REABLEMENT IN PRACTICE

Frequently Asked Questions

FREQUENTLY ASKED QUESTIONS

INTRODUCTION

Reablement services within the Commonwealth Home Support Programme (CHSP) are defined as short term, time-limited services focusing on client's individual goals. These goals generally aim to support clients getting back to doing things for themselves and regaining independence.

There are a range of resources available to inform Regional Assessment Services (RAS) and Service Providers about the theory of Reablement, including the benefits of, and requirements of individual roles.

To access these resources, visit:
https://www.health.gov.au/initiatives-and-programs/wellness-and-reablement-initiative

Purpose of the resource

The Reablement in Practice Resource Kit aims to provide additional detail to support the implementation of reablement in practice.

The resource provides practical advice to address challenges and barriers identified by service providers in Reablement Learning Logs[1] and seeks to promote a common understanding of good practice.

Who is the resource for?

The resource is designed for service providers involved in the identification and delivery of reablement services within the CHSP.

How is the resource organised?

The resource allows users to dip in and out of frequently asked questions relating to the 5 stages of an episode of reablement:

- Assessment
- Planning
- Service delivery
- Review
- Completion

1 Victorian Wellness & Reablement Consultants Reablement Learning Logs (2019/20) to capture good practice, challenges, and barriers

Where to access further resources

The Department of Health have a range of resources to support reablement activities which can be accessed online:

CHSP Digital Landing Page
https://www.health.gov.au/news/announcements/chsp-digital-landing-page-reablement-resources

Practical guide for embedding wellness and reablement into service delivery (health.gov.au)
https://www.health.gov.au/sites/default/files/documents/2021/01/practical-guide-for-embedding-wellness-and-reablement-into-service-delivery.pdf

Toolkit for embedding wellness and reablement into your organisation
https://www.health.gov.au/resources/publications/toolkit-for-embedding-wellness-and-reablement-into-your-organisation

Reablement CHSP Fact Sheet
https://www.health.gov.au/resources/publications/reablement-commonwealth-home-support-programme-chsp-fact-sheet

Further information

Please contact your local Wellness & Reablement Consultant to discuss opportunities to implement reablement approaches.

Taking a collaborative approach to reablement

Reablement works best when RAS and service providers work together to achieve positive client outcomes. This includes proactively supporting the client's motivation and achievement of time limited goals.

The key elements of the collaborative approach include:

- timely, effective, and efficient communication between RAS and Service Providers
- having a shared understanding of expectations – including timelines, goals, and active client participation.
- a commitment to being proactive and supporting the client to achieve a positive outcome.

Key points of communication

The client record in My Aged Care is the primary communication platform for information about an episode of reablement. Both RAS and service providers should ensure that information about assessment, planning, service delivery, review and completion of service are accurately maintained in the client record. In particular, progress towards goal achievement and changes in circumstances which are likely to impact the client outcomes and/or the period of reablement.

There will be times when other forms of communication such as a phone call or email may be required between RAS and service providers. All parties should be guided by local arrangements and the need to ensure appropriate access to, and clarity about, changes (improvements and challenges) that might impact the outcome of a period of reablement.

The key points of communication are outlined on the following tables.

<table>
<tr><td rowspan="4">ASSESSMENT</td><td colspan="2">The client is at the centre of all communication for both the broad-based holistic home support assessment (conducted by RAS) and the service specific assessment (conducted by service providers). RAS facilitate the assessment discussion with the client to understand their needs, determine appropriate services requirements and make referrals. Building on information gathered during the Home Support Assessment, service providers then engage clients in discussions that focus on information relevant to planning and delivery of service.</td></tr>
<tr><td>Regional Assessment Service</td><td>Service Provider</td></tr>
<tr><td>• Facilitate home support assessment discussion
• Communicate with relevant referral parties as appropriate
• Enter a start date, review date, recommended end date and reason for Reablement in My Aged Care</td><td>• Communicate accurate service description including service availability on My Aged Care
• Review referral (including referral notes) and process
• Review RAS assessment outcomes and support plan</td></tr>
<tr><td colspan="2">Communication outside of the client record on My Aged Care may include phone or email to clarify information shared or needed to progress an episode of reablement. For example, service type or availability, information documented in the assessment outcome or support plan.</td></tr>
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PLANNING

For RAS, planning involves communicating with the client to establish the Support Plan and associated assessment material collected as part of the Home Support Assessment.

