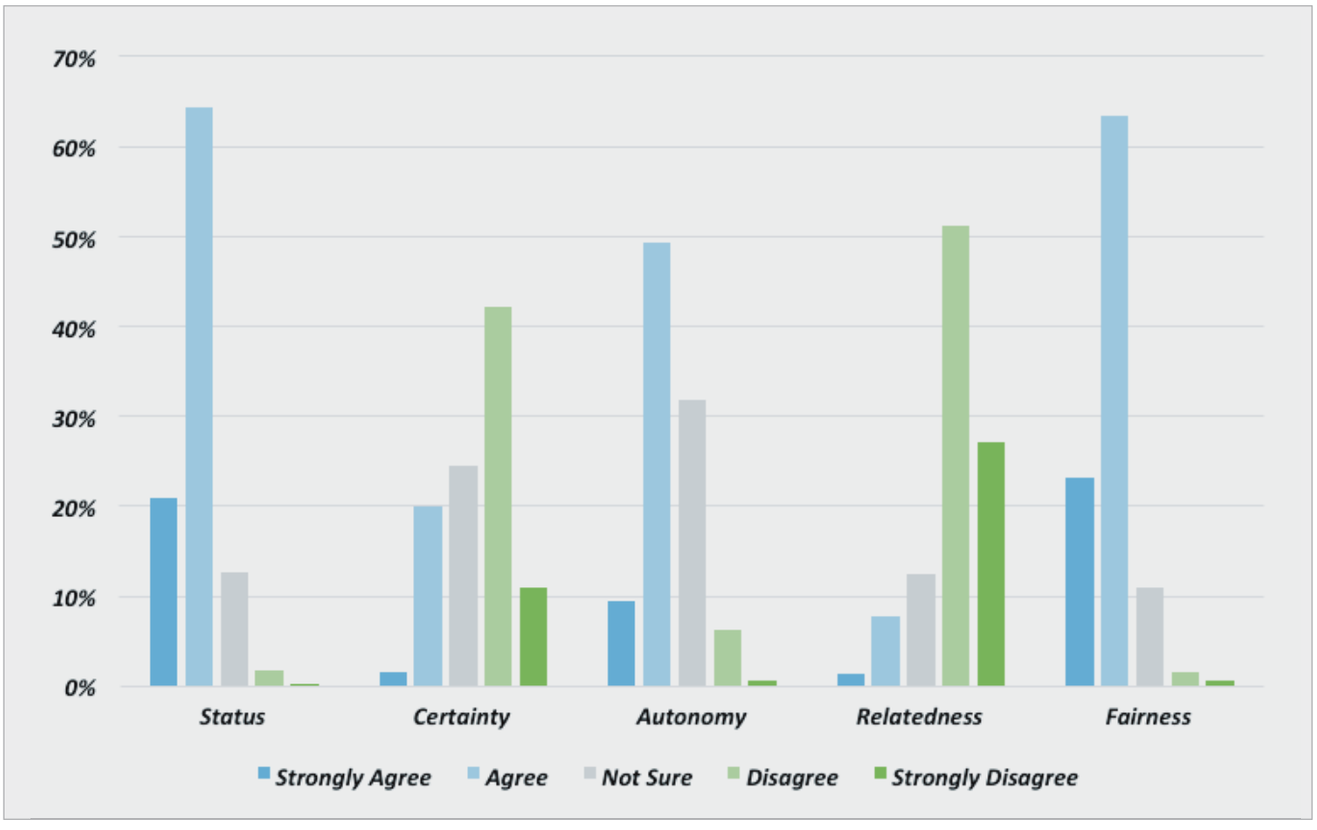


The internal consistency reliability of the ADL questionnaire scale was measured by the coefficient Cronbach's Alpha. This measure allows us to statistically test whether the questions we have asked are a reliable measure. Cronbach's alpha showed the questionnaire to reach just below acceptable reliability (0.70) at T1B, α = 0.67. Most items appeared to be worthy of retention, resulting in a decrease in the alpha if deleted.

SCARF Questionnaire

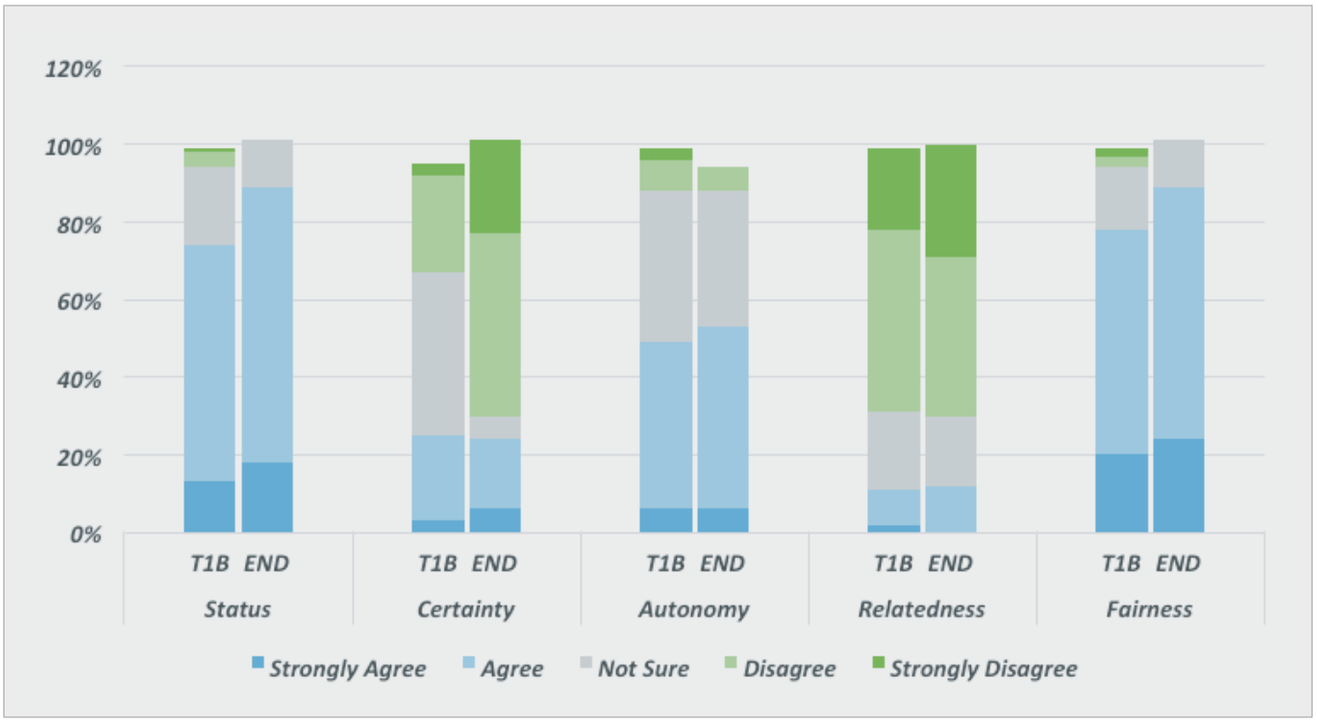
The SCARF questionnaire showed the relationship of staff with the reablement project differed across domains. Figure 7 shows that, across the 12-month project period, over 60% of staff felt respected in terms of reablement development across the time points (Status). Over 60% of staff felt fairly treated by their organisation in terms of reablement development (Fairness). Almost 50% of staff felt they had some control over what they do for their organisation (Autonomy) and over 50% of staff felt safe when discussing their views of reablement developments with their colleagues (Relatedness). Over 40% of staff indicated that the felt that they do have an idea of what the future of reablement looks like within their organisation (Certainty).

