

Adopting Reablement Mindset Within Care

Introduction

The reablement approach focuses on empowering older Australians to regain and maintain their independence by improving their functional capacity. This approach involves setting individualized goals, providing tailored support, and encouraging active participation in daily tasks. Below, we expand on **practical examples** of how aged care providers can support clients in completing daily tasks while using a reablement approach, grounded in **scientific best practice evidence**.

Key Principles of Reablement and Wellness

1. Client-Centered Care
2. Strengths-Based Approach
3. Collaboration and Empowerment
4. Holistic Care
5. Short-Term Interventions



Practical Examples of Supporting Daily Tasks Using the Reablement Approach

1. Bathing and Personal Hygiene

- **Support for Task Completion:** Initially, provide physical assistance with getting in and out of the bath/shower. As the client gains confidence and strength, encourage them to take an active role in washing themselves.
- **Reablement Approach:** Use adaptive equipment such as shower chairs, grab rails, or hand-held shower heads to make the process safer. Support the client by setting small, achievable goals such as washing one body part at a time or assisting with drying themselves.
- **Best Practice Evidence:** Studies show that assisting with adaptive equipment while encouraging self-care can lead to improved autonomy and self-esteem. A study published in the *Journal of Aging and Physical Activity* (2014) highlighted that functional independence in bathing, as well as the use of adaptive aids, significantly improves older adults' well-being and reduces dependence.

2. Meal Preparation and Eating

- **Support for Task Completion:** Encourage the client to help with meal preparation by chopping vegetables, stirring, or setting the table, depending on their abilities. Encourage them to use adaptive tools such as larger grips on utensils, or plate guards.
- **Reablement Approach:** Assist with tasks that are too complex or risky (e.g., handling hot pots), but encourage as much participation as possible. Develop a routine where the client is responsible for specific parts of the meal, such as cutting vegetables or arranging ingredients.
- **Best Practice Evidence:** According to the *Journal of Gerontological Nursing* (2017), encouraging participation in meal preparation increases the person's sense of autonomy and boosts their cognitive and physical engagement. Furthermore, using adaptive devices and encouraging self-feeding can enhance the dignity of clients while improving their functional skills over time.



3. Dressing and Personal Appearance

- **Support for Task Completion:** For clients with limited mobility or dexterity, guide them through the process of dressing while allowing them to do as much as possible independently. This might involve assisting with putting on socks or shoes while encouraging the client to manage other clothing items on their own.
- **Reablement Approach:** Use adaptive dressing aids, such as button hooks, zippers, or elastic shoelaces, to enable greater independence. Gradually reduce the level of assistance provided to increase the client's participation in dressing.
- **Best Practice Evidence:** Research in *Clinical Rehabilitation* (2016) found that clients who actively engage in dressing tasks, with or without assistive devices, experience increased feelings of accomplishment and a reduction in dependency, especially in older adults with chronic conditions or disabilities.

4. Mobility and Walking

- **Support for Task Completion:** For individuals with reduced mobility, initially, provide assistance with walking (e.g., holding an arm or using a walker). Encourage walking to a specific destination (e.g., from one room to another) as part of a daily routine.
- **Reablement Approach:** Start with short distances and gradually increase them. Use functional exercises such as walking from the bathroom to the bedroom to build stamina and strength. Introduce exercises like standing up from a seated position or walking in a straight line.
- **Best Practice Evidence:** According to the *American Journal of Preventive Medicine* (2013), encouraging daily walking and functional mobility exercises significantly reduces the risk of falls and enhances physical function. A study in *JAMA Internal Medicine* (2018) also demonstrated that targeted walking programs for older adults can reduce disability and improve independence.

5. Household Tasks (Cleaning, Laundry, etc.)

- **Support for Task Completion:** Assist with the heavier aspects of cleaning or laundry (e.g., lifting baskets, vacuuming). Encourage clients to sort laundry, fold towels, or dust areas within their reach.
- **Reablement Approach:** Break tasks down into smaller steps that the client can manage independently. For example, start by letting the client fold towels or organize items in drawers, gradually increasing the number of tasks they can complete.
- **Best Practice Evidence:** A study in the *Journal of Physical Activity and Health* (2014) indicates that breaking down household tasks into smaller steps and progressively increasing participation not only helps with functional independence but also promotes social and cognitive engagement, reducing feelings of helplessness or frustration.