For service providers it involves working with the client to develop the service specific care plan which builds on the goals identified in the support plan and guides the delivery of reablement services.

Regional Assessment Service	Service Provider
• Communicate with the client to identify their goals and develop a Support Plan and referral for service • Clearly identify episode of reablement in referral/referral notes	• Validate information communicated in Assessment outcome and Support Plan with client • Complete a service specific care plan which involves the breakdown of goals in Support Plan with client • Collaborate with other providers as required • Communicate commencement date in the client record on My Aged Care

Communication outside of the client record on My Aged Care may include phone or email to clarify information shared or needed to progress an episode of reablement. For example, where service providers identify the need to extend the reablement time period following a clinical assessment.

SERVICE DELIVERY

RAS and service providers should provide consistent messaging about reablement services to clients; that it is time limited and involves the delivery of flexible and timely services that are tailored to meet the individual needs of clients and supports them to have *more good days*. Service providers communicate with clients to engage and motivate them in activities that build on their strengths and support achievement of time-limited goals. For RAS, service delivery may involve coordinating multi-service provision and communicating to ensure all parties are working together to achieve the best outcomes for the client.

Regional Assessment Service	Service Provider
• Modify and amend the support plan with the client as required • Extend end date if the client requires additional time to achieve their goals and the person is still motivated • Communicate with providers to support care coordination • Communicate changes in the client record	• Discuss & determine service specific review date with client • Encourage and motivate client to achieve intended outcome/s • Regularly monitor progress through discussion with client • Modify supports where necessary and communicate changes in My Aged Care notes

Communication outside of the client record on My Aged Care may include phone or email to clarify information shared or needed to progress an episode of reablement. For example, changes to client circumstances.

REVIEW	Communication between RAS and service providers regarding the client's progress and/or achievement of outcomes after a review ensures all involved in the support journey are well informed and well placed to determine how services continue to be delivered or make decisions about ceasing services.	
	Regional Assessment Service	**Service Provider**
	• Undertake review conversation with client and communicate review outcome in client record My Aged Care	• Complete service review with client and communicate changes, progress and/or achievements in client record on My Aged Care
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COMPLETION	Reablement services are time-limited and will therefore include an end date. It is the responsibility of RAS and service providers to communicate the nature of time limited services with clients, including the options available to clients at the end of a reablement period. Periods of reablement may be closed early or extended beyond the original end date, depending on a client's circumstances. It is therefore important that RAS and service providers maintain accurate information in the Client record on My Aged Care so that all parties understand when and why a period of reablement has been concluded. The completion of a period of reablement may result in an exit from the service system or ongoing provision of service.	
	Regional Assessment Service	**Service Provider**
	• Indicate completed reablement period and enter the end date, outcome, and comments regarding achievement of goals • Finalise support plan	• Cessation of service delivery to client, if appropriate • Complete discharge
	Communication outside of the client record on My Aged Care may include phone or email to clarify information shared or needed to progress an episode of reablement.	

Reablement works best when RAS and service providers work together to achieve positive consumer outcomes.

ASSESSMENT

Assessment is a critical element of the client's journey through the aged care system. Both Regional Assessment Services (RAS) and service providers have assessment responsibilities.

RAS conduct a broad-based holistic home support assessment to understand the client needs and to determine appropriate services required.

Service providers are responsible for undertaking service specific assessments that use and build on information gathered during the Home Support Assessment. The service specific assessment may involve clinical assessments or discussion focused on information relevant to help plan and provide the service type they provide.

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When is an episode of reablement identified?

The RAS identify the need for a reablement episode during the assessment discussion and observation of the clients undertaking activities in their home. They do this by identifying recent changes experienced by the client, exploring what is important to the person and encouraging and motivating the person to engage in planning and goal setting that is important to them. Significantly, they determine that the consumer has an opportunity to regain levels of independence through timely and short-term intervention.