Figure 7. *Average Response Percentage SCARF Questionnaire.*



As seen in Figure 8 there were no significant changes over time (T1B to END) that suggested staff shifted their feelings from one active response to another (strongly agree, agree, disagree or strongly disagree). However, we did note that a large number of staff who responded "not sure" at time point T1B changed their response by the END time point for certainty (42% down to 6%), status (20% down to 12%) and fairness (16% to 12%).

Figure 8. *Comparisons T1B to END.*



The internal consistency reliability of the SCARF questionnaire scale was measured by the reliability coefficient Cronbach's Alpha. This measure allows us to statistically test whether the questions we have asked are a reliable measure. Cronbach's alpha showed the questionnaire to reach acceptable reliability (0.70) at T1B, $\alpha = 0.74$. All items appeared to be worthy of retention.

Training session evaluation

The training session evaluation forms, completed by 98 staff showed staff were generally pleased with the content, delivery mode and discussion within the training sessions. An average score of 8.64 out of a possible 10 was achieved. Some of the feedback from staff includes:

Positives of the session:

"I enjoyed learning new ways to approach clients, with different ways of assisting them"

"Reinforcing that clients have choices"

"Realising that I was doing ok"

Negatives of the session:

"Too late in the day"

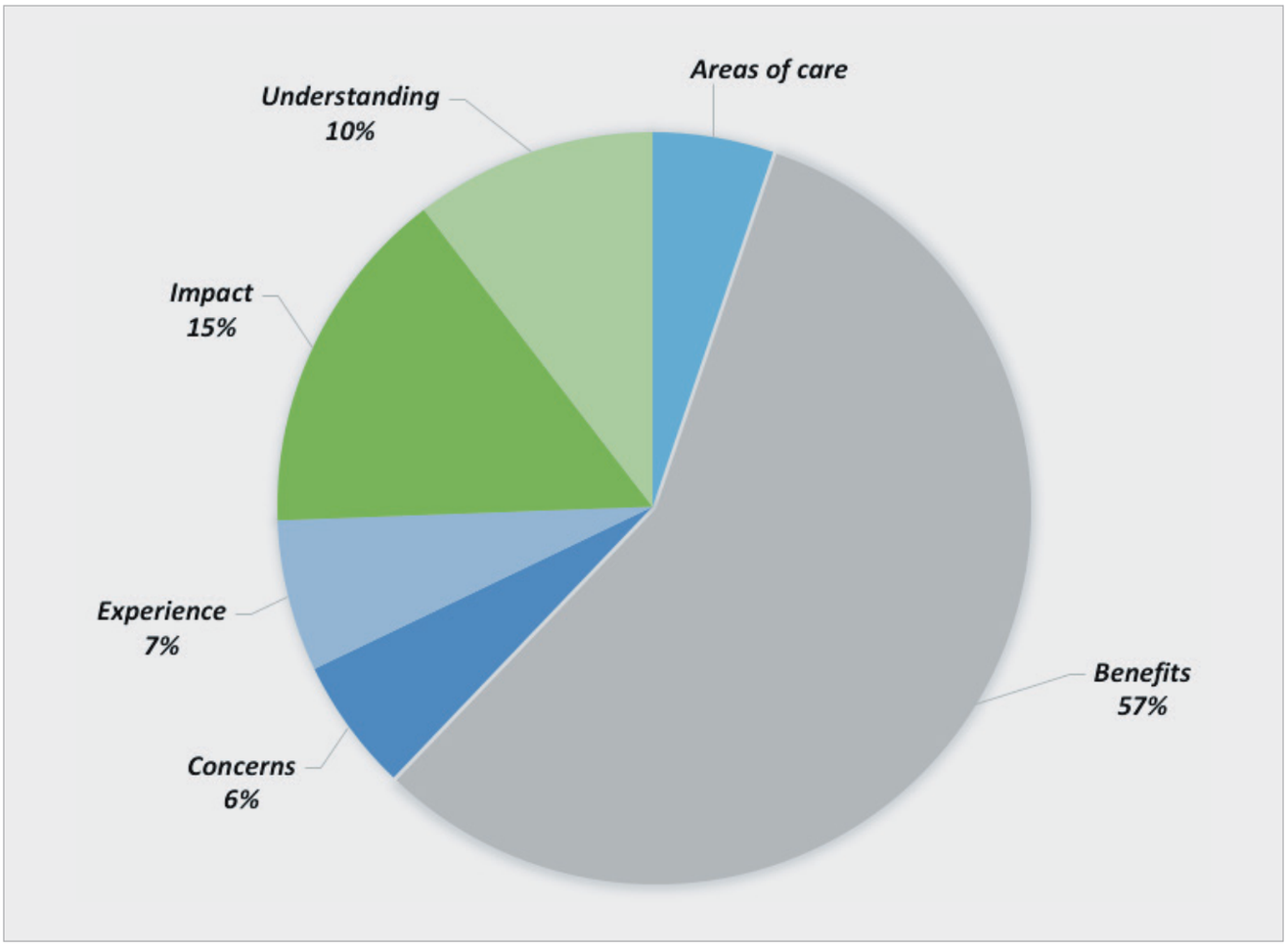
"Whether it will be a part of work in the future"

"The questionnaires were repetitive"

Phase 2: Interviews

A full thematic analysis of the direct care worker and client interview transcripts is ongoing, and the preliminary results are presented here. Preliminary results have yielded a number of important basic themes in relation to informing the adoption or challenging the adoption of reablement. Figure 9 shows the main areas, or themes, that were discussed during the staff and client interviews. This figure highlights the large proportion of time that was dedicated to discussion of the benefits of reablement.

Figure 9. *Number of Coding References.*



A word frequency analysis was conducted (Figure 10) displaying the top 50 words clients and staff associated with their experience of reablement. The bolder, larger words such as 'people', 'care', 'just', represent the majority of the words utilised in the interviews in relation to reablement practices and experience.

Figure 10. *Overview of top 50 words.*

Table 4 shows that the interview data suggested some important positive and negative impacts of reablement in the community setting. It demonstrates that clients and staff generally support a reablement view of direct care and that it is important socially, physically, mentally and emotionally to maintain independence and create a sense of "staying useful".

Ensuring that communication channels remain open and clear and both the clients and staff feel able to develop and build relationships can be a factor in the success of a reablement framework of care for individual clients and their families.

