THE INDEPENDENT LIVING PROJECT

FINAL REPORT
April, 2007.

Moreland
Home care tasks made easier

balance
the work
new habits
plan ahead
rest
the right equipment

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Executive Summary

Moreland Council has been trying to find ways of addressing the unmet demand for its' home care service. Faced with a large service base with low turnover, high community expectations of entitlement and an ageing population, Council's service had been struggling to manage waiting lists of those eligible, but not a priority for home care, as well as long delays in home based assessment for those assessed at Intake as not being in urgent need. It was estimated that approximately one third of all referrals for a home care service were neither urgent nor a high priority, yet not having the resources to respond to this group created distress, criticism and dissatisfaction, and little was known about how these people fared. Several recent Australian reports on community care suggested that those not receiving a service did less well than those who did, and that access to even one service can be a protective factor. (Turvey and Fine, 1996; Howe and Gray, 1999)

The Independent Living Project was devised to test out assumptions that many of the residents waiting for a home care service, and those being referred as non urgent, could possibly be assisted to better manage their own housework. It was also felt that those with a lower priority needed a different service approach, rather than being ignored. Given that most of Moreland's assessment staff had welfare backgrounds and were used to seeing home care as a way of providing an on going support service, it was decided to employ an occupational therapist, and to take a much more focused review of functional capacity in household tasks, and to try and find ways of assisting people to improve this capacity, through changes to equipment, techniques and physical capacity.

The project started small with enough resources to run the trial for 6 months and start with 30 people already on a waiting list for home care. It was expanded for another 12 months and 117 people by funding from the Department of Human Services (DHS) as part of the Home and Community Care Program (HACC) Active Service Models' pilot project, which also involved assistance from an external evaluator, and the peer support and learning from DHS staff and the other pilot projects.

There were difficulties trying to offer the ILP approach alongside the mainstream home care service, as it was hard to describe it to people, and having it accepted as a choice or more appropriate alternative, rather than a second best service, when all they wanted was a home care service. This lead to a series of stages in recruitment as the project tried different approaches and it evolved in an action research way. The analyses of how stage of recruitment impacted on outcomes has been somewhat mixed, as the uptake was greater when clients were streamed at Intake and the ILP home assessment was used as the response to their referral or request for service, but the level of improvement in functioning was greater with the clients recruited first, who had already been assessed and wait listed for home care. This could be because a higher proportion of the Stage I clients had been assessed at the lowest priority category (3) and Stage 2 had a higher proportion of medium priority (2) than in Stage 1, and thus there was more potential for achieving independence in the Stage 1 group.

147 people, in 96 households participated through the project to 3 months, with 28 of them also being reviewed at 12 months. With 2 exceptions, they all had medium or low priority for receiving a home care service. Difficulties in performing vacuuming, cleaning floors and bathrooms were identified as the three core household tasks commonly leading to a referral.

At ILP assessment, 65.3% of households were managing some or all core tasks independently, but with some difficulty; 23% were independent and 10.6% needed others to assist or do it for them. After three months, nearly two thirds of households (63.4%) had improved in their capacity to undertake one or more tasks independently, nearly a third (31.3%) made no improvements and 5.2% had deteriorated, or had mixed results of improving in some tasks but deteriorating in others.

Factors which seemed to link positively with improved functioning were:

- taking up all or most of the recommendations (particularly equipment and techniques),
- living alone,
- being aged between 75 and 79 years,
- having a low priority for home care,
- receiving some, but not necessarily the ongoing standard home care service intervention (e.g. spring clean, short term help), and
- having physiotherapy during the project period.

67% of the households reported an increase in confidence following their involvement with the project. 16 households reported an increase in confidence despite not making any improvements in tasks, or only improving in one task.

Most participants had connections to family, social activities or community groups and were involved in some form of regular exercise, most commonly walking. Although the project had some success in linking participants to additional physical of social capacity building activities, this worked best when an initial physiotherapist assessment was needed, and then a supported exercise program followed, as for many, there are barriers to overcome, such as cost, transport, confidence and motivation, to just joining a gym or other activity alone.

Although only half the participants responded to questions about the difference the project had made to them, most responded positively about it making things easier, feeling re-assured, encouraged and more confident, with more knowledge about alternative aids and accessing other services (especially physiotherapy). Twelve households reported that it had made no difference, reiterating that they still wanted a home care service. Participants in the Italian speaking focus group also reported dissatisfaction in not getting a home care service as an outcome of participating in the project, expressing their `right' to access Council home care as they had worked hard and paid taxes. There needs to be consistency and clear messaging about entitlement, assessment, priority of access and the place of home care services in supporting older people to live more independently at home.

Overall about two thirds of those participating in the project made improvements, although only 18% improved to independent level in all three tasks (and 23% were already independent). This suggests that a capacity building approach to functional assessment is successful, but that for many people it will not lead to them not requiring any assistance from services. It is more likely that the home care services need to be applied more selectively to achieve the tasks that cannot be done alone, and to restore or to build confidence and capacity in continuing to do other things. The project also indicated that more people can benefit from and need to be accessing physiotherapy.
The cost data indicates that although the ILP approach is more expensive at the front end i.e. in assessment and review visit time, and following through implementing the service plan, there are savings to be made in the amount and length of home care services needed. Given that most of the households in the ILP project would not have been getting a standard home care service in Moreland, it is thus difficult to be definitive about the longer term cost benefits and more work would need to be done on this area.

Although the ILP project started as a demand management strategy targeting low priority clients with alternate service options, its' possibilities as a capacity building approach to assessment and service delivery, which could be applied with benefit to clients at all three levels of priority, became more apparent over time. The Integration trial and workshop on assessment and home carer training, were steps towards understanding the elements necessary to achieve this. It has been beyond the resources and timing of this project to develop a full implementation plan for integrating the active service model in to the mainstream home care service and this will need further development. This will occur as the Department of Human Services reviews the evaluation and recommendations from all the Active Service Model projects and develops responses and as Moreland implements some other changes designed to strengthen assessment capability in its' home care structure.

Section One: Introduction

1.1 Facing Unmet Demand for Home Care

Like many Home and Community Care (HACC) providers, Moreland City Council has had difficulty in meeting the demand for home care services. Prioritizing services to those most at risk, reducing the average amount of service provided to households and reviewing existing clients to see if their needs had reduced, were strategies tried with little real impact on waiting lists for assessment and service provision. Although about one third of people requesting home care, and expecting it as a service Council provides for older people, have a relatively lower need for the standard home care service and are thus unlikely to get it, not accepting their referral, or putting them on a wait list that doesn't move, creates dissatisfaction with Council and is not an adequate response in terms of assisting people to manage better.

1.2 Finding a Better Response to the Unmet Need for Home Care

Moreland City Council decided to approach the problem from the opposite end by focusing on those with lower needs. Could people be assisted to manage their housework better themselves? Would this be a more proactive approach rather than the model of service currently in place which left them excluded from a service they felt they needed? How could this be done? What resources would be needed? What impact would this have for individuals and for service provision?

This lead to the development and trial of the **Independent Living Project (ILP)** which commenced in September 2004. The project started with the premise that people assessed as a low priority for home care services may be able to manage their own home care with adequate support to learn alternative methods, trial adapted equipment or undergo environmental modifications. It was felt that this would be best supported if their capacity to continue to manage their own home care was maximized through access to health promoting activities. Whilst the project commenced as a demand management strategy, it naturally evolved into a capacity building approach over the course of the initial pilot. This was enhanced by learning about and contact with similar projects in Western Australia and Queensland.

The project was extended in 2005 with the provision of funding from the Victorian Department of Human Services (DHS) under their HACC Active Service Model project. The Department is seeking to move the HACC Program from a dependency model of service delivery to capacity building and restorative care to improve people's functional abilities and quality of life, and delay or reduce their need for standard HACC services. The aim of the Active Service Model project was to investigate innovative service models that provide active intervention to facilitate older people to achieve their highest level of independence. The Independent Living Project became one of five funded pilots across metropolitan and regional Victoria.

Section Two: Background

2.1. Home and Community Care (HACC) Services

The HACC program funds basic maintenance and support services targeting frail aged, younger people with a disability and their carers. The major goal of the program is to *"enhance the independence of people in these groups and to avoid their premature or inappropriate admission to long term residential care"* (Victorian HACC Program Manual, February 2003:4). Targeting of the program is focused on client need with priority given to those with higher support needs.

The program is a joint Commonwealth / State government program and is financially supported by service providers and client fees. In Victoria, local government is the major provider of home care, home maintenance and delivered meals and contributes substantial additional funding into these and the related community care services it provides. In Victoria in the 2003-04 financial year over 216,000 people received a service from the HACC program. The majority of clients were aged 70 years and over, female and 40 % lived alone. Home Care was the most utilized service with over 72,387 recipients at an average of 33 hours per year each (Department of Human Services, Victoria, 2004).

2.1.1 Targeting in Community Care

Difficulties accessing residential care, higher community awareness and expectations to remain at home, workforce and financial pressures, and an ageing population are all factors facing HACC service providers in meeting the demand for provision of services. Shorter hospital stays, more outpatient and day treatments and no post acute home care provision from private hospitals, have also contributed to increased demand for HACC services. Often services target the people with higher needs and those who would benefit from a brief intervention or low levels of service are ignored (Matthews, 2004). The dilemma faced by many services is the debate about who to target, who misses out, how to maintain equity and how can services respond to the client demand.

It is not surprising that the common response has been to target assistance to those with the greatest immediate need, but the result is that those who required only small amounts of basic help have done without. This raises important questions for policy and for service providers. Who are those with the greatest need? What happens to those denied assistance? Would it be more effective to provide help in a preventative manner to the large number of those who only required small amounts of help, rather than focusing all effort on those few who need much more substantial amounts of assistance (Shaver in Turvey and Fine, M., 1996, Forward).

Research undertaken by Bebbington and Davies (1993) in the UK concluded *"to provide substantial services to some would be at the cost of the loss of services to many others"* (p. 374). They question the real cost of limiting or denying access to those with lower support needs, suggesting that they may decline in function without support and in the end cost more to the public purse. Other researchers (Isaacs, Livingstone and Neville, 1972) support this view, stating that neglect of service provision can often result in increased hospital admissions.

Howe and Gray (1998) and Davies, Bebbington, Charnley, Baines, Ferlie, Hughes and Twigg (1990) found that clients in receipt of higher levels of service were not necessarily better off than those in similar circumstances with lower support levels. In NSW there has been a trend *"towards a more intensive service allocation…with fewer people/ households receiving assistance, and an increasing concentration of resources on those clients with needs for greater amounts of support"* (Turvey and Fine, 1990:14).

Turvey and Fine (1996) found that over a period greater than 12 months, assistance with a basic level of home care service was associated with reduced mortality and a reduced rate of admission to residential care compared to those who received no support. This was also supported by the consultancy undertaken by Howe and Gray (1998). They further concluded that the group who were denied services reported a reduction in their need for help over time. Was this because they

had to cope and therefore found better ways to manage? The study participants stated they completed the heavier housework only when they felt able and had learnt to conserve their energy and simplify the tasks. This led the authors to question *"At what cost to the health and well being of the subject is the requirement to do heavy housework when he or she feels tired or unwell? What effect does the inability to maintain their homes as they would wish have on their quality of life and morale?*" (p. 44).

It was also suggested by Turvey and Fine (1990) that the provision of HACC services to clients, even at low levels, appears to reduce the decline in client ability and help them remain stable. It also appears to act as preventative measure for hospital admission and length of stay. *"Although it was not possible to demonstrate improved health outcomes for recipients, the positive effects of basic home help on the subjects perceived quality of life and subjective well being were undeniable*" (Turvey and Fine 1996, p. 67). Howe and Gray (1998) concluded that client independence can be restored with the provision of low cost services, advocating the allocation of one off services to clients with lower support needs to reduce the unmet need.

Turvey and Fine (1996) identified that reassessment of clients in receipt of services and the rationing of these services as per the clients' changed needs was a better solution than denying clients access to a service at all. *"If it were possible to reduce the length of service for a proportion of clients by enhancing their capacity to continue to live at home independently and providing them with the security of ready access to further assistance should their condition become unstable or their need for help increase, an equivalent proportion of resources would be freed up to provide assistance to applicants currently excluded"* (p. 73).

Anecdotal evidence from home care staff employed by Moreland Council indicated that there are clients in receipt of a regular service who probably do not continue to need the same level as they initially required, but the majority of clients are very reluctant to relinquish any service, as they are aware of the scarcity of hours and fear not being able to receive an increase if their needs change. It has also been suggested (Howe, in Lewin et al, 2001) that removal or reduction in existing services can be detrimental if the client has not been given the opportunity to regain function and their ability to resume the tasks. The provision of the current model of home care services is likely to be fostering dependence and loss of autonomy for some service users.

2.2 Moreland Council HACC Services

2.2.1 Moreland's Older Population

The growth in demand for Council's home care service has been largely driven by the growth in the aged population over the past decade. Moreland has a large ageing population from diverse cultural and linguistic backgrounds. Nearly 17% of the population is aged 65 years and over, compared to the metropolitan Melbourne average of 12.3%. The 2006 Department Of Infrastructure estimates suggest there are 17,746 residents aged 70 years plus and nearly 40 % of these are aged over 80 years. Whilst the total number of older people is not expected to increase significantly in Moreland over the next 5–10 years, the proportion of the very old (80+) will. Over half (51%) of those aged over 65 years do not speak English at home and 25% of these are not proficient in English. Italians and Greeks are the largest non English speaking older groups, with Italians representing over a quarter of Moreland's 65+ years population.

2.2.2 Moreland HACC Services

Moreland City Council is one of the larger Local Government HACC services in metropolitan Melbourne. In 2004/5 it provided 150,000 hours of home care, 6,896 hours of home maintenance and 171,000 meals to 4,773 local residents. Sixty four percent of HACC clients were female, 91% were aged over 60 years and 45% were aged over 80 years. Forty one percent of Moreland HACC clients live alone. Older HACC clients are more likely to live alone, with 49% of clients aged 80 years and over living on their own.

Two thirds of Moreland HACC clients (63%) use homecare services, a third (35%) home maintenance and one in four (26%) meals at home. Cultural background has an influence on the service type used, with clients who speak a language other than English at home less likely to use the meal services provided by HACC, but are more likely to use personal and respite care. The majority of Moreland HACC clients (70%) used only one service type.

Fifty nine percent of Moreland HACC clients speak English at home, with thirty one other languages being spoken by Moreland HACC clients in 2004-05. 1,237 or 26% of Moreland's HACC clients speak Italian at home. Thirty eight percent of Moreland HACC clients were born in Australia and 43% were born overseas in non-English speaking countries. Moreland's HACC clients were born in 56 countries: 1278 were born in Italy (27%); and, 201 clients were born in Greece (4%).

One third of the home care clients are Italian. Both English and Italian speakers aged 60+ are generally over represented in their use of home care, compared to their proportions in the population generally. At ages 70–79 years Italian speakers were 35% of the home care clients, although only 28% of the 70-79 year old population. At 80 years and over, 32% of home care users were Italian speakers compared to 21% in the Moreland population. Thus the home care service appears a highly accepted and valued service for many older Italians in Moreland, as the uptake is no where near as high for Greek or other language groups, nor do Italian speakers use the other HACC services to the same degree as home care.

There were 2,400 referrals for HACC services and 461 Moreland HACC clients (10%) exited the service in 2004-05. Of those who discontinued using HACC Services, the majority ceased because of death (31%) or because they moved into residential, institutional or supported accommodation (21%). Only 12% exited because they no longer needed the service.