6. Toileting and Continence Management

- **Support for Task Completion:** Offer initial assistance with getting to the bathroom, positioning, and cleaning up. Over time, support clients to increase their independence by using adapted toilet aids like raised toilet seats or grab bars.
- **Reablement Approach:** Implement a toileting schedule to encourage clients to recognize their body's needs. Gradually reduce the frequency of reminders and encourage the client to identify when they need to use the bathroom.
- **Best Practice Evidence:** According to the *Journal of Clinical Nursing* (2019), reablement strategies in continence care (e.g., toilet training and the use of adaptive devices) improve autonomy in toileting. This approach helps reduce incontinence issues, contributing to greater dignity and self-reliance.

7. Cognitive and Social Engagement

- **Support for Task Completion:** Encourage mental engagement by setting tasks like memory games, puzzles, or sorting activities. Help the client join in group activities, such as book clubs or community events, if they express interest.
- **Reablement Approach:** Introduce simple cognitive exercises such as recalling names, using calendars, or engaging in mental exercises like crossword puzzles. These activities can be linked to daily tasks, such as recalling where items are stored or managing simple schedules.
- **Best Practice Evidence:** Research from the *Journal of Aging and Social Policy* (2015) highlights that cognitive stimulation and social interaction significantly improve cognitive function in older adults. Social engagement is linked to improved mood, reduced risk of depression, and better overall health outcomes.

Support at Home Program Guidelines

The Support at Home Program encourages service providers to:

- Focus on **building functional capacity** through active participation, reducing dependency.
- Use **person-centered goals**: Work collaboratively with clients to set individualized goals for increasing functional independence in daily tasks.
- **Monitor and review progress** regularly to ensure clients are moving toward their goals.

Conclusion

Integrating the reablement approach in daily care duties not only supports independence but also promotes physical, cognitive, and emotional well-being. By focusing on the strengths of each individual and encouraging active participation in daily activities, aged care providers can help older Australians lead a fulfilling and independent life. Scientific best practice evidence underscores the positive impact of adaptive aids, individualized care plans, and progressive task engagement on maintaining independence and improving quality of life.

Care providers should aim to implement these strategies thoughtfully, adjusting the level of support as needed, to help clients achieve their personal goals and maximize their functional capacity.

Practical Guide for a Reablement Client-Centered Goal Plan and Exit Plans

Introduction

A reablement approach in aged care is designed to assist clients in regaining or maintaining their independence and improving their functional capacity. Creating a **client-centered goal plan** and **exit plan** is critical for ensuring that the individual's needs, preferences, and abilities are at the center of care. This guide uses the **Australian Government Practical Guide for Embedding Wellness and Reablement into Clinical Services** and the **Support at Home Program Guidelines** to outline how these plans can be created and implemented effectively.

Client-Centered Goal Plan

The **Client-Centered Goal Plan** focuses on empowering the client to set meaningful goals that are specific to their needs and aspirations. The reablement approach encourages a holistic view of the person, recognizing their strengths, values, and preferences.

Step 1: Initial Assessment

A thorough initial assessment is essential to understand the client's current functional capacity, health status, and personal preferences. This assessment forms the foundation of the goal plan.

- **Physical Function:** Assess mobility, strength, coordination, and any assistive devices used.
- **Cognitive Function:** Evaluate memory, problem-solving skills, and cognitive engagement.
- **Emotional and Social Well-being:** Assess mood, social networks, and participation in community activities.
- **Personal Preferences and Values:** Understand the client's daily routines, desires, and goals.

Best Practice Evidence: A comprehensive initial assessment ensures that the care provided is person-centered, as outlined by the Australian Government in the *Support at Home Program Guidelines*.

Step 2: Goal Setting

The next step involves **setting clear, individualized goals** that are meaningful to the client. Goals should be **SMART** (Specific, Measurable, Achievable, Relevant, and Time-bound).

- **Engage the Client:** Include the client in the goal-setting process. Ask them about their aspirations, what tasks they want to regain independence in, and what challenges they are currently facing.

Example:

- **Goal 1:** Improve mobility to walk independently for 10 minutes around the house by the end of 8 weeks (SMART).
- **Goal 2:** Regain the ability to prepare a simple meal (e.g., making a sandwich) within 4 weeks.
- **Short-Term Goals:** Focus on achievable outcomes that can be reached within a short time frame (e.g., 1-3 months). These may include regaining the ability to perform basic self-care tasks like dressing or grooming.
- **Long-Term Goals:** These may focus on broader independence, such as returning to full participation in community activities or managing personal care routines with minimal support.