Table 4 also shows that staff have their client's best interests in mind when performing their daily activities. Discussion around duty of care, respect, value and making people feel good really highlights the compassionate nature and genuine effort in helping to regain, or gain, some independence for clients through utilising reablement.

Table 4. *Preliminary Identification of Basic Themes from Interviews.*

Preliminary Analysis (Codes)	**Basic Themes**
Experience with Family Based Care	Clients want to feel useful
	Reablement can make a big difference to clients social wellbeing
	Reading the client and knowing what is best for them on that visit is vital
	Lack of experience and knowledge may hinder reablement
Understanding of Reablement	People need to be able to live the life they want to live
	Reablement is supported often without awareness
	Cultural respect plays a major role in client experience
	Encouragement fosters independence
	Good communication facilitates a reablement relationship
	Choice is important in making someone feel valued
Benefits of Reablement	Training enhances knowledge and understanding
	Encouragement and validation of staff results in improvement of working practice
	Collaboration can be beneficial to all parties and result in meaningful value-driven outcomes
	Conversations equal action
	Opportunities to develop skills and knowledge
	Empowerment and meaning in life
	Knowing the risks is important
	Reablement and enablement are separate terms
	A good philosophy of care can strengthen and build relationships
	Encouraging independence can lead to more meaningful interactions
	Freedom is happiness
	Rewards outweigh challenges
Areas of Care around Reablement	Working together equals achievement
	Having access to the right equipment is beneficial and makes things easier
	It is important to respecting the client perspectives and limitations
	Clients choices should be valued
Concerns around Reablement	Direct care workers have a duty of care to clients
	Knowing when and how to help is important
	Acknowledging that for some clients reablement is confronting
	Getting the client to accept they need assistance can be challenging
	Change is confronting
	Adequate time is important for adequate care
Impact of Reablement on Independence	What clients want from reablement will be different depending on their physical abilities
	Communicating the preferences of the client is important in reablement
	A partnership is vital for reablement to be successful
	Reablement can make a big difference to clients social wellbeing
	Supporting staff is important for clients
	Clients want to feel useful
	Being able to make an effort makes people feel good
	Governance often gets in the way
	Being in a home like environment is less stressful

Each area of analysis was supported by rich data that provided real insight into reablement within Family Based Care. Below are a number of quotes, directly from clients and staff that demonstrate the impact of reablement itself and the reablement training and evaluation.

Benefits of reablement

"broadened my views, and it gave me a lot more of an understanding about how other people perceived it to be"

"benefits are definitely for the people that you are supporting because it empowers them, because they have meaning to their lives… I believe they have a happier life … they feel more self-worth"

"more mindful of encouraging independence"

"And he now picks his own clothes out".

Concerns about implementing reablement

"*our duty of care*"

"We're all time poor"

"is that clients would think that their support workers wouldn't come if they were doing things themselves"

"now she ends up in hospital with a urinary tract infection, and it's because of poor hygiene"

"quite confronting"

Experience of reablement

"*and I don't want to feel lazy and I don't want people doing my jobs for me*"

"it's nice to be put on the same level as everybody else"

Impact of reablement

"I ch*anged people's point of view*"

"We'll take this training into residential aged care. We'll apply this training across disability, age, mental health, all the rest of it, so this becomes a standard practice, best practice, you know"

"it's just part of everyday life, and it's an expectation that this will happen every day"

"encouraging other people to take their own power"

"I'm here to keep you in your own home"

Understanding of reablement

"it really is about giving that to people what is rightly theirs, and it's about empowering them, and it's about strengthening and building relationships"

"Reablement is something that I believe a lot of people are actually supporting"

"It's also a form of reablement to make the choices"

Areas of care

"the carer, the client, the direct care worker and myself"

"So, together they work as a team, they're reenabling each other, and all they really needed was someone to come and to do some of those difficult things that they can't do, with the home and garden"

Overall, the interviews suggest that reablement education and training is valuable not only to teach the principles and value of reablement but also to reinforce the current independence-based practice for staff and their clients.

Phase 3: Focus groups

The care coordinator focus group sessions raised several important themes. Whilst a full final thematic analysis is still ongoing, a preliminary analysis is reported here.

The care coordinators focussed on four main areas of discussion:

1. how to better engage with their direct care workers;
2. review and evaluation of current practice;
3. the systems, processes and policies that govern them; and
4. the client focus (including the family).

Table 4 highlights some of the discussion points that were ongoing across the four sessions. Communicating with the direct care workers was an issue raised in many different scenarios. There is an obvious gap between what is happening currently and what the care coordinators would like to happen in the communication space. This was emphasised more particularly when brainstorming methods for reviewing and evaluating the way reablement is included in daily activities for clients. Being able to feedback to and from direct care workers about client needs, family needs, expectations and client wants can determine the extent to which reablement is applied to an individual client. A lack of a concrete connection remains a stressor for both groups. As such, strengthening the communication loop was highlighted as a priority area.

Similarly, further support for care coordinators from a human resource perspective was a much-discussed topic. This was born from exploring ways of building better relationships with direct care workers. The support for both care coordinators and direct care workers that comes from a structured system in the human resources space would allow more clarity around the expectations and deliverables for each role. This would also relieve personal pressure from coordinators who may not be equipped to deal with human resource type issues.

There was an obvious emphasis on client care during the focus group discussion which led to stories about the challenges and successes of working directly and indirectly with clients and their families. The two main lines of discussion were about the lack of direct contact with clients and their direct care workers and having an opportunity to make a difference to each client. The care coordinators expressed further interest in being able to have regular one on one conversations with their direct care workers in an effort to continually improve client care and develop better understanding of the challenges faced by direct care workers in the reablement space. Care coordinators felt their contribution to client care was not always recognised or understood and by having a more open relationship with direct care workers, this may be improved.

A culture of reablement within Family Based Care is evident from the conversations within the focus groups. However, it was suggested this could be improved. Whilst there was a general consensus that reablement features heavily in the care routines of direct care workers, a more consistent working definition and increased value placed on working within professional reablement boundaries is required. This discussion also centred around a number of external influences, particularly funding, and how that influences the way in which both care coordinators and direct care workers are able to carry out their daily tasks and routines. It was noted there was a definite lack of cohesiveness and flow between direct care workers and care coordinators at the client

care level and after further discussion a number of factors were unveiled. Physical structures such as building locations, parking availability and cost as well as food availability were all factors that had potential influence on the way direct care workers and care coordinators participated in team activities, including staff meetings.

The preliminary analysis shows there are many positive building blocks for a reablement-centered workforce and workplace.