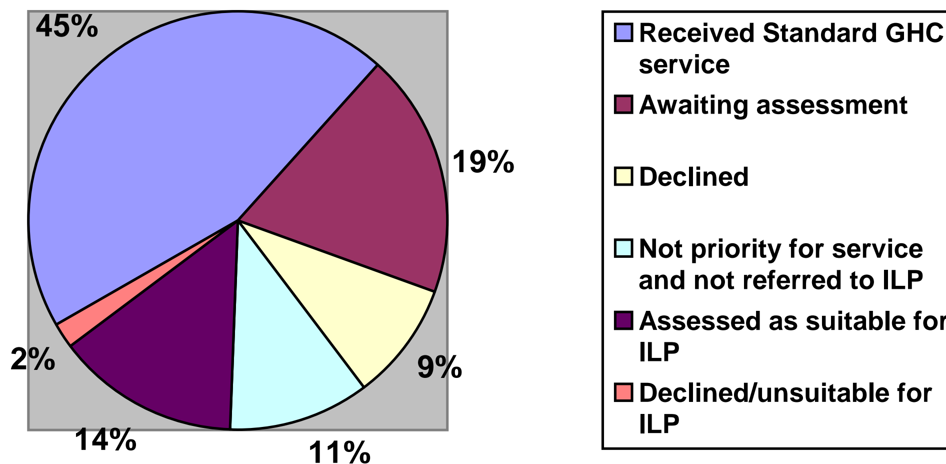
2.2.3 ILP and Home Care

The highest demand at Moreland City Council for HACC services is for the provision of general home care. Housework has *"considerable cultural and emotional significance, its performance being one of the attributes that defines a home and indicates the competence of the resident"* (Turvey and Fine, 1990:12).

In 2004/5, 3,175 clients (68%) accessed home care at an average 29.59 hours per year per client. This is under the Victorian average of 33 hours per year per client which indicates that home care is more rationed in Moreland than in many other areas of the State. Five hundred and fifty eight new clients (558) commenced on home care with 539 clients ceasing the service. This is a net gain of 19 clients for the year.

During the ILP project period, January 2005 – June 2006, Moreland City Council received 932 new referrals for General Home Care (GHC) services. Forty five percent (n=423) received a standard home care service after assessment. Nine percent (n=81) were assessed as a priority but declined, or did not go on to receive the service. Twenty seven percent of those referred (n=255) were not considered a priority for service. Of these, 51% (n=131) were assessed as suitable for the ILP project, 8% (n=21) being unsuitable or declining to participate and 41% of those not considered a priority for service, were not referred for assessment with ILP. It is unknown what proportion of these were offered ILP at Intake or following a standard assessment and declined. Nineteen percent (n=176) were still awaiting assessment at the project's completion.

Chart 1: Home Care Referrals and Outcome during ILP



Moreland seems to have a particular set of circumstances, undoubtedly related to funding, past allocation practice and demographic ageing, which has lead to a large base of long term service users, with turnover lower than demand. Moreland has had significant growth in its' aged population over the past decade, but until 8 years ago, was largely able to be provide home care to the majority of people needing it, even at lower levels of need. Council also used to provide a substantial number of hours above the HACC funded hours, but has been unable to sustain this as HACC subsidy Consumer Price Index (CPI) increments per annum set by the Commonwealth, are well below true wages growth, so subsidizing this shortfall each year, restricts Council's ability to sustain the additional unfunded hours, and put more resources into the assessment and review functions, which have also not been well funded in the HACC program. Moreland has more funded home care hours than the other Northern metropolitan region Councils and also has a higher proportion of its' HACC eligible population using the service. Although the demand now outstrips the supply, the expectation is that Council can continue to provide services as they have done in the past. Community expectations about home care eligibility and provision are generally incongruent with the reality. It is not unusual for people living in Moreland aged over 65 years, or their children, to feel they should be entitled to home care services because they are ageing and they have paid their rates, or because they know someone else who gets it whom they believe is no worse off than them. This entitlement perspective makes it difficult to understand relative need and prioritizing.

Moreland City Council HACC services have also had difficulty meeting the short term needs of clients in a timely manner. For example, Mr. Biggs who has recently had a private hospital admission requests home care until he is able to resume his own cleaning. It is likely that the delay to undertake an assessment would mean that he would have fully recovered before he received a service, or, if a timely assessment was completed, that he would receive a regular ongoing service, possibly without timely review. Either scenario means Mr. Biggs misses out on a service he would probably benefit from for a short period, or that he receives a longer term service that he really only needed for a short time and someone else misses out. Even when reviewed, it is likely he has become dependent on the service, enjoys the home carer visits and assistance and is reluctant to do without it, which after all is usually only every fortnight for an hour and a half, so doesn't seem excessive. The perception that there are long waiting lists for home care services has also encouraged people to refer themselves at a point when they are just beginning to find housework more difficult, but are still managing, "just in case" they need the service more in the future, or because they believe they will benefit from and are entitled to such help, or know

someone else, no more needy, who receives a service. This in turns delays the assessment and service provision to clients who need the service more immediately and uses up resources responding to complaints and client enquiries re the delays. The service has operated in a reactive framework and is looking at ways to turn this around.

2.3 Alternative HACC Models

2.3.1 The Home Independence Program

A large Western Australian HACC provider, Silver Chain Nursing Association, operates the Home Independence Program. It is *"a home based early intervention program directed at preventing, reversing or slowing down the disablement processes resulting from ageing and chronic disease associated with ageing*" (Lewin, O'Connell, Wheeler and Acker, 2001). It evolved from the increasing dilemma faced by many HACC providers where demand has outstripped supply. Silver Chain found themselves with over 1000 people on their waiting list, their books closed to new referrals and requests for service outnumbering the discharges from their service. This coupled with the reality that many of the people already in receipt of care were becoming increasingly more dependent and requiring an increase in services (Lewin et al, 2001).

Silver Chain chose to respond to this situation with the development of an innovative project designed to maintain or improve functional independence and consequently minimize the need for an ongoing home care service for clients referred with low level needs. This group can often go without or wait for long periods of time for a service. Instead of providing a service to compensate for the identified need, this project aimed to *"actively work to reduce the demand for ongoing home care"* (Lewin et al, 2001).

Silver Chain devised an alternative model of care that included the following evidence based interventions:

- a comprehensive multidimensional assessment;
- a care plan with goals decided by the service and the client;
- task analysis and redesign;
- provision of equipment and home modifications;
- person to person contact was minimized with telephone contact as the follow up means;
- education about healthy ageing, self management, injury prevention, and medications;
- capacity building programs aimed at improving strength, balance, and increasing activity levels;
- inclusion of family to maximise the support to attain independence;
- client involved and centered decision making;
- assisting clients to develop social supports; and,
- the accessing of local resources.

  (Lewin et al, 2001).

The project has demonstrated improved outcomes for the participants in the areas of confidence and functionality, and that these improvements are sustainable. After participation in the initial HIP project *"33% no longer required a home support service and 39% required a lower level of service"* (Lewin et al, 2001).

2.3.2 The Supported Independent Living Collaborative

The Supported Living Collaborative (SLC) project auspiced by the Mater Misercordiae Hospital in Brisbane commenced in 2003. The project received 18 months funding to *"investigate whether the low needs population would benefit from resource allocation for proactive early interventions that support independent living and thereby reduce their risk of becoming increasingly dependent on the HACC program*" (Matthews 2004; 4).

Clients who may normally have been denied services as their needs were assessed as a lower priority were provided with short term services to assist them to regain their independence. Clients were provided with a maximum of 10 hours service over 8 weeks. Services were not encouraged

to continue for more than three months. If the client had not obtained their independence in this timeframe they were referred for ongoing services.

A collaboration of services were able to provide allied health, domestic assistance, respite, transport, socialization, living skills, personal care, education and industrial cleaning. The project was funded sufficiently to broker these services on behalf of the client to ensure a rapid response and an early intervention approach.

One of higher demanded services provided in the project was for domestic assistance. This was associated with the heaviness of the tasks and the preference of people to have a clean home so they could have visitors. This was closely linked to an increased quality of life.

The project concluded *"the rehabilitative and proactive interventions have a positive effect on low need clients in the community*" (Matthews, 2004:17). Of the 117 clients who were anticipated to remain independent at home following intervention, 91 (77%) achieved this. Confidence was measured using the Australian Quality of Life evaluation tool indicating that overall the brief intervention helped clients to stay independent in their own home. Interventions to maximize safety and mobility and support independent living such as: equipment, environmental interventions and home exercise programs, enabled clients to undertake tasks independently. These interventions were generally low cost and required little resourcing.

The opportunity to provide access to a targeted population for low need has added value to the HACC program. Those who have been unable to access services have had the knowledge that basic assistance will be given to them to get them through periods of need. In turn, this has reduced waiting lists and contributed to delaying or avoiding progression into moderate to high user groups. The simple solution to meeting the requests of people with lower needs is to allocate funds to service provision and encourage service providers to use it a way that supports independent living (Matthews, 2004: 30).

2.4 The Importance of Continuing to do Domestic Tasks

Why is continuing to do domestic tasks important? Ageing in itself does not necessarily result in increasing dependence. Older people may have episodes of more dependent behavior followed by the resumption of independence. People's health is not static and hence variations in their ability to complete activities of daily living will also vary over time. Martel, Belanger and Berthelot (2002) conducted a longitudinal study looking at the loss and recovery of independence and found that a variety of demographic, socioeconomic, health and lifestyle factors are influential.

Mor, Wilcox, Rakowski, and Hiris (1994) conclude from their study on functional decline in older adults that independence is more related to health than age. Although Martel, Belanger and Berthelot (2002) suggested that *"even when other factors…were taken into account, advancing age increased the odds of losing independence and reduced the odds of recovering it"* (p. 42).

There has recently been a surge in studies providing overwhelming evidence that participation by older people in regular weight bearing exercise can have a positive effect on lifestyle, reducing the impact of depression, loneliness, loss of physical functioning, pain and enhance the ability to complete self care tasks. Mor, Murphy, Masterson-Allen, Willey, Razmpour, Jackson, Greer, and Katz (1989) found when comparing older people over a two year period, those who did not participate in regular exercise were 1.5 times more likely to decline in strength, endurance and ability to complete housework than those who exercised regularly. They concluded that their findings *"suggest the potential value of programs oriented toward the primary prevention of functional decline*" (p. 903).

Mattiason-Nilo, Sonn, Johannesson, Gosman-Hedstrom, Persson and Grimby (1990) suggested that completion of domestic activities is equally important in maintaining physical fitness as is walking. Other research further supports this claim suggesting that household work, walking and gardening are the most common tasks undertaken by older people who maintain their strength and

maximize their ability to remain independent (Rantanen, Era and Heikkinen, 1997). They concluded that *"old people should be encouraged to continue their familiar, physically demanding activities in order to maintain muscle strength at a level adequate for independent living*" (p. 1145).

The incidence of exercise is also a critical factor. Stessman, Hammerman-Rozenberg, and Maaravi (2002) found that the biggest protective factor against mortality in the older population they studied was the regularity and frequency of activity rather than the intensity. A recent study (Mannini et al, 2006) has gone even further, demonstrating that mortality can be lowered by approximately 30% in individuals who perform 1¼ hours of physical activity per day. What is most significant about this assertion is that the activities performed to achieve this, may include household chores, active caring and managing the lawn.

Continued participation in domestic duties is not only beneficial physically but can also impact on self esteem and self efficacy. *"Human engagement in occupational performance (including Activities of Daily Living) is central to health and wellness, and provides us with a sense of meaningfulness and personal identity*" (Hayase, Mosenteen, Thimmaiah, Zemke, Atler, and Fisher, 2004:192). This is especially so as we age, as the same authors found that functional ability declines after the age of 65 years and low levels of activity enhance this.

Farquhar (1995) found that when asking older people to rate their quality of life, factors such as social contacts, family relations, activities and reduced functional ability were more strongly related to quality of life than health. Others have suggested that two of the most important quality of life determinants are independence and autonomy (Lewin et al, 2001; Hellstrom and Hallberg, 2001).

A study looking at functional health status and ability to perform instrumental activities of daily living conducted by Whittle (1996) suggested that the focus of intervention should be *"educational programs with an emphasis on health promotion, and strategies to promote personal competence and functional independence in elderly people…*" (p. 225).

2.5. How can HACC programs respond?

Provision of home care services, as in Moreland, has often been based on a one point in time assessment, infrequent review, an implicit assumption that older people's level of independence is unlikely to improve much, and that the home care service is providing valued, preventive support. Thus a capacity building approach to assessment has not been commonly used. For example, a client who has had a recent decline in functional ability may benefit from assistance to clean their home for a short period whilst attending physiotherapy to assist recovery. After 6 weeks or so they may be in a position to re learn how to complete home care tasks for themselves with some support from their local HACC provider. Current models of service would be more likely to assess the client as needing home care and institute an ongoing service and thus contribute to functional decline rather than focus on facilitating independence and wellbeing. This approach is possibly less common in HACC service models where there has been a health or multi disciplinary approach to assessment, and where home care services are linked to allied health services. However in Victoria, over its long development, home care provided by local government has been more commonly linked to a social model of care than a health one.

Current models of home care service like Moreland's have habituated themselves into services that provide for, or substitute for, rather than facilitate the capacity of the service user for more independence. The rapidly increasing ageing population and the greater proportion of people living longer with disabilities will increase the demands on services. It has been shown that denying access to services can have a detrimental effect on the client's wellbeing. So how can home care programs better respond to this need?

Preventative programs that encompass skill development, adaptation and simplification of tasks and facilitate participation in capacity building programs to foster strength and endurance appear to be a better approach. These could assist clients to relearn or adapt some home care tasks to increase their capacity to manage on their own and/or with support with a reduced home care

service. This could in turn reduce the demand for ongoing services and promote successful ageing. The Home Independence Program in Western Australia is one such example of this.

Our current system essentially supports dependence and provides little or no support to those clients maintaining or wanting to retain their independence in domestic tasks. Our focus is at the mouth of the stream rather than upstream before the major issues have developed. Preventative programs are needed to stem the flow of requests and dependence on ongoing services, and more importantly, to assist older people to maintain their autonomy, independence and quality of life. Continued participation in housework has been shown to be a protective factor for functional decline and can boost a person's self efficacy.

"Independence gives the person a sense of self reliance and place in society, and helps them to keep a sense of belonging and meaning in life. Loss of independence can have a devastating effect" (Lewin et al, 2001).

Section Three: Project Design and Methodology

3.1 Project Design

The Moreland Independent Living Project was rolled out in 3 distinct phases:

Stage One: Commenced as an in-house project using existing funds to explore whether there was an alternative way of managing the demand for general home care services at Moreland City Council, by targeting those assessed as having a low level of need and on a waiting list for services they were unlikely to get. The project commenced in September 2004 and was due for completion in April/May 2005. The ILP ran as a stand alone service where clients were assessed and provided with appropriate support from the project and were referred to core home care services as needed (Refer to Appendix 1: Stage One Implementation Flowchart).

Stage Two: In March 2005, the Department of Human Services (Victoria) announced funding for HACC Active Service Model pilots. Moreland City Council was successful in its application for 12 months funding and consequently refocused the project to a more capacity building and restorative care approach to improve people's functional abilities and quality of life, and to delay or reduce their need for standard HACC services. Three other pilots were initially funded to test possible interventions, identify clients for whom an active service approach is indicated, identify systemic implementation issues and conduct cost benefit analyses (Refer to Appendix 2: Stage Two Implementation Flowchart).

Stage Three: The funding from DHS was extended for a further 3 months and Moreland City Council implemented an Integration Trial. This aimed to test the model of service in mainstream service delivery to identify the practice and systems issues, and measure whether the client outcomes differed. The team leader selected for the trial was provided with training and support for 6 weeks prior to the assessment of clients, on how to use the model of service. From July, the team leader assessed two clients per week using the ILP framework, assessment tool and model of service delivery, with support from the ILP project officer. (Refer to Appendix 3: Stage Three Implementation Flowchart).