Can a service provider initiate reablement episodes?

Service providers cannot initiate reablement episodes in My Aged Care. They can however identify opportunities for reablement during a service specific care plan review. These clients should be referred to RAS for a Support Plan Review.

Service providers should **apply** the principles of reablement with all clients whether clients are formally referred for reablement or not.

What are the indicators that reablement would be a suitable approach?

There are several indicators that demonstrate when a reablement approach may be suitable. These include motivation, goals, and tasks.

Reablement periods work best when the client is motivated to achieve their goal. Each individual's goal will be unique to them – however goals that focus on regaining independence, completing tasks of daily living independently or increasing confidence are suitable goals for reablement.

Age should not be used as an indicator – all clients regardless of age have the potential to maintain or regain confidence and independence.

Who determines the length of a reablement period?

RAS determine the length of a reablement period during the Home Support Assessment considering the client's goals and considering the service availability in the local area.

What if the length of reablement period needs to change?

Service providers may identify that additional time is required to achieve intended outcomes. Likewise, a period of reablement may cease earlier than anticipated because clients meet their goals earlier than expected.

In both circumstances, service providers should record changes in My Aged Care and communicate this to the RAS. The RAS will then review the reablement period with the client and either extend or close the episode of reablement.

Muriel

Muriel has been referred for a 12-week episode of reablement with a physiotherapist at ABC Community Health. On completion of the service specific assessment and care planning process, the physiotherapist recommends Muriel for an exercise program that is due to commence in 4 weeks' time. The program runs for 16 weeks and is generally scheduled to run 3 times a year. The physiotherapist contacts the RAS who completed the assessment to request an extension to the end date for the period of reablement. The RAS extend the period of reablement to include the delay in commencement of the service and considering the length of the program.

How are referrals for reablement generated?

Referrals for episodes of reablement may be directed to a specific service or broadcast across a geographic area, depending on the client's expressed wishes, and considering the availability and capacity of local providers to support the reablement referral.

Service providers must ensure that their service availability is up to date on My Aged Care and changes are regularly communicated to the RAS to ensure that timely referrals by RAS can be processed.

Collaborative relationships that include open, two-way communication between RAS and service providers is critical to ensuring that all parties maintain a local knowledge of service availability and reablement opportunities.

How does a service provider know if an incoming referral is for reablement?

The My Aged Care system does not flag incoming referrals for reablement. Service providers should review the Referral notes, where RAS include details to confirm the referral is for a period of reablement.

When is it appropriate to reject an incoming referral for reablement?

A service provider may reject an incoming referral where there is no availability of time-limited service due to waiting lists.

Service providers should contact the RAS if they have questions or would like to discuss the appropriateness of a referral. It is important, that the service provider add a note on My Aged Care explaining why the referral was rejected (especially where they do not communicate directly to the consumer or referring assessor).

What does a service specific assessment look like for clients referred for a reablement service?

Service providers should review the information collected as part of the Home Support Assessment, including the Support Plan, Assessment Summary, and relevant domains in the National Screening and Assessment Form (NSAF) prior to the service specific assessment. There is no need to duplicate information that has already been received. Instead, service providers should validate and confirm information collected during the Home Support Assessment; and gather additional information needed to inform future service provision, including detailing the way you work with each client.

Assessment is a critical element of the client's journey through the aged care system.

PLANNING

Planning is the responsibility of RAS and Service providers. For RAS it involves the establishment of the Support Plan and associated assessment material collected as part of the Home Support Assessment. For service providers it involves the development and completion of the service specific care plan. The Service Specific Care plan builds on the goals identified in the support plan and guides the delivery of reablement services.

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What if a service provider determines that the client is not appropriate for a reablement service once a referral is already accepted?

There will be instances where a referral for reablement is received and accepted by a service provider, but it is later determined that the episode of care requires more than a time limited service. In these instances, service providers should contact the RAS to discuss the circumstances. RAS can end periods of reablement early and, depending on the individual circumstances; record a partially achieved outcome for the period of reablement. Service providers should continue to apply the principles of wellness and reablement to support the client to achieve their best outcome.