Table 4. *Preliminary Identification of Themes from Focus Groups.*

Preliminary Analysis (Codes)	**Examples**
Communication Directives Opportunity Facilitation Connection	It was noted that there is currently a disconnect between the direct care workers and care-coordinators as the communication channels in place often fail. It was highlighted that an opportunity for care coordinators and direct care workers to discuss issues collectively with will further aid in evaluating the impact of reablement and also the teaching program for ongoing staff education.
	The use of a technology -based system for communication may improve professional relationships
	Electronic access to notes/files/requests would be beneficial to bridge the gap between DCW and CC
	Accessibility and opportunity
Work process Support Knowledge Fragmentation	A structured human resources system would aid in developing relationships between care coordinators and direct care worker which could ultimately lead to improvements in client care and reablement values within the organisation
	Format of organisational processes and policies should include continuous evaluation and consultation
	Staff can only do what is within their scope of practice – policy and procedure include restrictions
	Direct Care workers are too far away in their person and their roles
	Opportunities for improvement, strategies for engagement
Client focus Success Challenges	Walking the journey with the client is important
	Staff must feel safe to fail
	Clients are vulnerable, or are they?
	Sharing our successes, sharing our failures, sharing our stories. How do we know reablement is happening?
Culture Boundaries Professionalism Reflection	There is currently a culture of acknowledgement, value and learning
	Introducing and developing reablement as a culture within the FBC workplace across all levels of care is imperative to ensure consistency for clients and for staff
	There has been an improvement in culture and professional boundaries post reablement training
External Influences	Funding plays a big role in what can actually be done
	Physical buildings for support of direct care workers, meetings, interviews, catch ups – not always enticing. Geographical challenges.

There is the opportunity to enrich a person's life through their usual activities of daily living.

Discussion

Under the reablement approach, the direct care worker is present to work with the client to regain (or gain) activities of daily living. The key is the choice of the ADL(s) to be focussed on and are set by the client being at the centre of prioritisation, as per the Tuntland (2015) definition.

Continuing the 'working with' theme, under reablement, the direct care worker is not there to keep the house clean, but there to work with the client to keep the house clean. Indeed, the keeping of the house clean may simply be the formal and generic reason for the direct care worker to be present, however the prime reason for cleaning the house may be to keep the environment safe with the client by avoiding dangers, another activity of daily living.

Reablement is not about the direct care worker's notion or set of beliefs, but putting the needs of the client first, and the needs defined by the client first. This requires a resetting of the way the relationship between direct care worker and client works to create situations in which the client has the chance to shape their care, even if it is only a short episode, so that they get what they want out of it, and now what the direct care workers and potentially the coordinators presume the clients want.

Taking clients for a walk is a common activity. However, this activity in reablement terms can open up some huge potential. Some direct care workers report they regularly take their clients for walks, and some of these have several walks that they go on. When applying reablement principles to this activity, the key questions are about why a walk, and why those walks? The former may be answered in terms of fitness, which can then be further explored by asking about whether the fitness is to be improved or maintained. The reasons for these walks are interesting when direct care worker and client have fallen into standard ways of working. Sometimes both parties can't remember, or it's the direct care worker who made the decision about the location and duration of the walks. When applying reablement principles, asking the client where they would like to go is much more 'abling'. Not only does the client get to go where they want to go, but the direct care worker gets to find out more about the client, and so has more idea about the clients' motivations and drives. Changing over to reablement in terms of walks, may amount to asking the client where they would really like to go to, to get out of a rut. The process of walking itself and the opportunities to enrich the person's life by talking about places and people on the way can add significant value to the client. Of itself this appreciation of another individual by being interested in them is enriching. However, it also creates a greater depth of understanding of the client, and the context of the walk makes that understanding sometimes greater than the limited opportunities at home. Clients often reminisce about the past, and again that is worthwhile alone, but also allows the direct care worker to understand the client in different and unexpected ways.

In assisting clients with many activities of daily living, their involvement, doing with them, rather than doing for, remains all important. The adage, which remains true is "Use it or lose it". This can sometimes be a challenge, for instance, if the person has arthritis and they are in pain when assisting with washing or drying themselves. The challenge is threefold, gaining the client's agreement that they need to carry on doing as much as possible, and when is the threshold for too much pain. Secondly, is a medical opinion required on what the client can do or not? And finally gaining insight

and support from the client's family and close friends. The latter is clearest and yet most challenging to deal with. In assisting the client to continue to do what they can, the client's significant others can sometimes regard the direct care worker as cruel. And to make it worse, they might also regard the direct care worker as lazy as a result. This is a misunderstanding born of thinking that the direct care worker is there to do for the client, and not there to assist the client to remain as independent as possible, and preferably in his or her own home. It is this message that needs to be highlighted to the significant others – the reason for not doing, and the "use it or lose it" background. A one-off visit to the General Practitioner about potential pain related to walking may reassure both the client and the direct care worker. This might mean the client can engage pain relief strategies before the direct care worker visits. If the client and direct care worker both understand and share why they are doing what they are doing then there is little likelihood of conflict when the client is encouraged to participate in their care – for example washing and drying parts of their body. This is not static however, conversation and negotiation in terms of reablement enables client and direct care workers to constantly titrate the activities based on the clients' capacity and capability.

Reablement is about working with, not working for.

The theme of the direct care worker being misperceived as cruel and lazy has been recurrent during this reablement project. This is clearly about messaging at all levels in FBC, from the philosophy of FBC itself, through the way the phones are answered to the care plans that are created by the coordinators. The care plans need to state clearly that the direct care worker is ***assisting the*** client, ***working with*** the client and not merely doing for the client. Direct care workers may be fearful there might be complaints against them by relatives, because of this misperception of them being cruel and lazy, when, they are working with the client to maximise their abilities and hopefully avert them from having to live away from their home. Administrative staff are important in being able to explain that this is the goal of good reablement care, and that the direct care worker is doing right by the client and their loved ones. Another example of this potential misperception is in encouraging clients to do things that are very hard for them, but they want to achieve. It is essential that every individual in the organisation understands their part in the reablement "value chain", and the value and messages of reablement in order to be able to ensure that direct care workers are supported at all levels of interaction with the client.

> "A client who had had a stroke really wanted to be able to wear lace up shoes in public and when visiting relatives. To watch him trying was agonising, but after months of trying he was successful".

He was instrumental in handling his family and letting them know he wanted to do this. It could have been different, and the language of "lazy or cruel" related to direct care workers may have been inappropriately applied. There is an important context here, where old myths have been now been proven to be untrue. You can teach an old dog (person) new tricks. Brain plasticity (Kolb, 2013) has been proven to continue indefinitely, and therefore it is possible for people, post stroke for instance, to teach themselves to do up their shoe laces, but it can take time. Once the direct care worker has come to terms with this idea, the client needs to know it, and so do the family and significant others.

One of the most powerful forms of evidence gained from the participants in this project was about clients who go to Aged Care facilities for respite care. In the location in which the project was happening, according to project participants, it is/was common practice for staff within the Aged Care facilities to provide all care for the person, no

matter what the person was capable of. On return to their own home, the client had lost a lot of abilities, and the direct care workers had to work with their clients to regain their capacity – similar to where they were before admission to the Aged Care facility. This is the clearest example of why reablement is about working with clients, not working for them, or doing for them, and that the "use it or lose it" truism goes hand in hand with reablement.