3.2 Project Logic

The ILP project trial was initially established to test the following assumptions:

1. Some people eligible for Home Care who are assessed as having a low priority could be better assisted to safely continue and manage housework and other tasks of daily living with advice and other support services, rather than receiving no help and just remaining on the waiting list for very long periods.

2. Providing an alternative suite of services may better avert or delay the need to use the Home Care service and improve an individuals' capacity to manage household and other daily living tasks.

3. Criteria can be developed to identify, at point of referral, those residents with a lower need for Home Care who may benefit from the alternate suite of services to be developed and trialed.

4. Having other options for those with lower needs for Home Care will reduce the demand and waiting lists, and allow a more timely assessment response for those with more urgent or higher needs in line with the priority of access policy at Moreland City Council.

As the project progressed through Stage Two and Three, the focus altered to an overall capacity building approach. This involved the development of a model of service, identification of training and other resources, and change management processes that would make the model applicable to the majority of referrals for general home care rather than just those of lower priority. It was

identified that assessment and enhancement of functional capacity needed to be the focus of the approach adopted for all clients.

Thus the initial assumptions were still applicable but to a wider range of clients than first envisaged.

3.3 Goals

The initial overall goals of the project were to:

1. Assist in managing unmet demand for Home Care services.
2. Improve access to assessment services by the reduction of waiting times.
3. Provide a preventative service to clients with lower, less urgent need for Home Care.
4. Improve individual capacity to function safely at home.
5. Improve satisfaction with Moreland City Council HACC services.

Again these goals were clarified over the course of the project with the main focus looking at whether and how core HACC services could be refocused to provide a more flexible and individualized response to clients, in a timely manner.

3.4 Objectives

The objectives for the trial were revised in Stage One and divided into four distinct groups:

3.4.1 Clients

- To assess and enroll 30 clients to the Independent Living Project.
- To identify a range of suitable equipment and adaptive devices to minimize the strain of completing home care tasks.
- To trial a range of techniques, equipment and modifications with assessed clients to determine whether they can maintain or increase their ability to safely complete home care tasks.
- To increase client confidence in managing their home care tasks safely.

3.4.2 Community

- Identify and assist clients to access community based capacity building activities.
- Increase client access and knowledge of other community services to meet their identified need.
- Provide opportunities to share the learning's and strategies with other service providers, referrers and the broader Moreland community.

3.4.3 Products

- Develop an Intake screening criteria tool to identify clients who may be more suited to the Independent Living Project rather than core service delivery.
- Develop an Independent Living Manual translated into appropriate community languages.
- Provide training to a pool of 5 home care staff so they can promote and reinforce independent living techniques with assessed clients on the program.

3.4.4 Impact on HACC Service

- To identify and trial alternative models of HACC services to sustain clients living at home.
- Minimize the client need for ongoing HACC services through implementation of the Independent Living Project.

The objectives remained essentially relevant throughout the project although with the provision of extra funding, the number of clients was increased to 200. A further objective was also added.

- To develop a model of service that is sustainable and able to be integrated into the mainstream local government and community based HACC services.

3.5 Model of Service

The model of service established and trialed over the course of the project involved the following elements:

- Needs assessment, with a focus on enhancing functional capacity.
- Task analysis and problem identification.
- Development of a care plan.
- Targeted interventions.
- Monitoring and follow up.
- Review.

3.6 Staffing

3.6.1 Project Officer

An experienced occupational therapist commenced in the position of project officer at the beginning of September 2004 at 2.5 days per week. The first two months were taken up searching for relevant literature, selecting clients, developing assessment tools and processes, identifying resources and equipment to support clients in the program, and developing written instructions (ILP Manual) to re- inforce and assist clients with the new techniques demonstrated.

Client assessments for the project commenced in November 2004. The project officer increased to 4 days per week at the beginning of February 2005 to November 2005, and then took a period of leave. In October 2005 a new occupational therapist commenced on the project working 4 days per week. The new project officer completed an induction and accompanied the original project officer on 2 new assessments and 3 follow up visits. From March until the end of July 2006 there was a total of 1.2EFT staffing for the project that reduced back to 0.8EFT until the end of October 2006.

The position was based at the Moreland City Council office in Coburg, within standard hours of operation. The project officer had access to a council vehicle to allow for assessments in client's homes and the transporting of equipment.

3.6.2 Ancillary Staff

Five home care staff members from various area teams were provided with training in the ILP concept and alternative equipment. It was anticipated that they would work along side clients to facilitate independence rather then provide a passive service. These workers were engaged on occasions where their input was integral to the care plan. An additional worker was trained and engaged as an 'ILP assistant' for 10 hours a week from the 10th February 2006 until the cessation of the project. The workload mainly consisted of picking up and dropping off equipment, demonstrating and reinforcing correct use of the equipment and providing support and encouragement to clients. Two student occupational therapists were also involved in some aspects of the project whilst undertaking field placements.

3.7 Promotion and Referral

The ILP concept and model of service was introduced to the Aged Care Branch at Moreland Council via team meetings, so that all staff had a basic awareness of the project and the premise behind it. In Stage 1, the project officer engaged in one on one education and discussion with team leaders, collaboratively reviewing each team leader's assessment wait list for suitable project candidates. Through this process, exclusion criteria were developed and Intake was engaged in the task of identifying potential candidates at the point of referral. The Intake officer's existing knowledge and system for classifying incoming referrals as requiring an urgent or standard assessment was built on to do this. The project officer was available for consultation to both team leaders and intake officers, allowing verification of suitability prior to referral to the project.

Main external referrers and stakeholders were informed of the initiative and the referral processes through provision of presentations, in-service sessions and mail outs. These included both local and Statewide forums as interest in the project grew.

- Mail outs to local General Practitioners through the North West GP Division newsletters and practice mail outs.
- Presentation at the Moreland Aged Care Forum, May 2005.
- Meeting with the Direct Access Unit (Royal Melbourne Hospital, Parkville campus).
- Meetings with Moreland Community Health Centre physiotherapists.
- Meeting with Victorian Arabic Social Services.
- Meeting with Australian Greek Welfare Society.
- Presentation at the launch of the State's HACC Priorities 2006 – 9, by the State Minister for Aged Care, April 2006, held at a Moreland venue.
- Presentation at the Statewide Local Government Professionals (LGPRO) Aged and Disability Interest Group conference in May, 2006.

The local promotion drive did not prove very effective in producing direct referrals for the project, as apart from one GP, referrals continued to made for home care rather than for the ILP, which meant the clients already had the expectation that they would receive a home care service.

Nine education sessions were also conducted targeting senior citizens' groups in Moreland, including a range from Culturally and Linguistically Diverse (CALD) communities. These sessions came from a health/activity promotion framework, examining how housework is completed and the equipment and techniques commonly used, encouraging adaptation and continued activity. The project also demonstrated equipment and techniques at a stand at the Moreland Healthy Seniors - Health and Well Being day in 2005.

3.8 Steering Committee

A steering committee was formed before the project officer was engaged to advise on the scope and design of the project. It involved representatives from:

- The Department of Human Services
- Royal District Nursing Service
- Moreland Community Health Service
- Northwest Aged Care Assessment Service (Melbourne Health)
- CoAsIt Italian Assistance Association
- Hume Moreland Primary Care Partnership
- Post Acute Care Facilitation Unit at Melbourne Health
- Moreland City Council's Aged Services Branch

North West Division of GPs were invited but unable to provide a representative and elected to remain in touch with the project by email contact.

Although there were some changes in personnel, all agencies remained represented on the committee throughout the project. The committee met approximately every 3 – 4 months to receive updates and input into the next phase of the project until October 2006. Advice from committee members about cultural and discipline specific details were particularly valuable.

3.9 Methodology

3.9.1 Defining and Recruiting the Target Group

There were two distinct groups targeted at **Stage One** of the project:

1.1. Low priority - Assessed but waitlisted:
Initially, the focus was on those clients who had already been assessed as eligible for home care services but were listed as a low priority. Some of these clients had been assessed as long as 5 years ago and had still not received a service. They were essentially clients who did not immediately require a home care service but who felt they did, or had requested services "just in case" they may require it more at sometime in the future. MCC has since adjusted its policy and now no longer waitlists these clients as they are not likely to receive a home care service until their need changes, upon which a re-assessment is undertaken.

1.2. Screened at Intake as low priority – waiting assessment:
Secondly, standard (i.e. non urgent) referrals for home care services already identified at Intake as having a low level need and were waiting (many for more than 6 months) for a home - based assessment. The ILP project officer completed both the standard HACC assessment and ILP assessment for each client.

Clients were telephoned and the ILP concept explained to them. A telephone interpreter was used as needed. The client's explicit consent was sought in organizing an ILP visit and assessment (Refer to Appendix 4 : Client Consent Form).

In **Stage Two** the main clients targeted were significantly different, and two different recruitment strategies were undertaken: There were two parts to the first strategy.

2.1a. Current, incoming referrals screened at Intake, and offered choice of ILP if low priority.
Clients being referred for home care were screened at Intake as to the apparent urgency of their need and their ability to continue with their own homecare. Those that seemed unlikely to be a high priority for service were told about the ILP and asked whether they would prefer this option. Although we did not record the number of people who declined, anecdotally it was high. Discussion with the Intake officer suggested that it was a difficult concept to explain to people over the phone and for them to understand, particularly when they were requesting a home care service.

2.1b. Incoming referrals screened at Intake, and if low priority, streamed to ILP.
It was decided to change the approach by not explicitly explaining the ILP by phone, but taking a referral for an assessment for home care and streaming to the ILP project so that the explanation could take place face to face. Exclusions to this streaming included clients who:

- were primary carers
- had a significant mobility issue
- had cognitive decline
- were children
- required a personal care service
- were identified as being a priority for assessment for a home care service.

Those clients streamed to ILP received an integrated assessment approach that incorporated an assessment for home care in the ILP framework.

2.2. Referrals from Team leaders

The second recruitment strategy for Stage Two was referrals from team leaders who had recently assessed the client and had established that they were a lower priority for service. The team leaders sought the client's consent to refer. Once referred, the ILP project worker contacted the client and organized a time to conduct the functional assessment. This approach was complicated by the two part assessment process for the client.

Clients involved in the project at **Stage Three (Integration Trial)** were those who were referred and allocated to one geographical team as per core Moreland City Council processes. Two clients per week were randomly selected and assessed and provided support and services using the ILP model of service. These clients were identified at Intake as having high to medium priority for general home care services. Those clients identified as having a lower level need for service were still referred to the ILP directly.

Table 1 : Number of ILP referrals over 3 Recruitment Stages by Priority Status.

	Stage 1	Stage 2	Stage 3	Total
Priority 1				
Priority 2				
Priority 3				
Total	92	130	10	232

3.9.2 Assessment

We were unable to identify an existing validated assessment tool sensitive enough to detect change and cover the tasks normally provided by HACC home care. Hence we set about developing one that would address the areas required for this project and also identify others that could be included in future assessment tools for home care (Refer to Appendix 5: ILP Assessment Tool).

The tool was developed using an occupational performance framework based on the assumption that the client's ability to undertake home care was determined by their motivation, the equipment and technique used, the environment and their physical capacity. It initially included a section for discussing the frequency and priority for each home care task assessed to establish which activities clients valued and attempted to complete the most. After several assessments, this section was removed from the tool as it made the process too cumbersome and confusing. It was easier to get a sense of their home care priorities through the general discussion.

The assessment process generally involved, on average, a one and a half to two hour face to face meeting with the household residents. The provision of an integrated comprehensive assessment involved the mandated elements of a HACC screening tool (SCTT), components that covered the Council's occupational health and safety obligations as well as the ILP data collection tool. To complete the ILP tool, clients demonstrated the equipment and technique they used to complete individual home care tasks, and:

- notes were made about the environment in which the client completed the individual tasks, including storage and impediments,
- clients were assessed and rated in their ability to complete the individual home care tasks,
- the frequency and time spent completing each task was identified,
- how they usually completed all the home care tasks over the week was recorded,
- clients completed a self rating of their confidence to undertake identified personal and domestic activities of daily living,
- clients completed a self rating of their need for assistance with home care,
- background information on medical issues, access to services and capacity building activities was recorded.

3.9.3 Task Analysis

Use of the ILP assessment tool involved a process of clinical reasoning through detailed task analysis and learned alternative techniques that had been developed in the earlier stages of the project. It was very common that the main reason why vacuuming was such a difficult task for many people, was a combination of the vacuum cleaner itself, the way it was used and the amount of vacuuming that people expected to complete in one session.

3.9.4 Care Planning

At the conclusion of the assessment, the identified issues and strategies were recorded, along with the agreed implementation plan. This included strategies related to home care and other identified needs such as referral to local services. The session was concluded with the client signing a consent form for all identified referrals and for their data to be used in the project reports and presentations.

The care planning phase also allowed the reinforcement of strategies discussed during the assessment and further planning around the implementation.

3.9.5 Targeted Interventions

Strategies to overcome or minimize the identified issues were discussed and demonstrated to the client as the assessment was being completed. For example, if Mrs Jones demonstrated poor technique when using her vacuum cleaner during the assessment, the occupational therapist would discuss an alternative method. Thus the assessment and intervention were intermingled. To support this, each client was given the ILP Manual that had been developed and translated into three common community languages (Italian, Greek and Arabic). This detailed the strategies discussed with the client during the assessment.

The home care strategies may have included:

- advice about safe body movements,
- advice about equipment, technique and products,
- purchase or loan of suitable equipment,
- completion of home modifications necessary to improve storage, safety and improve capacity,
- client training, skill development, confidence boosting performed by either the occupational therapist or trained home care staff,
- provision of an initial spring clean or intermittent home care for clients assessed as requiring this service.

Two other service types were regularly discussed with the client and appropriate referrals made to:

- encourage and assist attendance at health promotion, fitness and strength building activities , and other activities to improve social engagement,
- connection to other needed health services such as physiotherapy, and support services such as community transport, etc.

3.9.6 Monitoring and Follow Up

Some clients were able to purchase any recommended products or equipment and implement the strategies independently after this initial assessment. Other clients required support to learn new techniques or purchase equipment. A combination of staff were used to follow up with these clients including the occupational therapist, student occupational therapists and/or home care staff who had been specifically trained in the ILP techniques. Furthermore, some clients required some form of home care service provision. This could have been a one off specific clean such as the bathroom, a regular spring clean such as a quarterly service or a regular reduced ongoing home care service such as a monthly service. The standard provision of home care in Moreland is a 1.5 hour per fortnight service. Clients who received some regular or intermittent service still benefited from strategies in other areas such as being able to sweep the floors independently.

3.9.7 Review

Initial reviews were undertaken at three months. The review process was to establish:

- what strategies they had adopted,
- whether the support provided was appropriate,
- whether a change in the care plan was required,
- whether any other referrals were required,
- any required changes in home care service delivery,
- a repeat of the self ratings for their need for a service and their confidence to complete activities of daily living,
- their rating of the ILP project,
- further problem solving if needed.

Reviews were commonly completed in the clients' home although some were conducted as telephone interviews when the client did not wish for another home visit. They usually took approximately 30 minutes.

27 clients (28%) also participated in a review at 12 months or more since they had completed the ILP. This was to gather information on whether clients sustained the changes and how they were managing in their own homes. As vacuuming, washing of the floors and cleaning of the bathroom were the areas that required the highest level of intervention, these were selected as the functional areas for this review. The self rated confidence scales and the need for service were also reapplied. These were conducted in the client's home and took around 20 minutes each.

