APPENDIX A

AN ACTIVE SERVICE APPROACH - WHAT DOES IT MEAN IN PRACTICE FOR THE SERVICES AND CLIENTS?

Case examples from Councils in Victoria that were involved in pilot projects :

1. Mr T is an 83 year old man who was referred to Council for personal care.
He had fallen a fortnight ago and although he sustained no specific injuries, he was now lacking in confidence and wasn't showering himself. He was motivated to regain his independence again, and in fact was adamant that he wouldn't have other people showering him.
Supporting his goal to shower himself, a care plan was developed to:

- Connect him to physiotherapy to improve his balance and strength and to provide some falls education;
- An Occupational Therapist bathroom assessment re fitting equipment to assist him to shower safely, followed by Councils home maintenance installations and modification work;
- A Council male personal care worker chosen to work with him, respecting his privacy and feelings, to build his capacity and confidence to shower on his own again using the new equipment. Meanwhile, the home carer shows him how and supports him to maintain adequate levels of personal hygiene himself, with minimal intrusion and supervision.

After four weeks of a three day a week personal care service, plus the Physio and Occupational therapists' interventions and home maintenance, he had regained his independence in showering himself and HACC services were no longer required.

In this example, Mr T received the care he needed, when he needed it and for the time he needed it, and in a way that allowed him to remain in control and respected what mattered to him.

2. Mr. and Mrs. C were referred to their local council by their general practitioner for a home care service. The assessor found that Mr. C used to do most of the house cleaning tasks prior to his recent hospital admission for a fall and other complicated medical issues. Mr. C now had reduced mobility and was no longer able to vacuum or wash the floor. Mrs. C was on 24 hour oxygen and experienced shortness of breath after minimal exertion during cleaning tasks.

A care plan was put in place aimed at increasing their physical capacity as well as strategies to facilitate their ability to resume cleaning tasks.

Mr. C was referred to physiotherapy for an ongoing exercise group to increase his mobility and Mrs. C was engaged in home care tasks with alternative techniques and equipment.
On review, Mrs. C had purchased her own motorized light weight carpet sweeper and was cleaning a room or two at a time. She had purchased a microlite mop and was managing to wash the floors well. Council instituted a reduced ongoing service of .5 hours per month to vacuum the corners. Mr. C's mobility was slowly improving and he assisted his wife with other household tasks such as meal preparation and washing up.
Mrs. C commented; *"There is a big difference……the gadgets you've recommended have made cleaning a lot easier……..now I can last longer".*

Without an assessment which focused on their strengths and opportunities for building capacity, it is likely that the C's would have received an ongoing fortnightly home care service that would have completed tasks for them. They were motivated to do as many of these tasks themselves and were assisted to simplify the tasks and build their confidence in using new equpiment.

3. Mrs.D is an 80 year old, living in an inner city Office of Housing flat. In September 2007, she had two falls a day apart. In the second fall, she broke both an arm and a hip and was hospitalised for 3 weeks. Prior to the falls, she lived at home independently, with occasional assistance from her son who lived nearby. On discharge she returned home and her son moved in with her temporarily to provide assistance.

Her son was concerned at her slow progress and lack of confidence to go out, despite physiotherapy, and enquired about other community services. The physiotherapist suggested he talk to council and she was assessed in late November. They were allocated 1½ hours home care and 3 hours in-home respite per week. A joint review with the CHC Occupational Therapist and the Council Assessment Officer was completed in mid January 2008, with a focus on capacity building. At this stage, the only time Mrs. D left her flat was with her son to attend weekly physiotherapy at the local Community Health Centre. She expressed a fear of falling and was continuing to experience ongoing pain in her arms and back.

During the review, Mrs. D commented on the link between her pain and her activity levels, stating that she feels less pain when she goes out and talks with people. She acknowledged that remaining sitting at home increased her pain and her fear of falls, as she continues to think about them. She also stated that she was not sleeping well. The OT discussed the link between activity levels, pain and sleep and Mrs. D expressed a wish to increase her activity levels, but remained fearful of falling.

The review resulted in a change of service for Mrs. D. The home care remained at 1 ½ hours weekly, given her physical limitations, but with encouragement for her to participate more (e.g. putting the dishes away, dusting), to get used to working alongside the home carer, rather than just sitting whilst the carer did everything. Rather than 3 hours of in-home respite, she began to receive 1 hour of respite weekly with the home carer taking her to and from a Greek seniors group. As her confidence developed, she was able to go in the community bus with others to these activities. Her son was also encouraged to take her out shopping, rather than do the shopping for her.

4. **Mrs A** is an 82 year old widow who lives alone and has assistance with home care. Following training on incontinence, the home care worker observed that Mrs A had a problem with incontinence and discussed it with her, the possibility of having this assessed and getting more advice on how to manage it. Mrs A said that she manages her life's activities around her continence issues, but would rather have more control.
The Councils Home Care Team Leader arranged for a home based continence assessment and the RDNS continence nurse and Mrs A identified her goals:

- To attend her granddaughter's wedding in the country in 4 months;
- To improve her walking; and ,
- To make it easier to go to the toilet at night.

The nurse developed a continence management plan with Mrs A; made referrals to physiotherapy and, ensured the Council's home care staff were informed of all strategies so they could reinforce and support Mrs A.

After 12 weeks Mrs .A noted a marked improvement in her ability to control her bladder which she attributes to the support from her home care worker. She sleeps better at night with the commode by her bed as she can get in and out quickly without any 'accidents'. Her mobility has improved with her walking frame and she no longer suffers shoulder pain from using a single stick. She has already booked her accommodation for her granddaughter's wedding