What if a client is appropriate for a reablement service but this has not been identified as part of the RAS Assessment?

See 'Assessment' section. Service providers should apply the principles of reablement with all clients.

If a provider identifies a reablement opportunity for an existing client they should refer the client back to My Aged Care for a Support Plan Review, clearly documenting the reason and service recommendation. RAS assessors will conduct the review and recommend a period of reablement where appropriate.

RAS are unable to assign reablement services when the client is referred to ACAS for an assessment.

Maintaining regular communication between RAS and Service Providers about opportunities for reablement within relevant programs enables maximum potential for appropriate reablement referrals.

What does a service specific care plan look like for clients referred for a reablement service?

This plan breaks down the reablement goals identified in the Support Plan into achievable steps and strategies with clear timelines and points of review.

How does service planning differ for clients referred for a reablement service?

Given the nature of time limited goal focused services, it is likely that reablement services may require a greater level of flexibility; both in the number of hours-of-service delivery and the scheduling or frequency of contact with the consumer. It is expected that the level of service will vary during the reablement period – with support reducing as a client's confidence or functioning increases.

How is service monitoring and review planned?

RAS set a review date for episodes of reablement during the Home Support Assessment.

Service specific review dates should align with the review dates set by RAS, and be agreed upon with clients, as part of the initial service specific planning. based on their goals, the service type, and the length of the reablement period.

Clients involved in reablement services may require additional monitoring and review by the RAS and service provider to measure their progress towards goal achievement.

SERVICE DELIVERY

Service delivery should be approached as being time limited at the onset and involving the delivery of flexible and timely services that are tailored to meet the individual needs of clients identified thought the care planning process. Service providers support clients to engage in activities that build on their strengths and support them to have more good days. For RAS, service delivery may involve service coordination of multi-service provision for clients accessing a reablement service.

SERVICE DELIVERY

RAS and service providers should provide consistent messaging about reablement services to clients; that it is time limited and involves the delivery of flexible and timely services that are tailored to meet the individual needs of clients and supports them to have *more good days*. Service providers communicate with clients to engage and motivate them in activities that build on their strengths and support achievement of time-limited goals. For RAS, service delivery may involve coordinating multi-service provision and communicating to ensure all parties are working together to achieve the best outcomes for the client.

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How does service delivery with a reablement client differ to the way they might work with other clients?

Given the nature of time limited goal focused reablement services, it is likely that episodes of reablement may involve a greater level of flexibility; both in the number of hours-of-service delivery and the scheduling, or frequency of contact with the client. It is expected that the level of service and support is closely monitored so that these can be varied as a client's confidence or functioning increases.

What if the client's circumstances change during service delivery?

In addition to considering the intensity of supports, service providers should consider how staff undertake this support. This may include using and encouraging strategies and techniques such as:

- engaging clients in discussion about how they have overcome or addressed a similar situation in the past
- Activity Analysis – breaking a task down into smaller and easier steps to finish
- working with the client and/or family
- providing access to aids and equipment

More information on these techniques can be found in the My Aged Care Learning Environment (MACLE).

Service delivery for reablement services will be different for each client, tailored to their specific needs and goals.

What is the role of a RAS after the referral has been accepted by the service provider?

RAS continue to have a co-ordination and review role throughout the period of reablement.

RAS can provide coordination support throughout the different stages of a reablement period, particularly when there are multiple service types involved.

RAS should set regular review dates with the client and ensure that that these reviews are completed; and the outcomes communicated to all parties.

Service providers should document client progress (improvements/regressions) in My Aged Care notes to support the RAS review discussion with the client. Similarly, RAS will document their correspondence and any other relevant notes relating to the Reablement episode in My Aged Care.

RAS staff

RAS staff coordinate different service types as needed and can act as the link between different service providers.