3.9.8 Focus Groups

Two focus groups conducted by an external facilitator explored:

- what home care means to clients,
- the relationship between the perceived cleanliness of clients' environments and their mood and sense of control,
- the importance of continued engagement in home care tasks by clients themselves,
- clients' concepts of satisfactory levels of cleaning activity in their home.

Thirty participants who had completed the ILP project were randomly selected and invited to attend sessions at Moreland City Council. Letters of invitation were sent out, in English and Italian outlining the aims of the group and details of attendance. Follow up phone calls were made to ascertain attendance and need for transport. Participants were split into English and Italian speaking groups on the day, and two interpreters were engaged to assist with the latter group. Participants were assisted with transport on the day as required.

3.9.9 Integration Trial

As the project progressed it became apparent that instead of a stand alone or alongside service for a section of the population being referred to general home care, ILP presented an alternative assessment framework for all. It provided a means of assessing an individual's capacity to engage in home care tasks, a measure to assist in the making of priority of access decisions, and a model with which to make a care plan to maintain or improve client's activity levels. The integration trial aimed to identify the practice, systems and training issues this presented, and measure whether the client outcomes differed. It also aimed to test the model's efficacy with clients' identified as having a higher level of need on referral (Refer to Appendix 6: Integration Trial Project Brief).

A team leader was selected from the Home Care Unit to undergo training and complete assessments of clients referred for general home care services using the ILP tool and framework. She had qualifications in both nursing and social work and many years experience in home care. Due to the existing workload, a quota of two assessments a week was set, with the targeted completion of 12 assessments by the end of the trial. Over a six week period prior to the commencement of the trial, the team leader underwent training in the ILP model and assessment

tool. This involved a 1 ½ hour orientation session covering; model description and explanation, orientation to the tool and reasoning process underpinning its use, equipment commonly prescribed, principles of adaptation and the provision of a client manual which outlined means of adapting techniques most commonly recommended. In addition, a copy of the collection tool with prompts and explanations was provided as a reference point (Refer to Appendix 4: ILP Assessment Tool). Protocols for loaning equipment and utilizing the ILP assistant in the program were explained.

The team leader accompanied the project officer on five varied assessments during this training period, averaging one a week. Each assessment was followed by discussions on the reasoning process taken, recommendations made and the follow up required. The sessions afforded the team leader an opportunity to view the assessment of equipment, environment and techniques, along with the prescription of alternatives. The assessment documentation was made available to the team leader for review. Discussions were had to clarify the difference between practicing ILP as a model of assessment and care planning from initial contact, as opposed to implementing it as a 'service type' following a preliminary assessment. During the team leader's independent assessment period, the project officer was available for advice and consultation.

3.9.10 Workforce Skills and Training

Moreland City Council deliberately employed an occupational therapist when establishing the ILP, recognising the capacity of the OT to provide a functional assessment and intervention. Once it became clear that the approach could apply to all assessments, the issue of whether the model could be undertaken by other health and welfare professionals with some upskilling in the area of functional assessment had to be considered. This also raised the question of what training and how to deliver this.

One of the risks of assessment staff being inadequately trained is that using the equipment and technique strategies developed would become another standard intervention rather than assessing the functioning of the client and matching the recommendations to the client need.

An in house training program was developed and conducted by the project officers with one assessment officer and five home care staff, using demonstration, written materials, and discussion methods. Five home care staff were selected and provided with basic training in a capacity building approach to service provision. These staff were involved with the clients who required short term and one off support to integrate the recommendations into their home care routine. The staff were excited and stimulated by the capacity building approach and embraced the change in the way they delivered services.

A workshop was conducted with a number of people experienced in conducting HACC assessment and home care training to explore what training is occurring and what would need to be changed to facilitate staff development in an active and capacity building approach. Links were also made with the Western Australian WATCH project, which is developing a home care training program, building on the Silver Chain HIP program. Basically, the industry trainers thought it would be possible to either modify current modules in the HACC Certificate 3 course, to include a restorative approach, or to add in additional modules. Everyone agreed that there is no current training program suitable for HACC service assessment, and as this is an area being considered by the Department of Human Services as part of the HACC Assessment Framework, it would be better if the Active Service Models' needs could be taken up as part of that work.

3.10 Evaluation

As the project operated in an action research framework, evaluation was undertaken in both a qualitative and quantitative manner against the revised objectives. Quantitative outcome measures include the total number of intervention hours and cost for each client, and pre and post intervention:

- assessment of instrumental activities of daily living independence,
- client rating of need for a home care service,
- client rating of their confidence in performing a range of activities of daily living,
- recording of equipment used by clients,
- client connectivity to other services and/or activities.

Qualitative evaluation was primarily focused around the recording of clients' experience of the project with the selection of case studies to highlight key elements. With the appointment of an external evaluator for all the DHS funded Active Service projects and the setting of a broader evaluation framework, two qualitative questions were added to the review process*; "Overall, what difference did the ILP make?*" and, "*To what extent did ILP meet your expectations?".* As these were introduced at a later date in the project, not all clients reviewed have provided a response for these. Data collection occurred from November 2004 until the end of July 2006 for clients seen directly by the ILP. Although the ILP continued to provide service to clients beyond July 2006, their data was not included in the analysis as they had not undergone review. The data for the clients participating in the Integration Trial was also not included in the analysis as we focused more on the process issues and client outcomes in terms of service delivery.

It was difficult to identify an assessment tool sensitive enough to measure the changes in instrumental activities of daily living (IADL) being targeted by the project. A tool was developed for the trial, and was tested and modified as the project developed (Refer to Appendix 5: ILP Assessment Tool). The rating scale was a modified version of that used in the Barthel Index and adapted for a more detailed focus on IADLs. A description of the equipment and procedure used by each client for each IADL was also recorded pre and post intervention.

With the extension of the project, we also decided to conduct client reviews for those who had completed the project more than 12 months ago to focus on the sustainability of the interventions and longer term client outcomes.

Section Four: Outcomes

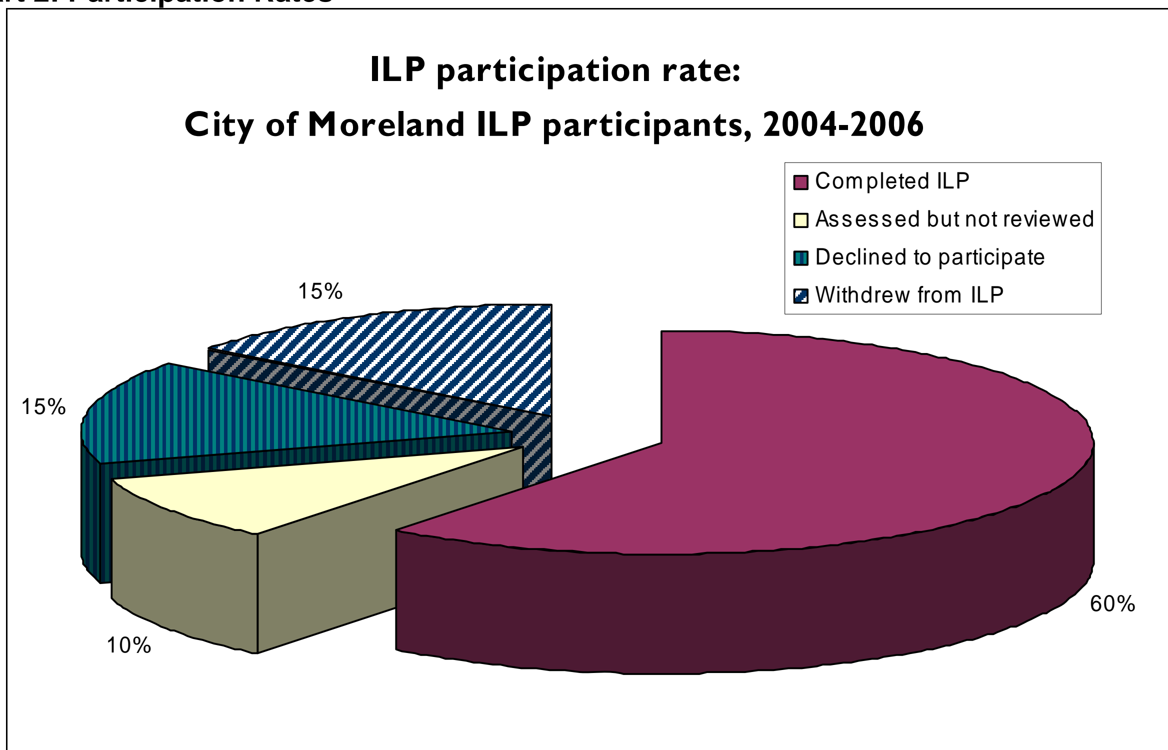
4.1 Participation Rates

A total of 246 clients were approached by the ILP between November 2004 and July 2006. Sixty percent of these clients (149 individual clients; 96 households) went on to complete the ILP process to the 3 month review stage, and 28% (27 households went on to a 12 month review. Ten percent (24 clients) have been assessed by the ILP but were not due for review until after the data collection phase ended in July 2006. Fifteen percent (37 people) declined to participate when contacted at the client engagement phase; 15% (thirty-six people) withdrew either during or after the initial assessment.

Ninety-two clients were approached during Stage One. Of this group, nearly half (47%) completed the ILP program, 31% declined to participate and 22% withdrew from the project. A further 130 clients were approached during Stage Two. Of these, 6% declined to participate, 12% withdrew and 82% completed the ILP program.

Statistics were kept on the number of people who were actually approached by the ILP team, but not on the number who declined when offered the ILP either by the Intake worker or by other Home Care Unit team members. We are therefore unable to calculate the exact number of clients who were candidates for the ILP, regardless of whether they agreed or declined to participate in the project.

Chart 2: Participation Rates



The **people who declined** were more likely to be older females (average age of 77 years), persons who were born overseas, and/or persons residing with a spouse or family member. The three main reasons why thirty-seven people declined to participate when offered the ILP were:

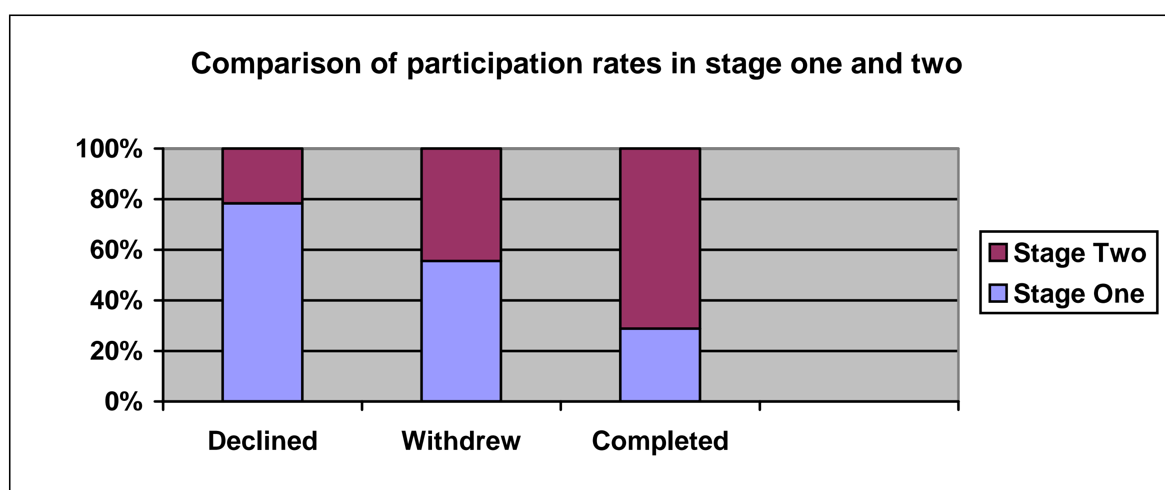
- not interested in the ILP concept (49%),
- had a change in circumstances since the initial referral (32%), or
- had accepted another service type (19%).

In contrast, the **people who withdrew** during or after the ILP assessment, were slightly younger, with an average age of 75 years. There was an even distribution of males and females, and of people living alone or with others. Again, the majority of people who withdrew were more likely to be born overseas, particularly in Italy. For those who withdrew:

- 53% declined to participate, stating they only wanted an ongoing home care service,
- 28% had a change in their circumstances, such as a decline in health, during their involvement with the ILP,
- 3% had accepted another service, and
- 16% withdrew without a clear explanation.

There was a much better participant uptake and retention from the second recruitment stage, suggesting that the project got better at explaining the concept to potential clients, and that people were more receptive when they had not already been waiting some time for a home care service, or when the assessment took place without trying to explain ILP as an alternate approach.

Chart 3. Participation Rates by Stage of Recruitment



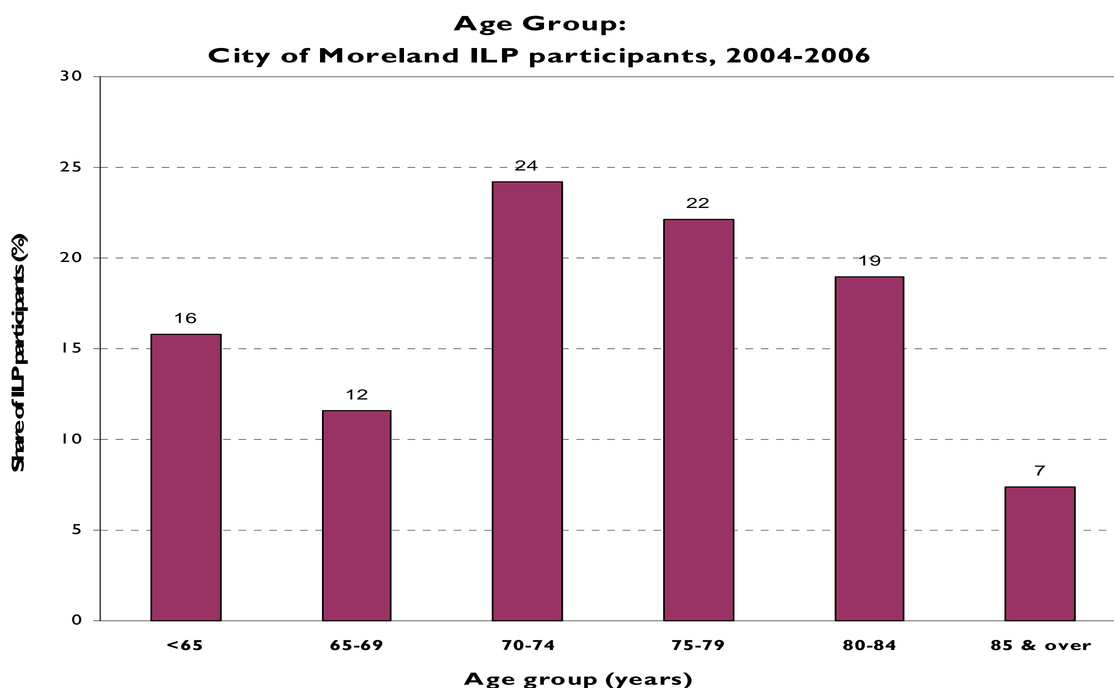
4.2 Client Characteristics

One hundred and forty nine people, residing in ninety-six households, completed the ILP before the end of July 2006. Most people residing in households shared the home care duties, so the ILP was targeted at all members of the household. Demographic data was collected for both members of the household, whilst level of function reflected the household as a whole. For ease of data analysis, the household member most involved with, and most targeted by the ILP, is identified and functional outcomes for the household are attributed to this individual. As a result, demographic data is provided for all of the 149 individual participants, while functional data is presented for the ninety-six households, to allow for valid comparisons when looking at patterns in outcomes. The ten clients engaged during the integration process are considered separately.