A common polarised discussion in the teaching sessions related to whether the direct care workers were able to change the care plans or not. One group were very clear they could and spoke of the good relationship that they had with their care coordinator. Others were just as clear that they would lose their job if they were to deviate from the care plan and would certainly not negotiate with their care coordinator, who they preferred to keep at a distance. The latter may well be using their concern for losing their job as an excuse not to change what they are doing. However, there are some facts in the background, such as health and safety, and items that fall outside the funding package that can cause challenges.

The way in which care plans are written is also a potential way to limit the reablement process. If they are written in a manner that is all about doing for, rather than working with, then this is clearly at odds with what FBC are trying to achieve. Care coordinators have a large role to play in setting the tone and scene for direct care workers, including introducing the notion of reablement to the client and their significant others. Feedback from direct care workers indicate there are some clients and their significant others who regard them as being there to do whatever they ask. For a young and inexperienced direct care worker, this situation can be very challenging, on their own in the person's home. This may be exacerbated by who is paying for the care. To reiterate earlier statements, direct care workers are not there just to, for instance, clean, they are there to assist the client to keep the house clean. It is the wording and the explanation of reablement by care coordinators which can make a great deal of difference in setting the scene with a new client.

One of the differences in this reablement project is the emphasis upon **working with clients not working for them**. This emphasis is also couched in terms of direct care workers not looking for the immediate gratification of doing for the client, but the delayed gratification of seeing their client more in control of their care, more re-abled. This was termed **doing good work not being a do gooder.** The approach taken in the teaching also stressed the need for clients to be **involved in decision making**, in prioritising care, as well as in being active in their care, rather than passive. Like advocacy approaches, direct care workers, using the reablement approach, **walk alongside their client, not in front, or behind**. Implicit in reablement is an adage of **use it or lose it** for the clients in terms of their capacity to function.

Therefore, some direct care workers need to make changes to the way they work, no matter how well guided, and appreciated by their clients. And for others who are already sympathetic to reablement in the way they work, to open up their practice to even more reablement. The teaching team acknowledged the participants who were already "doing reablement" and they should be proud that they did so, but they should focus their efforts to take reablement further. Others, who were more resistant to reablement were asked simply to try the approach and be open to its potential for their clients.

In order to adopt reablement, direct care workers, and the organisations that support them need to adopt behaviours that are concordant with reablement itself. The first requirement has already been stated in terms of "doing with, rather than doing for" the client. The next step is to identify behaviours that needed to be changed at the functional level of the clients. The approach adopted was via "activities of daily living". There are various definitions of the activities of daily living, but the key ADLs would seem to be the following: walking, breathing, elimination, eat and drink, movement, sleep and rest, select clothes, learning and discovery, body temperature, keep clean, avoid dangers, communicate, worship, work accomplishment and play. These principles were therefore applied and embedded into the creation of the teaching material, its teaching, as well as the evaluation of the impact of reablement across FBC.

Towards a new definition of Reablement.

Reablement is an approach or philosophy of care that needs to be grasped by the care coordinators and direct care workers and the client in partnership. It is about the client fulfilling his or her own potential, as the client sees it, by being encouraged to set goals, and the carer working with the client to fulfil these goals. It is a philosophy which might be applied short-term for somebody who suffers some kind of physical setback, but it is as much an enduring approach to the care and partnership. It is a philosophy which is best fulfilled by the organisation providing the care, as a whole, and developing the organisation to support the client/carer partnership."

References

Australian Bureau of Statistics (ABS). (2016). ***Population by Age and Sex: Australia, States and Territories Report***. Retrieved from: http://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument

Australian Government, Department of Health. (2018). ***Australia's Health Landscape Infographic***. Retrieved from: https://beta.health.gov.au/resources/publications/australias-health-landscape-infographic

Barton P., Bryan S., Glasby J. et al. (2005) ***A National Evaluation of the Costs and Outcomes of Intermediate Care for Older People, Draft Report***. Intermediate Care National Evaluation Team, Nuffield Community Care Studies Unit, University of Leicester, Leicester.

Burton, E., et al. (2013). Physical Activity Levels of Older Adults Receiving a Home Care Service.***Journal of Aging & Physical Activity 21(2): 140-154.***

Calder, R., Dunkin, R., Rochford, C., & Nichols, T. (2019). ***Australian health services: too complex to navigate. A review of the national reviews of Australia's health service arrangements***. Policy Issues Paper No.1 12019: AHPC

Department of Health (DOH). (2007). ***Care Services Efficiency Delivery Programme. 'Homecare Re-ablement Workstream: Retrospective Longitudinal Study November 2007'***. London, United Kingdom.

Department of Health. (2016). Home and community care (HACC) program in Western Australia: Triennial Plan 2015-2018. Retrieved from: https://healthywa.wa.gov.au/~/media/Files/Corporate/general%20documents/HACC/PDF/HACC_WA_Triennial_Plan_2015-18.pdf

Department of Health (DOH). (2018***). Commonwealth Home Support Programme: Program Manual***. Australian Government. Retrieved from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/04_2018/chsp_manual_-_effective_as_of_1_july_2018.pdf

Dickinson, H., & Carey, G. (2017). Managing care integration during the implementation of large-scale reforms: The case of the Australian National Disability Insurance Scheme. *Journal of Integrated Care*, *25*(1), 1-10.

Doty, P., Mahoney, K. J., & Simon-Rusinowitz, L. (2007). Designing the Cash and Counseling Demonstration and Evaluation. ***Health services research***, ***42***(1 Pt 2), 378–396. doi:10.1111/j.1475-6773.2006.00678.x

Family Based Care North West Inc. (2017). ***Annual Report 2017***. Family Based Care North West: Burnie.

Godfrey M., Keen J., Townsend J. et al. (2005) ***An Evaluation of Intermediate Care for Older People.*** Institute of Health Sciences and Public Research, University of Leeds, Leeds, UK.

Hjelle, K. M., Tuntland, H. , Førland, O. and Alvsvåg, H. (2017), Driving forces for home-based reablement; a qualitative study of older adults' experiences. ***Health Soc Care Community,*** 25: 1581-1589. doi:10.1111/hsc.12324

Kolb, B., 2013. *Brain plasticity and behavior.* Psychology Press

Kjerstad, E. and Tuntland, H. K. (2016) Reablement in community-dwelling older adults: a cost-effectiveness analysis alongside a randomised controlled trial. *Health Economics Review.* 6:15. doi: 10.1186/s13561-016-0092-8

Lawn, S., Westwood, T., Jordans, S., Zabeen, S., & O'Connor, J. (2017). Support workers can develop the skills to work with complexity in community aged care: An Australian study of training provided across aged care community services. *Gerontology & Geriatrics Education*, *38*(4), 453-470. doi:10.1080/02701960.2015.1116070

Legg, L., Gladman, J., Drummond, A. & Davison, A. (2016) A systematic review of the evidence on home care reablement services. Clinical Rehabilitation. 30(8): 741 – 749.