Christine's goal is to be able to do her own shopping again following a recent fall. Christine has been referred to Physiotherapy to increase her physical strength and mobility, as well as for Shopping Assistance... Whilst Christine is commencing physiotherapy to build strength and increase her confidence, she may require Domestic Assistance and have Shopping assistance undertaken for her. As her strength and confidence builds, Christine may transition to undertaking shopping with support.

How might episodes of care be monitored during reablement?

Service providers should have systems in place to ensure regular monitoring of the client's progress towards achieving their goals. It is also important to have processes in place to ensure that feedback about progress is shared with appropriate staff and RAS.

Some service providers have found that booking multiple reablement appointments for a reablement client from the onset is beneficial and helps with monitoring progress.

Given the nature of time limited services, it may be appropriate to establish more regular monitoring and feedback at a service delivery level to ensure that any changes in the client's circumstances can be identified early and flagged for attention.

REVIEW

Regular reviews during a period of reablement involve checking with the client to ensure that they are on track to achieve their intended outcomes. Both service providers and RAS are responsible for regularly reviewing a client's progress during a period of reablement. For RAS, this involves maintaining regular contact through the reablement period – both with the client and service providers as required, and final review toward the end of the reablement period. For service providers, service reviews should be established within monitoring and feedback processes.

REVIEW	Communication between RAS and service providers regarding the client's progress and/or achievement of outcomes after a review ensures all involved in the support journey are well informed and well placed to determine how services continue to be delivered or make decisions about ceasing services.	
	Regional Assessment Service	**Service Provider**
	• Undertake review conversation with client and communicate review outcome in client record My Aged Care	• Complete service review with client and communicate changes, progress and/or achievements in client record on My Aged Care
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> Any review outcomes or discussions should be included in the Notes in My Aged Care.

Who is responsible for leading the review process for episodes of reablement?

RAS and service providers both have responsibility for reviewing the clients progress towards goal achievement. RAS are primarily responsible for leading the Reablement period review in collaboration with the client.

Service providers are responsible for regularly monitoring the services in place and reviewing the progress toward the client goal.

What does the review process for an episode of reablement involve?

The review process involves a discussion with the client (and/or their carer) to understand how they are progressing towards goal achievement.

For RAS, the review process will be undertaken as part of the scheduled reablement review (mid-point & final) or in response to feedback from the client or service provider. The review discussion should focus on what's working well and what opportunities exist to further meet the client's goals or identify new goals. The review process is a great opportunity to reinforce the value and benefits of a reablement service and to motivate the client towards goal achievement.

For service providers, a review may be triggered through their monitoring and feedback processes including information shared by the direct care staff.

It is important that RAS and service providers respond flexibly to the outcomes of a review. This may involve:

- adjusting the service plan and delivery,
- extending the end date of the reablement period if the client requires a small amount of additional time to achieve their goals, or
- ceasing a reablement period if goals are achieved or if ongoing services are required.

How often should reviews occur during a reablement period?

A mid reablement review date is identified by RAS at the establishment of the reablement episode. Additionally, RAS and service provider reviews should occur throughout the reablement period when changes are identified. RAS will complete a final review with the client at the end of the reablement period.

Where are the outcomes of a review recorded?

It is important that the outcome of reviews are communicated between RAS and Service Providers.

Any review outcomes or discussions should be included in the Notes in My Aged Care.

What happens if the outcome of a service review identifies that the client requires more time to achieve their goals?

Where the outcome of a service review identifies the need for additional time to complete the episode of reablement, the service provider should contact the RAS to discuss. RAS have flexibility to extend the end date of a reablement period for a short time. This will depend on the nature of the service, the additional time required (generally less than 4 weeks) and the client's level of motivation.

Where a longer period of time is required, RAS staff may close/end a reablement period and provide an ongoing referral which the Service Provider can manage as needed – i.e., Establish short term review.

What happens if the outcome of a service review identifies that the client's circumstances have changed, and they are unlikely to achieve their goals?

When service providers undertake a service review and it is determined that the client circumstances have changed, deteriorated, or identifies that the client may now require additional services the service provider should advise the RAS and document the review outcome within Notes in My Aged Care. RAS can then undertake a final review and may cease the Reablement period and arrange ongoing services instead.