4.2.1. Age, Sex and Household Type

Age:
Forty –six percent of ILP participants were aged 70-79 years (compared to 36% of Moreland Council's Home and Community Care (HACC) service users in 2004/5) with the average age being 73 years. This was lower than for those people who withdrew from or declined the ILP. Participants were distributed quite broadly across the age groups. Twenty – six percent were aged 80 years or more (compared to 45% of HACC service users); 12% were aged 65-69, and 16% were aged less than 65 years - a total of 28% under 70 years compared to 20% of HACC users. (Note that this data refers to the household member most involved with the ILP). It is clear that a higher proportion of the ILP participants were younger, than those receiving Council services in 2004/5.

Chart 4: Age of ILP Participants



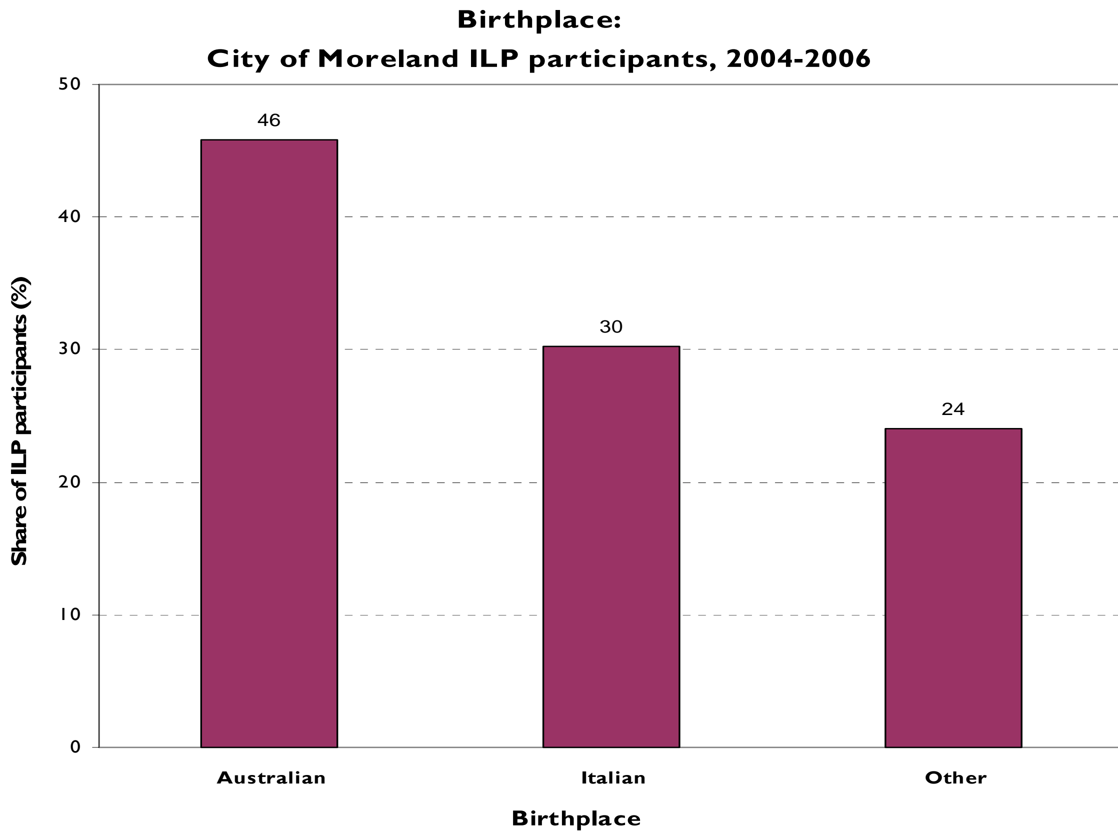
Gender:
A total of sixty-one males and eighty-eight females participated in the project, giving a male to female ratio of 41:59. This is as could be expected given the over-representation of females amongst older residents, especially those living alone. However it is lower than in the HACC services - 64% of Moreland's HACC clients in 2004/5 were female.

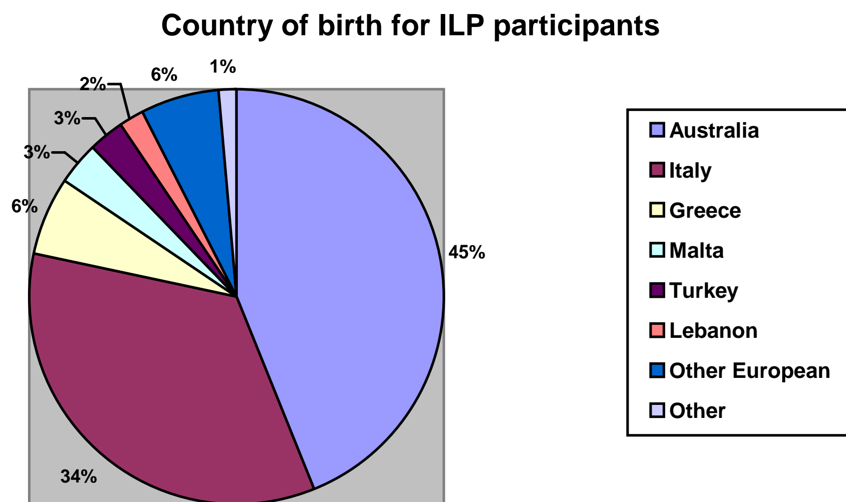
Household:
One-third of participants lived on their own (fifty-one persons), with the remainder residing with their spouse or other family members. In household terms, 49.5% of households were sole person households whilst 50.5% were family households. In 2004/5, 41% of HACC users in Moreland lived alone.

4.2.2 Birthplace

Most ILP participants were born in Australia (46%) or Italy (30%). Other countries of birth accounted for 24% of the total, with Greece, Malta, Turkey, Lebanon and other European countries the main groups, consistent with the ethnic profile of Moreland 's aged population. There was an over representation of Australian born residents, compared to those using Moreland's HACC services in 2004/5 (38%) and also of Italian born residents (27%) and Greeks (6% in ILP compared to 4% in HACC services).

Chart 5: Birthplace of ILP Participants

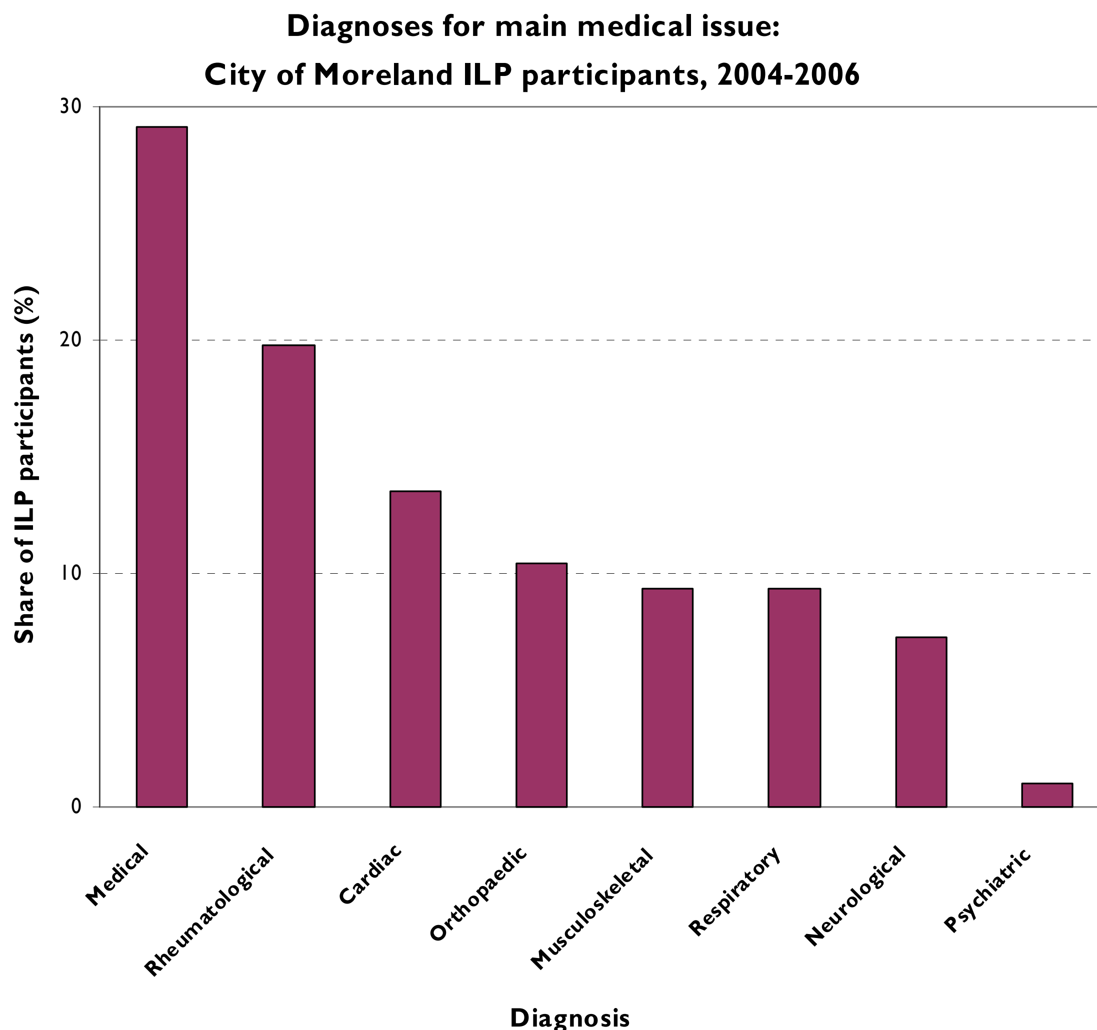




4.2.3 Medical Diagnosis

The 149 participants were categorised into one of eight diagnostic codes according to the main presenting health issue that impacted on their independence with household tasks. There was a broad distribution across the categories with the medical (29%), rheumatology (20%), cardiac (13%) orthopaedic and musculoskeletal complaints rating the highest. The medical category included people who had multiple chronic issues.

Chart 6: Health Conditions Limiting Capacity for ILP Participants



4.3 Baseline Functioning at Assessment

At the initial assessment, each household was assessed as to their functional capacity to complete all household tasks. Three main tasks stood out as being representative of the household's capacity to manage household tasks: vacuuming, washing the floor and cleaning the bathroom. These are the main areas that participants had difficulties in, and are often the areas that trigger a request for service. Six households were managing all the three tasks of vacuuming, cleaning the bathroom and washing the floors independently. Most people were managing these tasks independently, but with some difficulty. A slightly higher proportion were dependent on others for help cleaning the bathroom, than for vacuuming, or for washing the floors.

4.3.1 Vacuuming

Nineteen households (20%) were independently managing to vacuum their home at the initial assessment. The majority, sixty-four households (67%), were managing independently but with some degree of difficulty. Four households (4%) required some assistance with vacuuming and six (6%) were dependent for this task. Three households (3%) did not need to undertake vacuuming as part of their home care.

4.3.2 Washing the floors

Washing the floors was completed independently by 28% of households, with difficulty by 64%, with assistance by 3% and dependently by 5% of households.

4.3.3 Cleaning the bathroom

Twenty one percent of households were managing to independently clean the bathroom; 65% were managing with some difficulty; 7% required some assistance; and 7% were dependent for this task at initial assessment.

4.4 Improvements in Functional Capacity Outcomes

4.4.1 Improvements by Number of Tasks at 3 Months

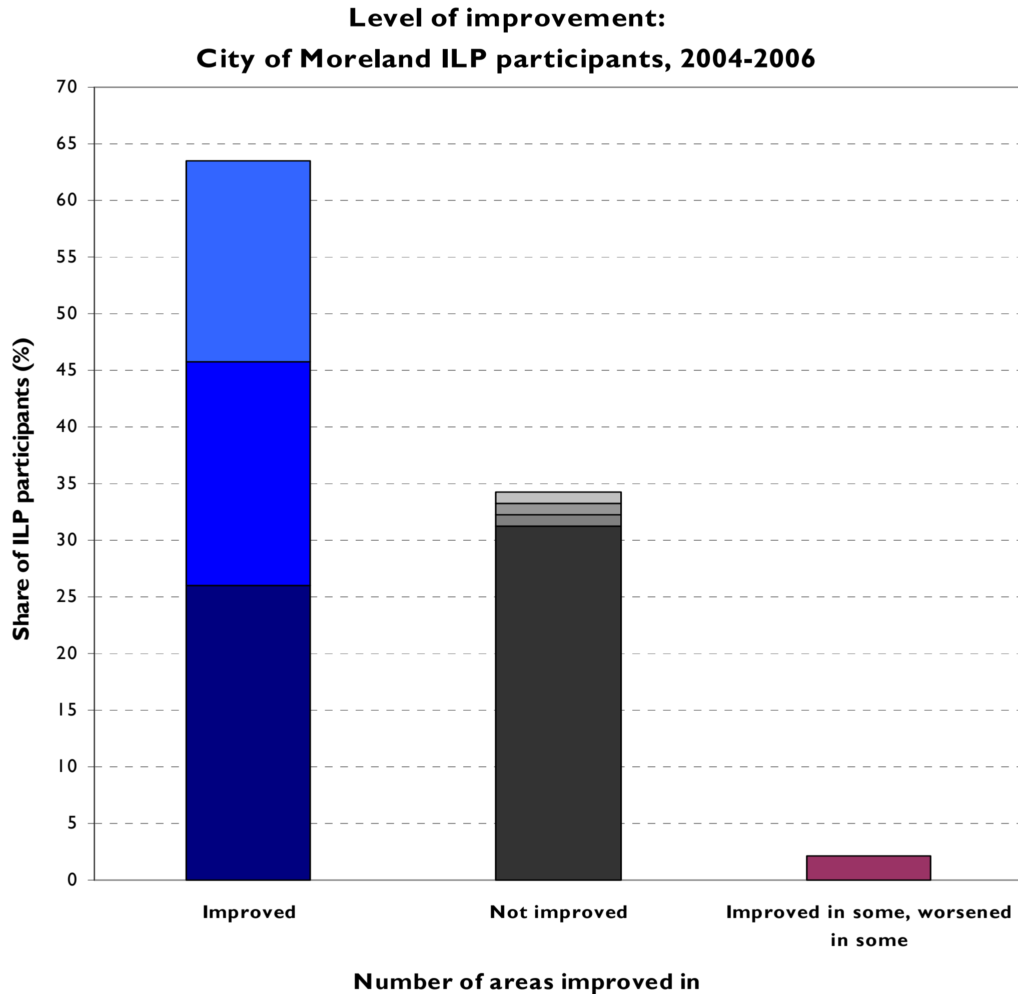
When reviewed three months after their initial assessment**, 63.5% of households had improved in at least one area** – 26% had improved in one area, 20% in two areas and 18% in all three areas. Thirty-one percent showed no change, 3% had worsened in some areas, and 2% had worsened in some but improved in others.

Table 2: Improvements in Tasks after 3 Months: City of Moreland ILP participants, 2004-2006

Number of areas improved in	Frequency	Share of total (%)
One	25	26.0
Two	19	19.8
All three	17	17.7
Total improved in one or more	**61**	**63.5**
Total with no improvement	**30**	**31.3**
Worsened in one	1	1.0
Worsened in two	1	1.0
Worsened in three	1	1.0
Total worsened in one or more	**3**	**3**
Improved in some, worsened in some	**2**	**2.2**
Total	96	100.0

If those who had maintained their previous independence is included, **48% of households had either made improvements and/or maintained their independence in all three areas of vacuuming, washing the floors and cleaning the bathroom**, when reviewed three months after the initial assessment.