Lewin, G., Allan, J., Patterson, C., Knuiman, M., Boldy, D., & Hendrie D. (2014). A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service. *Health Soc Care Com*. 22(3):328–36.

Lewin, G.F., Alfonso, H.S. and Alan, J.J. (2013). Evidence for the long term cost effectiveness of home care reablement programs. *Clin Interv Aging*. 8:1273–81.

Lewin, G., Calver, J., McCormack, B., Coster, C., O'Connell, H., Wheeler, B., Smith, J., & Vandermeulen, S. (2008). The Home Independence Project [online]. *Geriaction*, 26(3): 13-20.

Mann, R., Beresford, B., Parker, G., Rabiee, P., Weatherly, H., Faria, R., … Aspinal, F. (2016). Models of reablement evaluation (MoRE): a study protocol of quasi-experimental mixed methods evaluation of reablement services in England. *BMC Health Services Research*. 16:37.5

Parsons, J., Burton, E., Graff, L., Metzelthin, S., O'Connell, H., Tuntland, H. (2019). Reablement as an evolution in community care: a comparison of implementation across five countries. *In Draft*

Procter, S., Biott, C., Campbell, S.J., Edward, S., Redpath, N. and Moran, M., 1999. *Preparation for the developing role of the Community Children's Nurse*. London: English National Board for Nursing and Midwifery.

Rabiee, P. and Glendinning, C. (2011). Organisation and delivery of home care re-ablement: what makes a difference?. *Health and Social Care in the Community*. 19(5): 495-503.

Rock, D & Cox, C (2012). SCARF® in 2012: updating the social neuroscience of collaborating with others. *Neuroleadership Journal*. 4: 1-14.

Smith R. (2016). To articulate the benefits of reablement for older people to inform government implementation plans - New Zealand, UK and Denmark [Internet]. The Winston Churchill Memorial Trust of Australia. Retrieved from: https://www.churchilltrust.com.au/media/fellows/Smith_R_2016_Reablement_for_older_people_to_inform_government_implementation_plans.pdf

Tinetti, M., Baker, D., Gallo, W.T., Nanda, A., Charpentier, P. and O'Leary, J. (2002). Evaluation of restorative care vs usual care for older adults receiving an acute episode of home care. *JAMA*. 287(16):2098–2105. I2.

Tinetti, M., Charpentier, P., Gottschalk, M. and Baker, D. (2012) Effect of a Restorative Model of Post-hospital Home Care on Hospital Readmissions. *J Am Geriatr Soc*. 60(8): 1521–1526.

Tuntland, H., Aaslund, M. K..m Espehaug, B., Forland, O. and Kjeken, I. (2015). Reablement in community-dwelling older adults: a randomised controlled trial. *BMC Geriatrics*. 15:145.

Tuntland, H., Doh, D., Ranner, M., Guidetti, S., and Zingmark, M. (2019). Examining clients level outcomes of reablement: A cross-country comparative analysis. *In Draft*

Winkel, A., Lanberg, H and Waehrens, E. E. (2015). Reablement in a community setting. *Disability and Rehabilitation*. 37(15): 1347 – 1352.

Appendices

Appendix A: Survey 1. The Activities of Daily Living questionnaire.

Your responses to this questionnaire are confidential and to emphasise this, we will not provide the information from this questionnaire to anybody in Family Based Care, or any other individual outside the UTAS research team. The results will be pulled together, and presented in terms of frequencies of responses, as well as trends.

Your participation in this questionnaire is entirely voluntary, however, if we do not receive a completed response from you we will ask you twice more to complete the questionnaire, then we will leave you alone and respect that you do not wish to complete the questionnaire. The code number on the questionnaire is used to identify you so that we do not chase you again if you have completed the questionnaire and is not a way to identify you in our findings.

You are being invited to complete this questionnaire, because you are either:

- About to undertake the reablement training provided by the University of Tasmania, on behalf of Family Based Care; or
- You have undertaken the reablement training; or
- You have been trying to use reablement in your day to day work.

Please turn over the page.

We are interested in this case in your views about reablement, before the training, after it, and in your day to day practice working for Family Based Care.

There are statements below, and you are being asked to read each statement and tick the box that best fits your view of reablement with respect to each activity of daily living. There is no right or wrong, this is just about your view. We would also like you to let us know what proportion of your clients, you think your view is based upon.

An example:

Statement	Strongly agree	Agree	Not sure	Disagree	Strongly disagree	Not applicable	% clients	
Walking It's up to the client how much walking he or she does, it's no business of mine		✓					All	
							High	✓
							Medium	
							Low	

This completed example means that the person agrees (not strongly agrees) with the statement about walking and this is based upon the person applying this to a high percentage of their clients.

Please turn over the page.

Now for your views, please tick below as per the example on the previous page.

Statement	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Not Applicable	% clients	
Breathing 1. Clients can get puffed out, and my role is to work with them to try to avoid this.							All	
							High	
							Medium	
							Low	
Elimination 2. How and when clients go to the toilet is down to them it's not my business.							All	
							High	
							Medium	
							Low	
Eat and Drink 3. I know best what clients should eat, it's not their choice to make.							All	
							High	
							Medium	
							Low	
Movement 4. Clients know what goals they want to achieve in moving about, I'm there to support these.							All	
							High	
							Medium	
							Low	
Sleep and Rest 5. Clients should have regular sleep and rest times, it's not up to them to offer preferences.							All	
							High	
							Medium	
							Low	
Select Clothes 6. Clients should be told what to wear not given the choice.							All	
							High	
							Medium	
							Low	
Body Temp 7. Clients can make wrong choices about heating in the house, my job is to work with them so their temperature is about right.							All	
							High	
							Medium	
							Low	

Statement	Strongly Agree	Agree	Not sure	Disagree	Strongly disagree	Not Applicable	% clients	
Keep Clean 8. Cleanliness is all important, I need to make sure that the client knows this, it isn't an option for them to decide.							All	
							High	
							Medium	
							Low	
Avoid dangers 9. Clients can make judgements about risk, it's not up to me to force them to avoid them.							All	
							HIgh	
							Medium	
							Low	
Communicate 10. I've been doing this a long time, I know what to expect, I don't need to be open to listening to the clients for more that they might want to share.							All	
							High	
							Medium	
							Low	
Worship 11. Clients beliefs and worshipping is their choice, my views are nothing to do with it.							All	
							High	
							Medium	
							Low	
Work accomplishment 12. Things need to get done, it's not important that this makes the client feel good.							All	
							High	
							Medium	
							Low	
Play 13. Play and recreation is all about what the client wants to do, not what I think they should do.							All	
							High	
							Medium	
							Low	
Learning and discovery. 14. If a client can't work it out for themselves, it's best if I do it for them.							All	
							High	
							Medium	
							Low	

Appendix B: Survey 2. The SCARF questionnaire.