Can an episode of reablement be initiated from a support plan review?

Yes. RAS can initiate a reablement period during a support plan review.

If a service provider has identified a client who may benefit from a reablement period, they should request a Support Plan review via My Aged Care.

Service providers should include specific information regarding the change in circumstance and can offer service recommendations.

It is important to note that the My Aged Care system will automatically assign the 'reablement period' to the last assessor (last full Home Support Assessment) and RAS Outlets will need to manually reassign the client to the current assessor.

COMPLETION

Reablement services are time-limited and will therefore include an end date for service delivery. At the conclusion of a reablement period, both service providers and RAS have a responsibility to ensure that the outcomes of the intervention are recorded appropriately and that the needs of the client are addressed. This may result in an exit from the service system or ongoing provision of service.

COMPLETION	Reablement services are time-limited and will therefore include an end date. It is the responsibility of RAS and service providers to communicate the nature of time limited services with clients, including the options available to clients at the end of a reablement period. Periods of reablement may be closed early or extended beyond the original end date, depending on a client's circumstances. It is therefore important that RAS and service providers maintain accurate information in the Client record on My Aged Care so that all parties understand when and why a period of reablement has been concluded. The completion of a period of reablement may result in an exit from the service system or ongoing provision of service.	
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What happens when an episode of reablement ends?

Following the final review of the reablement period, RAS Staff will finalise the support plan, end the reablement support period, record the client's goal attainment (met/partially met/not met) and record the outcome of the reablement period in My Aged Care.

What happens when an episode of reablement ends, and the client's goals **have been** fully met?

RAS will report the outcome of the Reablement period within My Aged Care.

Service providers will be notified of the completion of a reablement period by RAS in the Notes section of My Aged Care.

Service providers then need to undertake necessary actions within My Aged Care to end the service date.

What happens when an episode of reablement ends but the client's goals **have not** been fully met?

On completion of a reablement period, it is likely that some clients will require ongoing services.

In these circumstances, RAS will finalise the Support Plan and end the period of reablement.

The assessor will discuss the need for extended or ongoing services with the service provider. This may require the service provider to remove any scheduled service 'end date' to ensure that the clients service continues. In some cases, referral for additional services may also be required.

Service providers will need to establish and agree on new ongoing service arrangements with the client. This will involve creating a new Service Specific care plan that includes review dates.

Clear communication between RAS and service providers is essential to ensure smooth transition from Reablement to on-going services.

Can clients re-enter the service system or access another Reablement period in the future?

Yes. If a person's circumstances change and they require support to regain or maintain independence into the future, they may contact the My Aged Care Contact Centre for a Support Plan Review or re assessment at any time.

Measuring client outcomes and goal attainment

When a period of reablement ends, RAS record the client's goal attainment in My Aged Care as:

- goal met
- partially met or
- not met

Determining goal attainment requires a conversation with the client to understand the extent to which the client has achieved their identified goal/s and expected outcomes.

Additionally, RAS staff record the outcome of the Reablement period as being:

- No further action required
- CHSP required
- Other services required
- Services unavailable
- Client deceased
- Client opted out
- Incomplete

There will be times when an episode of reablement is ended before the full reablement period is completed. In these circumstances, RAS will determine the extent to which goals are achieved and record outcomes accordingly in My Aged Care.

The Reablement in Practice Resource is developed by the Victorian Wellness and Reablement Consultants to support a common understanding and good practice approach to Reablement. The Victorian Wellness and Reablement Consultants acknowledge and extend thanks for the contribution of service providers in the development of the resource.

This working document reflects current good practice and may be subject to changes to reflect evolving reablement approaches and practices. The information provided does not replace existing material that is available to support and/or promote wellness and reablement as part of the CHSP. Please refer to relevant program manuals and associated documentation for further information.

The Victorian Wellness & Reablement Consultants are supported by the Australian Government Department of Health. Visit the Department of Health website (http://www.health.gov.au/) for more information. Disclaimer: Although funding for this resource has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.

Version 1.1: Current as at May 2022

Reablement goals generally aim to support clients getting back to doing things for themselves and regaining independence.

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