Chart 7: Level of Improvement at 3 Months



4.4.2 Improvements in Functional Outcomes at 12 Months

Twenty-eight percent of participants (27 persons) also had a twelve-month review. Of this group, most (70%) had maintained their level of functioning in vacuuming, floor washing and bathroom cleaning. Similarly, 52% of this group had maintained all recommendations and 33% had maintained most recommendations.

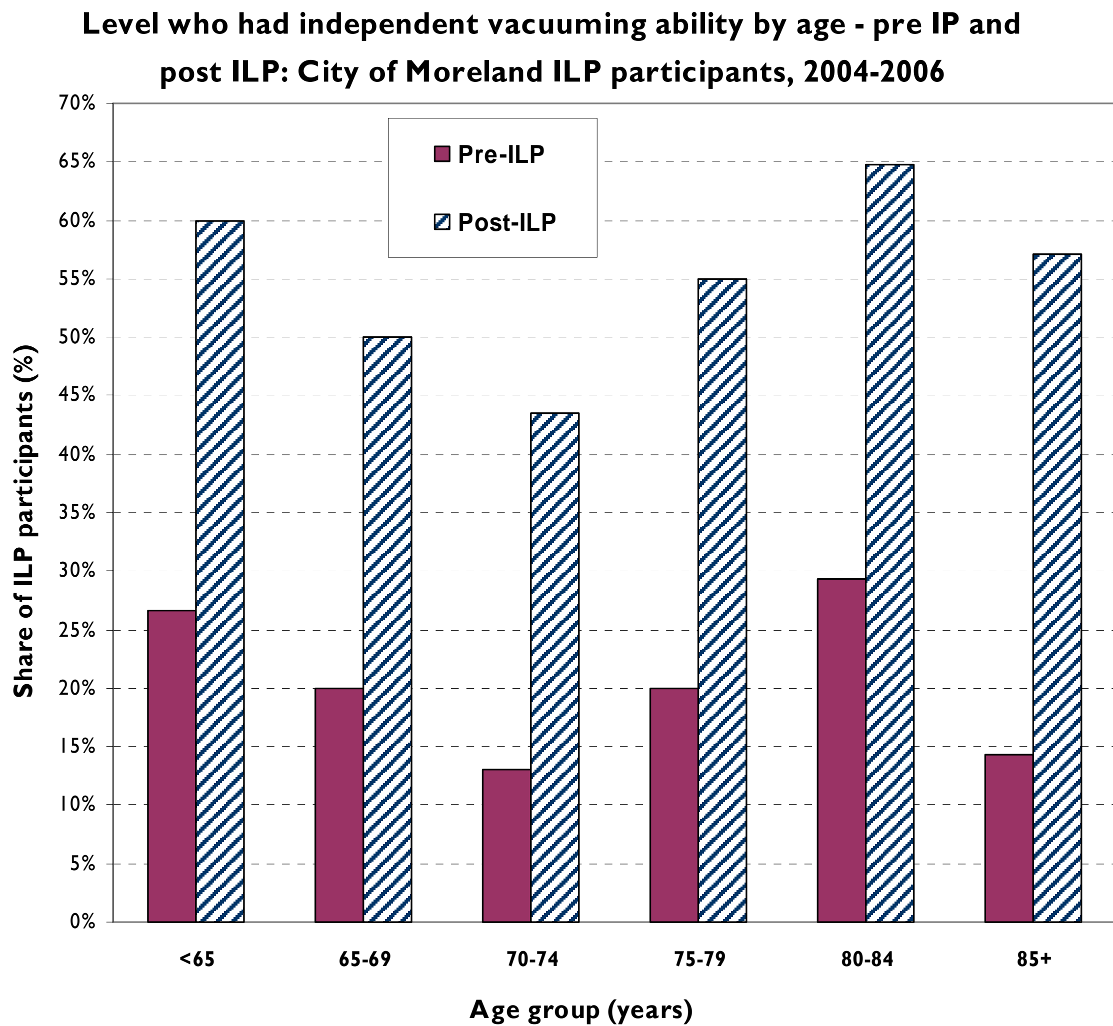
4.4.3 Level of Improvement by Level of Independence Pre-ILP

The capacity to perform the selected key tasks varied significantly by age before the ILP started. The level of improvement varies significantly by age, with the improvement being most marked in the age groups who were least independent to begin with.

The level of improvement in vacuuming ability varied significantly depending on whether or not participants were living alone, but not the level of floor washing or bathroom cleaning ability. The level of improvement in bathroom cleaning ability and floor washing ability varied significantly according to ethnicity, but not the level of vacuuming ability. Thus the scope for improvement seems to vary as much by task as by characteristics – age seems to be the most consistent indicator of scope for improved independence levels.

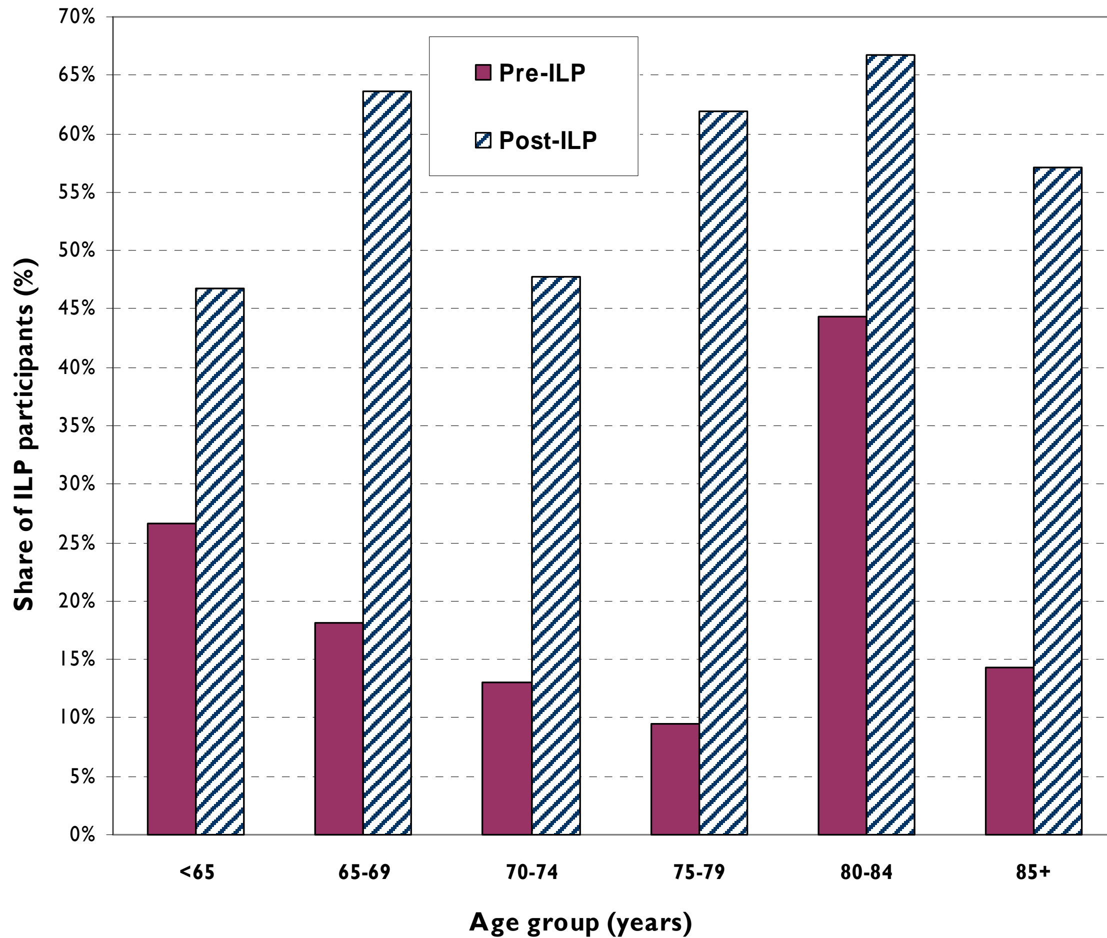
Whilst the level for those aged less than 65 years, who were independent in vacuuming ability, was higher than for most other age groups - 27%, compared to 20% for 65-69 year olds, 13% for 70-74 year olds and 20% for 75-79 year olds, the 80-84 year olds actually had the highest level of independence, at 29%. In all age groups, the number who were independent at the end of the ILP more than doubled.

Chart 8: Independent in Vacuuming Ability by Age - pre and post ILP



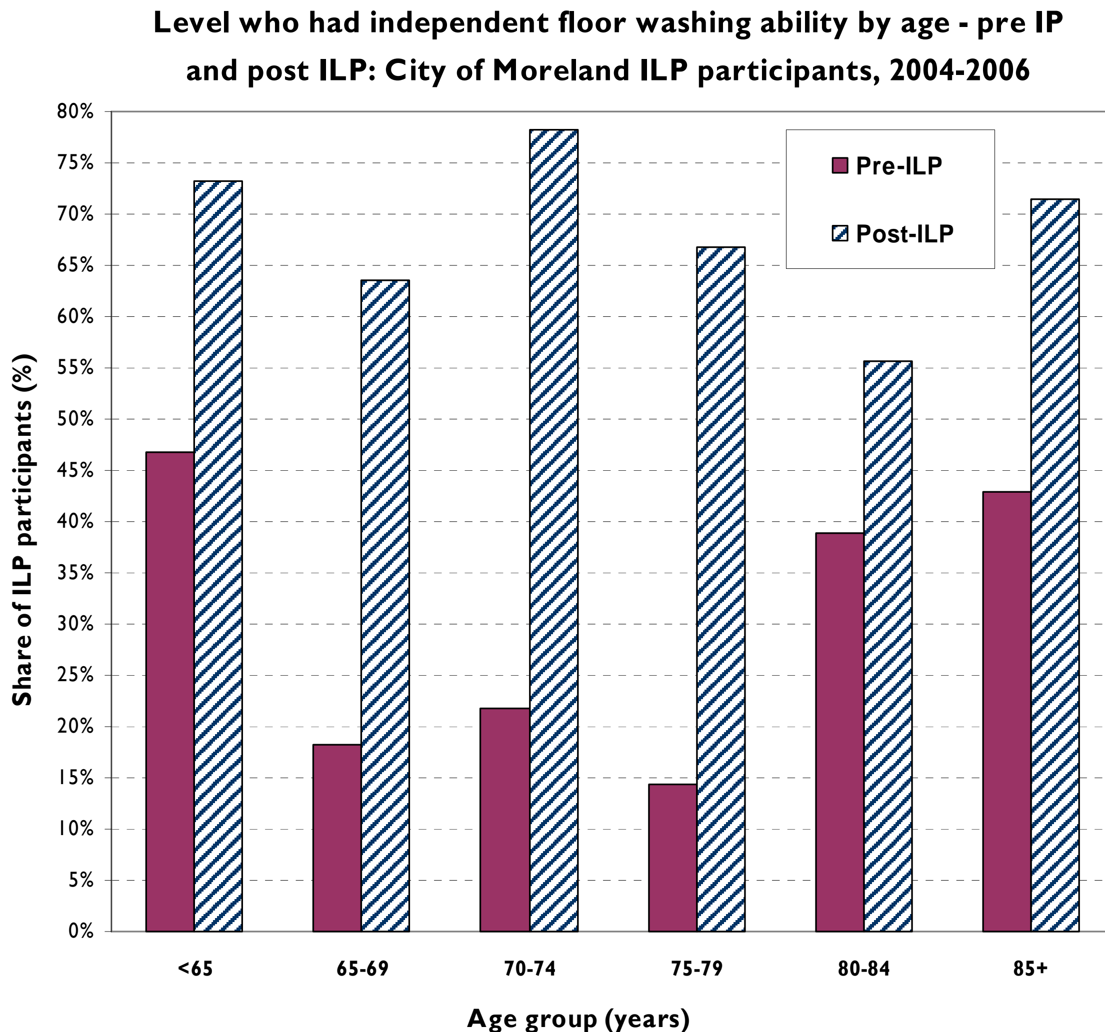
The picture is similar for bathroom cleaning ability. The level who were independent in bathroom cleaning ability to begin with was highest for 80-84 year olds (44%) and those aged less than 65 (27%). The level was 18% for 65-69 year olds, 13% for 70-74 year olds, 9.5% for 75-79 year olds and 14% for persons aged 85 plus. In all age groups except for the 80-84 year olds and those aged less than 65, the level who were independent in bathroom cleaning ability at the end of the ILP more than doubled. These two age groups would have shown less improvement because less of them had scope for improvement, since more were independent to begin with.

Chart 9: Independent Bathroom Cleaning Capacity by Age - pre and post ILP



The level who were independent in washing floors to begin with was highest for those aged less than 65 (47%), those aged 85 plus (43%) and 80-84 year olds (39%). The level was 18% for 65-69 year olds, 22% for 70-74 year olds and 14% for 75-79 year olds. Those aged 65-79 (who did not have high independence levels to begin with) showed the most improvement – the numbers who were independent in floor washing ability at the end of the ILP more than tripled in these age groups.

Chart 10: Independent Floor Washing Capacity by Age –pre and post ILP



The scope to improve also varied with household type. Persons living alone showed the most improvement in vacuuming ability – 16% were independent before the ILP, compared to 25% of those who were not living alone. This level more than tripled during the ILP, with 49% of those who were living alone being independent in vacuuming ability at the end of the ILP. The level of those who were not living alone and had independent vacuuming ability more than doubled, to 58%. However, there were no significant differences in the level of independent bathroom cleaning or washing floors ability by household type at the start of the ILP.

Whilst the level of independent vacuuming ability before the ILP varied significantly by ethnicity, the level of improvement did not vary greatly. The level of those born in Australia who were independent rose from 26% to 70%, a 169% improvement. The level of Italian born participants who were independent rose from 18% to 50%, a 178% improvement.
The level of independent bathroom cleaning ability before the ILP did not vary significantly by ethnicity, but the level of improvement did vary. The level of Australian born participants who were independent rose from 23% to 63%, a 174% improvement. The level of Italian born participants who were independent rose from 24% to 55%, a 129% improvement.

In the area of independent floor washing ability, the level varied significantly by ethnicity prior to the ILP, and the level of improvement also varied significantly. The level of Australian born participants who were independent rose from 42% to 77%, an 83% improvement. The level of Italian participants who were independent rose from 17% to 59%, an improvement of nearly 250%.

4.5 Factors related to Improvements in Functional Capacity at 3 months

4.5.1 Level of Improvement by Client Characteristics

Age

Those aged 75 –79 years were most likely to improve, with 33% improving in all three areas. Eighteen percent of 65-69 year olds improved in all three areas, as did 17% of 70-74 year olds. The improvements were less marked at the high and low ends of the age range, with 11% of 80-84 year olds and 7% of under-65 year olds improving in all three areas. Although 14% of those 85 years plus improved in all 3 tasks, there were too few persons in this group to be confident of this result.

Age does appear to be a significant factor in improvement, with noticeable differences in the level of improvement between age groups; the main improvement in one or more tasks was amongst the 65-79 year olds, with less improvement amongst the older group aged 80 years and over, and those under 65 years. Those aged 80 –84 were also more likely to have reduced capacity to perform the tasks at 3 months. The reduced improvement amongst participants under 65 years and 80 – 84 years is likely to be because they had less dependency in the first place and had less scope for improvement – persons aged less than 65 were by far the most likely to stay the same. Although the numbers (7) were very small for those aged 85 year+, the results do indicate that some improvement is possible, at least with one task.