Your responses to this questionnaire are confidential and to emphasise this, we will not provide the information from this questionnaire to anybody in Family Based Care, or any other individual outside the UTAS research team. The results will be pulled together, and presented in terms of frequencies of responses, as well as trends.

Your participation in this questionnaire is entirely voluntary, however, if we do not receive a completed response from you we will ask you twice more to complete the questionnaire, then we will leave you alone and respect that you do not wish to complete the questionnaire. The code number on the questionnaire is used to identify you so that we do not chase you again if you have completed the questionnaire, and is not a way to identify you in our findings.

You are being invited to complete this questionnaire, because you are either:

- About to undertake the reablement training provided by the University of Tasmania, on behalf of Family Based Care; or
- You have undertaken the reablement training; or
- You have been trying to use reablement in your day to day work.

Please turn over the page.

We are interested in this case in how you feel about the way the project is going and your relationship with it.

There are five statements below, and you are being asked to read each statement and tick the box that best fits how you feel about the way the reablement project is going.

Statement	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree	Not Applicable
Status. 1. I think my status and experience in the organisation is respected when I think about the reablement developments.						
Certainty. 2. I have no idea about what the future looks like in this organisation when I think about the reablement developments.						
Autonomy 3. The reablement developments show that I have control over what I do for the organisation.						
Relatedness. 4. When it comes to the reablement developments, I do not feel safe when discussing my views with my colleagues						
Fairness. 5. When I think about the reablement developments, I am treated fairly within the organisation.						

Appendix C: Reablement Interview Guide for FBC clients.

Introduction:

I am here today to chat with you about your experience of 'enablement' during the last few weeks. The interview will last approximately 30 to 45 minutes.

1. Can you please describe your experiences with FBC ? How long have they provided a service to you?

2. Please tell me your understandings of reablement?

3. What were the main benefits you have experienced since reablement was introduced at FBC?

4. Are there any areas of your care which you would like to see reablement used in? Please explain.

5. What benefits has the reablement approach had on your day to day care?

6. Do you have any concerns about FBC staff using reablement in their day to day work? What are these concerns?

7. Do you think the reablement method is a better way of care for staff at FBC to use? If not, why not?

8. Do you think using reablement is having an impact on your:
    a. resilience,
    b. independence
    c. self-management?

Please explain.

9. Are there any other comments you would like to make?

Thank you for your time today.

Appendix D: Publications and Conferences

Publications

Campbell S, Bramble M, Maxwell H, Marlow A, Heath AL, Prior S and Doherty D. *'Building Capacity to deliver Reablement in Regional Communities: What are the Benefits and Challenges?'*, 2018 Western NSW Health Research Network Conference, 16 - 17 August 2018, Orange, New South Wales, Australia (2018) [Conference Extract]

Campbell SJ, Bramble MD, Maxwell H, Marlow AH, Prior SJ, Heath A and Doherty D. *'Building Capacity to Deliver Reablement in Regional Communities: Workforce Benefits and Challenges'*, AAG Conference 2018: Active Players, a Fair Future, 21-23 November 2018, Melbourne (2018) [Conference Extract]

Maxwell H, Campbell S, Bramble M, Marlow A, Heath AL, Prior SJ and Doherty D. *'Building rural workforce capacity in rural communities through a reablement teaching program: The case of Family Based Care'*, The Annual Rural Health and Collaborative Research Symposium, 20 September 2018, Launceston, Tasmania (2018) [Conference Extract]

Prior S, Campbell S, Bramble M, Maxwell H, Marlow A, Heath A, Doherty, D (2019). *A pilot evaluation of a teaching program: Using activities of daily living to enhance staff practice of reablement. Thinking Innovatively in Collaborative Healthcare Practice*, 18-19 September 2019, Brisbane, Queensland

Conferences Attended

Transforming Care Conference. Changing priorities: The making of care policy and practices, 24-26 June 2019, Copenhagen, Denmark.

Appendix E: Reablement Action Plan 2019

Goal: To develop a reablement culture at Family Based Care through communication and practice.

Objectives						
Action Description	**Who is Responsible?**	**Date to Begin**	**Date Due**	**Resources Required**	**Desired Outcome**	**Evaluation Plan**
Form Reablement leadership group. The group would be made up of volunteers from the PCs who attended the four focus groups. Approximately 6 – 8 people? (Is this too many people?)	Decision on who leads this group needed.	Start date for FBC as a whole is needed.			Action plan delivered as planned	Data collected on each aspect of the action plan and collated each year by the leadership group.
Initiate and sustain reablement education and training for new members of staff, including those who have started since the early 2018 UTAS sessions.	Decision needed on who to do this at FBC	Now	Ongoing	Names of all new starters since UTAS training. Access to conference room, 2 hours. Release of staff and educator. UTAS happy to 'train the trainers'	All members of staff at FBC have the same ideas about what reablement is and how it applies to their work.	Data collected on completion of training (such as sessions held, numbers attending and names of participants)
Develop a tag line for FBC that can go on all communication and is reflective of reablement. (Could come from combining ideas from Xmas 2018)	Reablement leadership group.	Now	By 1 March	Group meeting time, and some critical analysis of suggestions.	There is consistent messaging going out that FBC is a reablement organization.	Tag line visible. Clients Families and Public comments on tag line.
Strengthening HR performance systems to ensure that performance is carried out in a meaningful manner each year.	CEO FBC	Ongoing	Ongoing		If the PCs are to have the 'enactment of reablement' as one of their KPIs, then this is only meaningful if there is a good solid performance process for staff.	This may be occurring already, but an analysis of the proportion of PCs who had performance process over last three years is required. And a sample to see whether it was sufficiently in depth and meaningful for all stakeholders.

All PCs have Enactment of Reablement as a KPI in their performance expectations for each year.	CEO FBC	Now	Ongoing		PCs are in the best position to work with DCWs to ensure reablement is imitated, developed and maintained with their clients.	Each PC provides evidence of having fulfilled this KPI. These data are collated and go to the Reablement leadership group.
Inform PCs' understanding of confidentiality. There is a narrow interpretation currently.	CEO FBC			Regular general workshop sessions and ongoing professional development	For all staff within FBC to have a consistent understanding of confidentiality within the context of their daily practice.	Confidentiality is maintained as per policy and procedural processes within FBC.
Build Reablement concepts into all meetings.	Reablement Leadership Group	1 March	Ongoing		Starting all meetings with a reablement story, will permeate the organization with ideas of reablement. (Including correcting misinterpretation of reablement.)	Collection of the stories, as well as ensuring reablement stories are on each agenda, and actually happen.
Undertake review process of client care with smaller groups of DCWs	Each PC with their staff	1 April	Ongoing	An audit of regular scheduled reviews is maintained	Getting to the actual care and making sure that reablement is happening where it can with each client.	Noting changes to plans as a result of the reviews.
Care planning software is reablement sympathetic. I.e. the drop-down menus include reablement focused language.	CEO FBC with the reablement monitoring group	1 May	Ongoing			
Creating a flow of reablement stories, by collecting them centrally, and sharing them electronically each month. Sharing stories of how changing language and focus has impacted clients, their families and staff within FBC	Reablement leadership group/team	1 March	Ongoing	Potential cost of videoing the story. Although iPhone standard may be good enough.	Using stories to spread the message about what great impact that reablement can have on clients.	Having a set of reablement stories which can be reported against the adverse event reporting as good news. A reablement story of the year, which is show cased at the AGM.