Best Practice Evidence: According to the *Journal of Clinical Nursing* (2019), setting short-term, achievable goals and gradually increasing their complexity has been shown to improve self-efficacy and independence in older adults.

Step 3: Develop Action Plans

For each goal, create an **action plan** that outlines:

- **Tasks and interventions** required to achieve the goal.
- **Level of support** needed (e.g., partial assistance, prompting, or full support).
- **Assistive devices** or modifications that will aid the process (e.g., grab bars, mobility aids).
- **Timeline** for achieving the goal, with regular reviews to track progress.

Example for Goal 1:

- **Action Plan:**
 - **Week 1-2:** Walk with the aid of a walker for 5 minutes in the home with carer support.
 - **Week 3-4:** Increase walking duration to 7 minutes.
 - **Week 5-6:** Walk 10 minutes independently, with supervision nearby for safety.

Best Practice Evidence: Research from the *Journal of Gerontology* (2015) shows that structured goal-setting, with regular monitoring, increases client motivation and enhances the likelihood of achieving functional independence.



Exit Plan

The **Exit Plan** is developed once the client has achieved their reablement goals or when they are nearing the point where continued formal care is no longer required. The plan ensures that the client is equipped with the tools, support, and knowledge to maintain their independence.

Step 1: Review Progress

Before exiting the reablement program, conduct a **final assessment** to review the progress of the client's goals.

- **Achievement of Goals:** Evaluate if the client has met their short-term and long-term goals.
- **Current Needs:** Assess if the client still needs support or if they can manage daily tasks independently.
- **New Needs:** Identify if there are any new or emerging needs that should be addressed post-exit, such as ongoing health monitoring or community support.

Example:

- If the client successfully walks 10 minutes independently but still requires assistance with meal preparation, the exit plan should reflect this transition.

Step 2: Transition Planning

Prepare the client for a **transition** from reablement services to either independent living or minimal support.

- **Ongoing Support:** Identify whether the client needs continued home support (e.g., for specific tasks like cleaning or grocery shopping).
- **Community Resources:** Provide information about community programs, social groups, and volunteer opportunities that will support the client's ongoing independence and social engagement.
- **Caregiver Involvement:** If applicable, ensure that caregivers are trained to continue supporting the client, including teaching them how to provide assistance in a way that promotes independence.

Example:

- A client who has regained the ability to perform most daily tasks independently may still require weekly support for certain activities, like grocery shopping. The exit plan would include a recommendation for home care visits once a week.

Step 3: Document the Exit Plan

Create a **formal exit document** that includes:

- **A summary of the client's progress** during the reablement program.
- **Final goals and outcomes** (e.g., walking independently, preparing simple meals).
- **Recommendations** for continued independence or minimal care.
- **Follow-up Schedule:** Determine if any follow-up reviews or check-ins are required to monitor progress (e.g., 3-6 months after exit).

Best Practice Evidence: The Australian Government's *Support at Home Program* emphasizes the importance of developing a structured exit plan to ensure continuity of care and that clients maintain independence once reablement support ends.

Step 4: Empowering the Client Post-Exit

Once the client exits the reablement program:

- **Self-Management Education:** Ensure that the client knows how to continue using any assistive devices, strategies, or techniques that have helped them regain independence (e.g., memory aids, mobility aids).
- **Encourage Social Engagement:** Promote continued participation in social and community activities. Offer guidance on local clubs, fitness programs, or volunteer opportunities.
- **Health Monitoring:** If necessary, ensure that the client has access to ongoing health services (e.g., physiotherapy, occupational therapy, or mental health services).

Example:

- A client may be encouraged to join a community walking group to maintain their mobility and social connections after completing the reablement program.

Best Practice Evidence: Research published in *The Gerontologist* (2020) shows that older adults who continue participating in social and physical activities post-reablement maintain higher levels of physical and mental well-being, reducing the risk of future health issues.

Conclusion

A **client-centered goal plan** and **exit plan** are essential components of the reablement approach in aged care. By focusing on the client's strengths, goals, and preferences, service providers can create a personalized plan that enhances independence and quality of life. The **initial assessment**, **goal-setting**, **action plans**, and **exit strategies** ensure that clients receive the right level of support while preparing them to live independently after the program concludes.

The **Australian Government's Practical Guide for Embedding Wellness and Reablement into Clinical Services** and **Support at Home Program Guidelines** both emphasize the importance of person-centered care, continuous monitoring, and appropriate transition planning for long-term success in maintaining independence.