Table 3: Number of Areas of Improvement by Age:
City of Moreland ILP participants, 2004-2006

Number of areas improved in	Age (years)						Total
	<65	65-69	70-74	75-79	80-84	85 & over	
All three	**6.7%**	**18.2%**	**17.4%**	**33.3%**	**11.1%**	**14.3%**	**17.9%**
Two	13.3%	18.2%	21.7%	19.0%	27.8%	14.3%	20.0%
One	33.3%	36.4%	26.1%	23.8%	5.6%	42.9%	25.3%
Improved in one or more	**53.3%**	**72.8%**	**65.2%**	**76.1%**	**44.5%**	**71.5%**	**63.2%**
None/Stayed the same	**46.7%**	**18.2%**	**30.4%**	**23.8%**	**38.9%**	**28.6%**	**31.6%**
Worsened in three					5.6%		1.1%
Worsened in two					5.6%		1.1%
Worsened in one					5.6%		1.1%
Worsened in one or more					**16.8%%**		**3.3%**
Improved in some, worsened in some		**9.1%**	**4.3%**				**2.1%**
Total N	15	11	23	21	18	7	95
Total %	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Birthplace

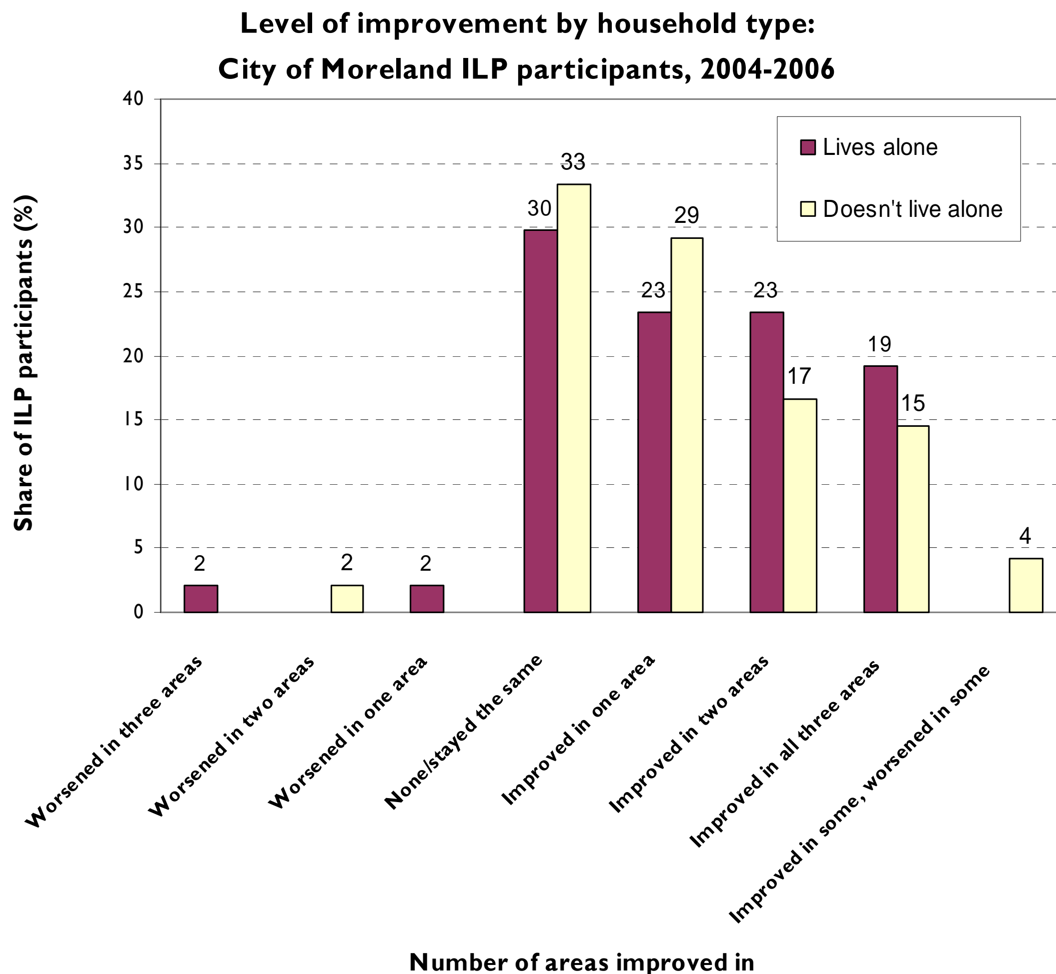
There was no significant variation by birthplace, using the level of participants who improved in all three areas as an indicator. Eighteen percent of Australians improved in all three areas, compared to 17% of Italians and 17% of persons born in other countries.

Household Type

Household type is a possible indicator of improvement. People living alone were more likely to improve in two or three areas, and less likely to improve in none or one. Nineteen percent of persons living alone improved in all three areas, compared to 15% of those who were not living alone. Twenty – three percent improved in two areas compared to 17% of persons not living

alone. Persons living alone may have more scope for improvement and benefit more from the ILP than those living with a spouse or other relatives; however, they may be more dependent in the first place. Those living with others tended to share the tasks between household members.

Chart 11: Level of Improvement by Household Type



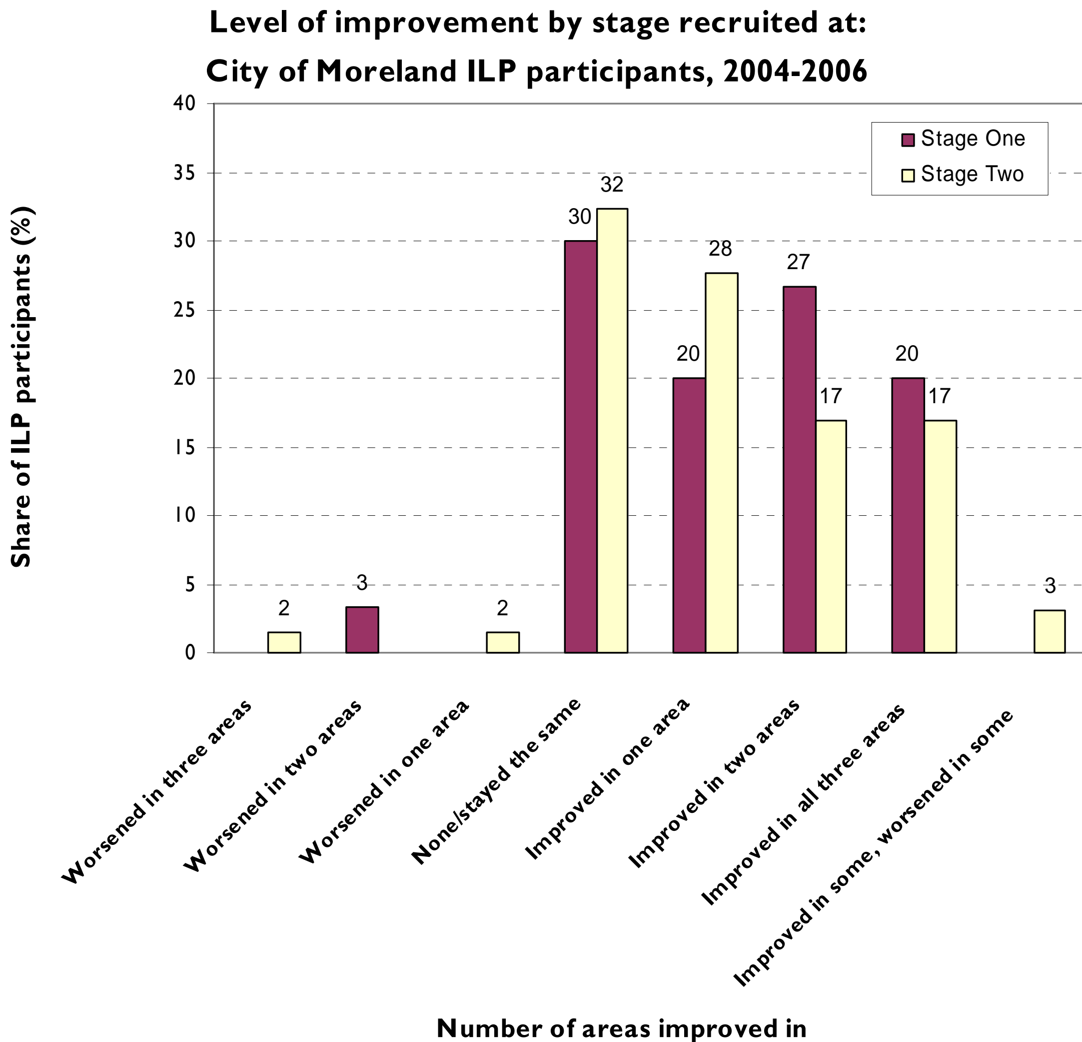
Diagnosis

The relationship between improvements and the main conditions impacting on capacity cannot be reliably analysed by the eight diagnoses codes, as the groups within each category are too small.

4.5.2 Improvement by Stage of Recruitment

Those recruited in Stage One were more likely to improve in two or three areas than those recruited in Stage Two. Forty-seven percent of those recruited in Stage One improved in two or three areas, compared to 34% of those recruited in Stage Two. A higher proportion of the Stage One participants had been assessed at the lowest level of priority, (62%)versus 49% of Stage Two recruits, so may have had more capacity to improve. Stage One recruits were also more likely to be living alone (55% compared to 47% of Stage Two recruits), also a factor in those with more improvement. They were slightly more like to be Australian or Italian (48% were Australian compared to 45% of Stage Two recruits and 34.5% were Italian compared to 29% of Stage Two recruits), and were more likely to be aged 75-79 (31% compared to 18.5% of Stage two recruits).

Chart 12: Level of Improvement by Recruitment Stage



Those recruited in Stage One were much more likely to have been assessed at the lowest priority level of need for a home care service. Sixty – two percent of Stage One recruits were assigned priority 3 compared with 49% of Stage Two recruits.

Table 4: Assessed Client Priority by Stage of Recruitment: City of Moreland ILP participants, 2004-2006

Assessed client priority	Stage of recruitment		Total
	1	2	
1	3.1%	2.1%	3.1%
2	37.9%	47.7%	44.7%
3	62.1%	49.2%	53.2%
Total	100.0%	100.0%	100.0%

4.5.3 Improvement by Priority Level

Most clients were initially assessed as being of lower priority for a home care service -second or third priority (45% and 53% respectively). Only two participants (3%) were assessed as priority one (high). Not surprisingly, those who were initially assessed as being of lower client priority were more likely to improve in all three areas: 22% of priority three clients improved in all three areas,

compared to 14% of priority two clients (no priority one clients improved in all three areas, but there were only two clients in this grouping). The priority three group may have had more scope for improvement, however, they were less likely to improve in two areas (16% compared to 23%), but more likely to improve in one area (31% compared to 19%). **The data is therefore suggestive that client priority levels, as have been applied at Moreland, are a useful but not an entirely consistent indicator of improvement in capacity.**

4.5.4 Improvement by Clients' Perceived Need for Assistance

As would be expected, the number of areas improved in was strongly related to whether clients' self-rated need for assistance had reduced. Fifty-five percent of those who reported that their need for assistance had reduced, had improved in two or three task areas; however, amongst those whose need had not reduced, 20% (nine persons) had still had an improvement in two or three areas.

4.5.5 Improvement in Confidence

Similarly, the number of areas improved in was strongly related to whether the ILP had improved clients' self-rated confidence. Forty-nine percent of those whose confidence had increased, had improved in two or three areas, compared to only 13% of those whose confidence had not increased. Of those who made no improvements in the main areas of difficulty, six people (43%), still rated an increase in their confidence to complete home care tasks.

4.5.6 Take up of Recommendations

The level of improvement was strongly related to the percentage of recommendations taken up, in all three task areas. Those who took up 100% of recommendations made, were much more likely to improve in two or three areas (65% of this group). Forty-six percent of those who took up 50-99% of recommendations improved in two or three areas, compared to 21% of those who took up 1-49%. There is a high percentage of clients not taking up the recommendations made to them in one or more areas, so improving the take-up rate is likely to have a positive impact on client improvement.

Most participants took up at least some of the recommendations made to them – 24% took up all recommendations, 29.5% took up 50-99% and 30.5% took up 1-49%. Results were similar across all three task areas. Participants who were independent prior to commencing the ILP still took up recommendations which simplified home care tasks for them.

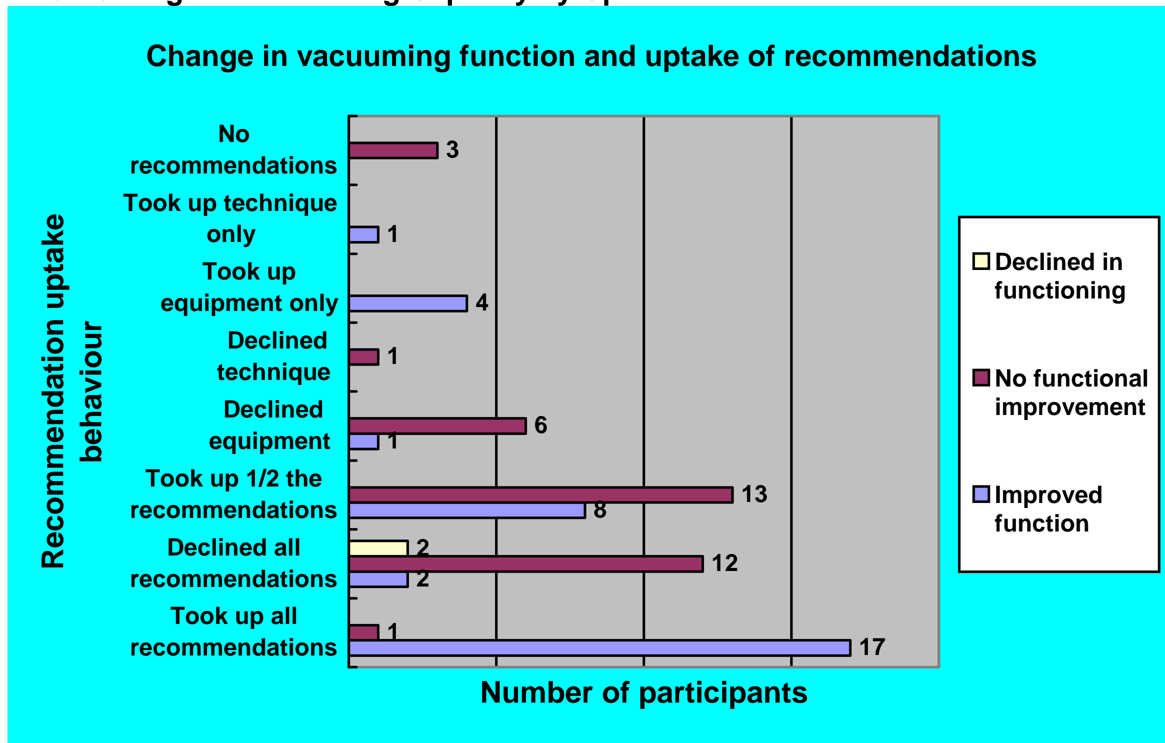
The take-up rate for recommendations does appear to be a clear indicator of level of improvement.

Vacuuming

Thirty four households (46%) had made a functional improvement, 37 (50%) had showed no improvement and, three households(4%) had declined in their ability to vacuum from the initial assessment at the 3 month review. Overall the number of people who were able to complete vacuuming independently had increased from 19 to 50 (163 %) and for those who were independent with difficulty, the number had decreased from 64 to 32 (50%) at the three month mark. There appeared to be little impact on the total number of people who were rated as requiring assistance or who were dependent in vacuuming.

It is apparent that those who improved in vacuuming were more likely to have taken up the recommendations, with a combination of both equipment and technique appearing to be the most effective.