Appendix F: Training Session 1 Presentation

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Welcome to Reablement training at Family Based Care

- Please register for the session.
- Pick up your pack.
- Please have a look at the papers outside the envelope.

Session 1/2

March 2018

The UTAS Research Team. Introductions.

Prof Steve Campbell
A/Prof. Annette Marlow
Dr. Anne Heath
Dr. Sarah Prior

A/Prof. Marguerite Bramble (CSU)
Dr. Hazel Maxwell (UTAS in Sydney)

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Ethical approval and Informed Consent

Independent research team.
Research plan has been appraised for ethics.
Members of FBC will not receive any identifiable information.
Code on envelopes only known by researchers.
Explanation of research process.
Voluntary. Will only "chase" you twice

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Any Questions about the research?
Thank you.

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Aims and Objectives of the Session

1. To introduce the research team.
2. To explain the research process.
3. To explain the background to reablement.
4. To give some examples of reablement.
5. To get the chance to discuss these examples of reablement.
6. To work out how to apply these to your practice.

Background

Family Based Care and University of Tasmania

Doug's Introduction

The birth of the Reablement Project

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Aims

The aim of reablement is to:

- achieve sufficient functional skills to allow community-dwelling older adults to remain in their homes with less or no further assistance from the community (Winkel, et al. 2014),
- shift from reactive home care services to preventative and proactive models of care (Legg, et al. 2016),
- increase independence in daily activities, and enable people to age in place, be active and participate socially and societally (Tuntland et al 2014).

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A definition to consider

> *a goal-directed and intensive intervention, which takes place in the person's home and local surroundings with a focus on enhancing performance of everyday activities defined as important by the person (Tuntland, 2014, p.4).*

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Definition

The literature provides us with so many definitions, but it really is not clear what Reablement is in a practical sense.

But... it becomes clear when we think of it as a behaviour

"*to do one thing, rather than the other*"

But what does this look like in practice.....

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Activities of daily living

Walking	Body temperature
Breathing	Keep Clean
Elimination	Avoid Dangers
Eat and Drink	Communicate
Movement	Worship
Sleep and rest	Work accomplishment
Select Clothes	Play
Learning and Discovery	

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Example 1 Please thank your colleagues.

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Example 2

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Example 3

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How did we do in the Session?

1. Introduced the research team.
2. Explained the research process.
3. Explained the background to reablement.
4. To give some examples of reablement.
5. To get the chance to discuss these examples of reablement.
6. To work out how to apply these to your practice.

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SCARF

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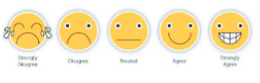
Summary

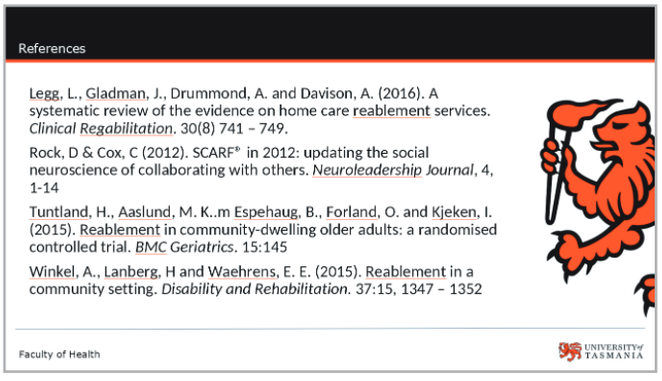
Likert



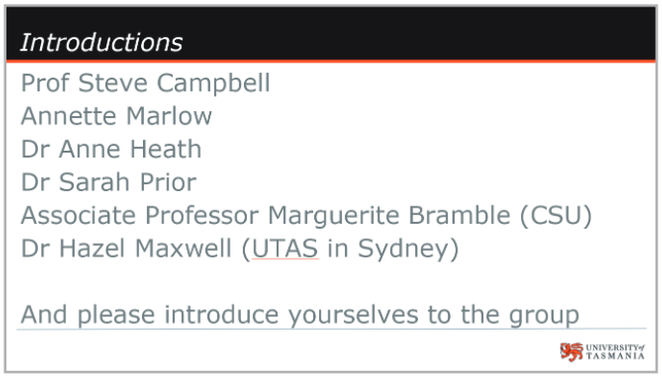
Evaluation

Faculty of Health

UNIVERSITY of TASMANIA



Appendix G: Training Session 2 Presentation



Aims and Objectives of the Session

1. To introduce us all to each other
2. To remind ourselves of what we learnt at the first session
3. Examples of reablement, familiar and new
4. To discuss your experiences of reablement
5. To work out what works well and what is challenging in applying reablement principles

Background

Reminder:

Why is Doug Doherty so keen on introducing reablement into Family Based Care?

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Reminders

- Doing with the client not doing for the client
- *Walking alongside the client, not walking in front or behind*
- Not *just a support worker*
- Working with the client on what he or she sees as the important stuff, his or her priorities
- Not a cleaner, a support worker

Reminders

- Unfreezing and recreating the way the support worker works with the client
- Feeling good about ourselves if we do reablement already, but trying to do more
- Use it or lose it
- Explaining what we are trying to do together
- Not being cruel or lazy
- *Doing good work, not being a do gooder*
- Using *rather than* statements

Reminders

- Getting to know the client in different ways
- Use of reminiscence for some clients
- A walk is not just a walk
- We carry on learning throughout our lives
- Involvement in decision making
- It's not about making yourself happy, it's what the client wants or needs

Keeping clients in their homes for as long as possible

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Familiar Example

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Group Work. *10 minute discussion, then 20 minutes feedback*

In your group:

1. Discuss the ways in which you have tried out reablement since the last teaching session
2. Identify 2 clients from your discussions that you have started reablement with
3. Why did you choose them?
4. What did the client want to get out of this?
5. Was anything challenging?

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New Example 1

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New Example 2

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Group Work

In your groups

1. What lessons would you share with colleagues to help make reablement work?
2. What would you avoid?
3. Provide two examples of reablement in action
4. What additional wording in care plans (if any) would assist to promote reablement?

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How did we do in the Session?

1. Collegiality and Conversation
2. To remind ourselves of what we learnt at the first session
3. Examples of reablement, familiar and new
4. To discuss your experiences of reablement
5. To work out what works well and what is challenging in promoting reablement

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Nearly at the end

1. Before you go, if you could complete the questionnaires marked **T2E** in your yellow/orange envelope.
2. If you've left it behind, please let us know, and we will provide you with a replacement.
3. When you've completed them you can go.

Thank you for your participation

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