Chart 13: Change in Vacuuming Capacity by Uptake of Recommendations

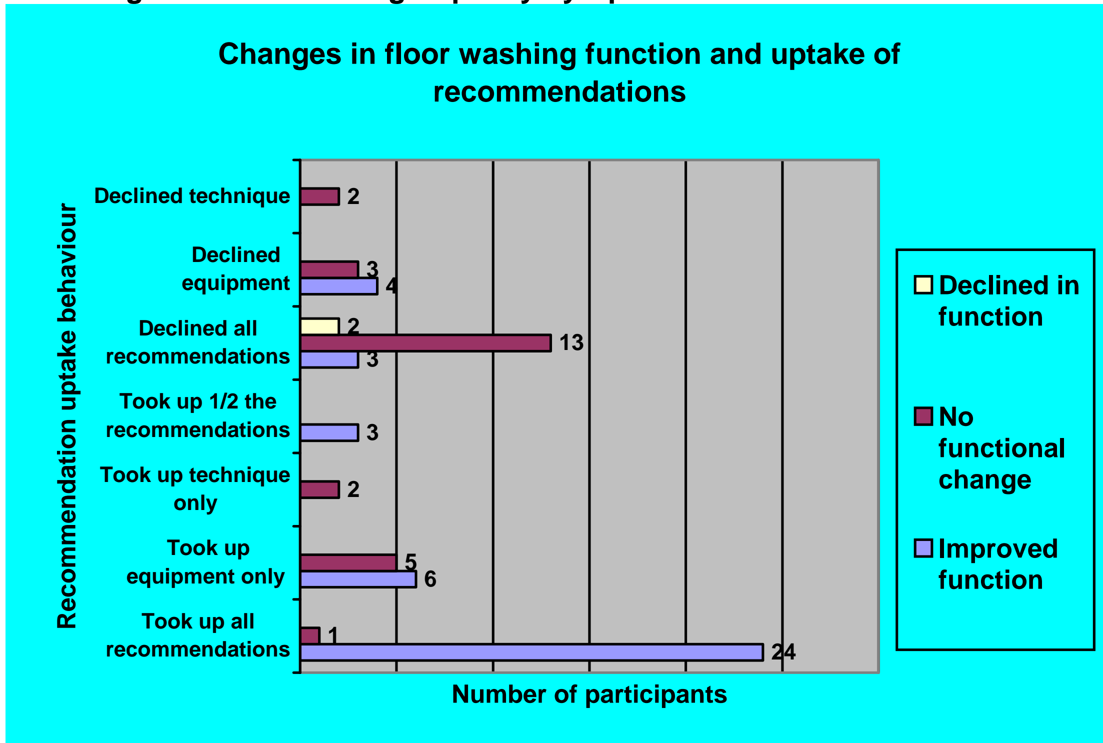


Washing Floors

Forty households (58%) had made a functional improvement, 26 (38%) had showed no improvement and, three (4%) had declined in their ability to wash the floors from the initial assessment at the 3 month review. Overall there was an increase from 27 to 65 (141%) in the number of households who were managing floor washing independently after the 3 month review. Those who made functional gains to this level, predominantly came from the group who were assessed as managing floor washing with difficulty at the initial assessment. There was an overall (39%) decline in the numbers who were managing with difficulty.. It is difficult to draw any conclusions from the groups who were requiring assistance or dependent in this task at initial assessment, as they were small in numbers, but there was a higher rate of improvement achieved than in the vacuuming task.

Again there is a higher association between uptake of both equipment and technique recommendations and improved functioning in washing floors. This is further supported by the higher rate of those who declined all recommendations and did not change in their floor washing ability.

Chart 14: Change in Floor Washing Capacity by Uptake of Recommendations

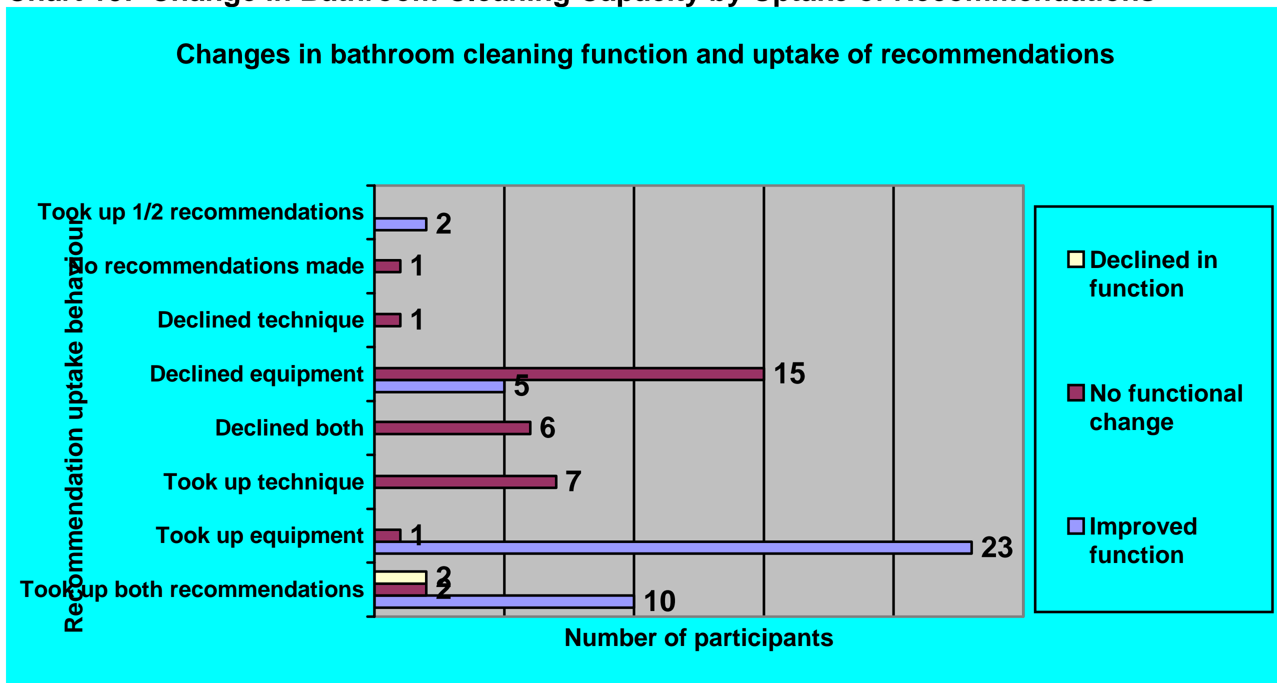


Cleaning the bathroom

Overall improvements were made by 41 households (54%), whilst 32 (42%) made no improvement and three households (4%) declined. There was an increase of those who could complete cleaning the bathroom at an independent level from 20 to 55 (175%), again these were predominantly from the group who experienced some difficulty at initial assessment. Although the numbers are small, there was a shift in the number of households who were dependent or required assistance from 14 to 9.

The data indicates that equipment rather than technique change was more effective in improving functioning in ability to clean the bathroom. The greatest number of households who improved in their functional ability to clean the bathroom adopted equipment techniques only.

Chart 15: Change in Bathroom Cleaning Capacity by Uptake of Recommendations



4.5.7 Use of Services

Home Care Services
One of the strategies offered to 23 participants in the ILP was assistance from home care services. Eleven households were offered a short term service to either support them whilst recovering from an acute illness or to establish a baseline of cleanliness for them to maintain. This averaged 2.7 hours of service per household. Seven of these households received a once only service of 1 hour.

Twelve households had a change in circumstances, such as a decline in health or functional ability that warranted the commencement of an ongoing home care service. Six of these households received a standard ongoing service of 1.5 hours per fortnight whilst the remaining 6 households received a reduced service such as 1 hour per month or quarter. In addition one other household was eligible for and accepted an ongoing service from the Department of Veteran Affairs (DVA). Thus of the 96 households who participated in the ILP: 71 (75%) received no home care services; 12 (11%) received only a short term service; 6 (6%) received a reduced ongoing home care service; six (6%) received a standard ongoing home care service; one took up a DVA home care service.

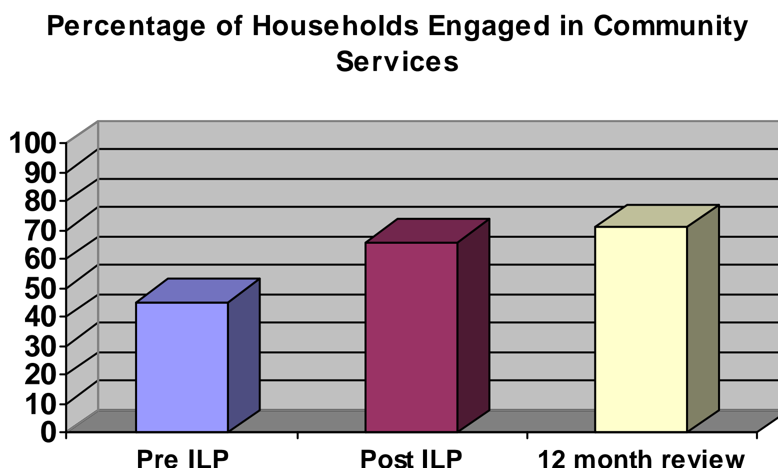
Although the numbers are small, the available data does indicate that those receiving any level of home care service were more likely to improve in all three areas than those who were receiving none.

Other Community Services
A component of the ILP assessment included identifying and recommending to clients when other service types may be of assistance to them. This included referrals to home maintenance, occupational therapy or carer support services to name a few.

Forty seven (45%) households already had contact with other community services when assessed by the ILP at an average of 1.4 services each. After ILP involvement, 66 households (63%) had contact with other community services at an average of one per household. At the three month review, 37 (39%) households had an increase in the number of community services they accessed; 53 households (55%) maintained the same number of services; and six (6%) households had decreased the number of services they accessed.

For the 28 households who participated in the 12 month review process, 20 (71%) of them had contact with other community services at an average of 1.65 services each. Six households (21%) had experienced an increase in the number of services they accessed, 17 households (61%) maintained the same number of services, and 5 households (18%) had a decrease.

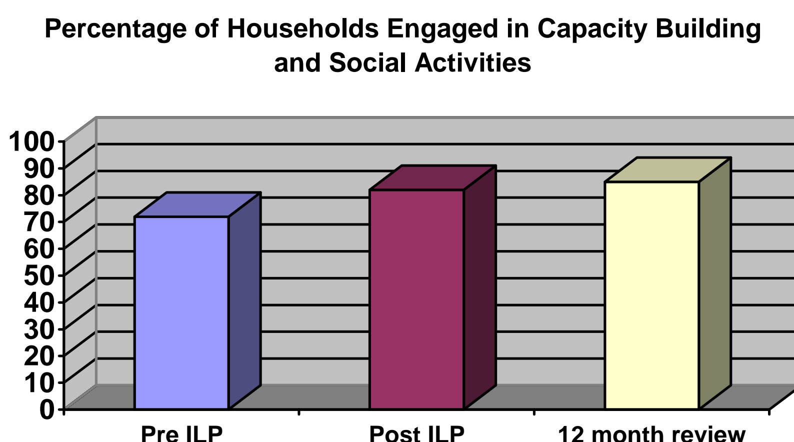
Chart 16: Involvement in Community Services



Capacity Building and Social Activities
Another objective of the ILP process was to encourage clients to participate in physical capacity building and socialisation activities such as exercise groups and programs at local leisure centres. At initial assessment 72 households (75%) were already engaged in social or capacity building activities with an average of 1.8 activities each. Thirty percent were not currently doing any regular physical activity, but of those who were, walking was the most common activity, followed by participation in programs conducted by health services (e.g. physiotherapy, falls and exercise programs, walking groups);activities at local facilities such as swimming, water aerobics, strength training, bowls and bocce; home based exercise including using a treadmill or exercise bicycle and gardening ; group activities conducted at Federation Village (retirement village) , or neighbourhood houses, such as exercises, tai chi.
After ILP involvement this increased to 82 households (85%) engaged in social and physical capacity building activities, at an average of 1.9 activities each.
Seventeen households (18%) had increased the number of activities they participated in at the three month review, with 74 households (77%) maintaining the same level and five households (5%) experiencing a decrease. Most of those who had not been engaged in any activities at initial assessment, where referred to or offered options, but 14 people (48%) had not taken these up at the three month review. The percentages for household participation in capacity building and social activities at the 12 month review remained fairly similar to that at three months.

Physiotherapy
Twenty-five percent of clients were actively involved with physiotherapy during the ILP program, including those referred by ILP. Forty-two percent (42%) of this group improved in two or three task areas, compared to 36% of those who were not involved in physiotherapy. Although the numbers involved in physiotherapy (twenty-four clients) is small, it did appear to have an impact on improved capacity. 50% of those using physiotherapy had rheumatological or orthopaedic conditions, compared to 31% in the overall ILP population. A higher proportion were also in the Priority 2 category than the general ILP group.

Chart 17: Involvement in Capacity Building and Social Activities



4.6 Client Perspectives and Satisfaction with the ILP

4.6.1 Client Satisfaction and Confidence

A review question about satisfaction levels was added following the engagement of an external consultant for the statewide evaluation process. Forty – eight of the ILP households (50%) were asked to rate their satisfaction with the program. Of these, 65% reported that they were either very satisfied or satisfied with their involvement, 21% were neither satisfied nor dissatisfied and 14% were dissatisfied. At review, 67% reported an increase in confidence following their involvement with the project. A significant number (39%) still reported an increase in confidence despite not making any improvements in tasks, or only improving in one task.

4.6.2 Client Expectations

Forty - eight clients (50%) responded to an inquiry about the project meeting their expectations. This proved a difficult question to pose, as the majority of participants contacted Moreland City Council expecting to access a general home care service and did not anticipate engagement with an alternative model of assessment and service provision. As a result, expectations were centred on this, rather than the project. Involvement sometimes resulted from an attitude of *'something's better than nothing'* or the hope that they would find themselves in receipt of a service at the end of the project. Of the clients responding to the question about expectations, 60% reported engaging with MCC to access a service, 10% had no expectations, and 6% reported that the referral was initiated by a hospital worker. One client commented:

"I felt that I needed to get help. It's always nice to talk to someone who knows what they are talking about, but I needed a service"

4.6.3 Differences ILP Made

Forty – eight participants responded to a question about the overall difference the project had made for them. Of these, twelve people (25%) reported that it made no difference, many reiterating that they still wanted a home care service:

"Showing me has helped nothing; only difference you could make is to send someone"

In contrast, sixteen people (34%) reported that it made things easier or that they experienced less discomfort or pain during home care tasks:

"I can manage with a few variations…it has made my work easier – I've seen other people doing it but I didn't think to. I think it's important to keep your independence as long as you can"

Twelve people (25%) responded with comments that reflected themes of being heard, reassured, encouraged and increased confidence:

"Increased my confidence (the difference made). I'm managing much better….I was pretty crook inside myself"

"You encouraged me a lot. I now have hope that I will be helped in the future (when needed)…..you explained things to me"

Seven people (15%) reported that they had an increased awareness of alternative equipment and ways of doing things:

"You don't know that aids are available and that you need them….you don't think"

Two of the participants cited their referral and subsequent involvement in physiotherapy, as the main difference the project had made for them.

4.6.4 Case Studies

To demonstrate the process involved and the range of input individuals required with the ILP, a number of case studies (not real names) are outlined below. They reflect variations in client engagement, need, capacity for improvement and the ILP responses to these. As also seen from a number of the comments above, and from the focus groups below, the project had difficulty providing an acceptable outcome when individuals with a lower priority for services didn't want to engage in a more independent approach, but just wanted the support of someone else doing the tasks for them.

Case Study One: Mr. and Mrs. Luccio
Mr. and Mrs. Luccio were referred for a general home care service by a community based occupational therapist (OT). The OT became involved with Mrs. Luccio following her repeated falls due to hypertension and dizziness. Mrs. Luccio was 71 and Mr. Luccio was aged 77 at the time of initial assessment.

On assessment, the couple was found to be independent in all community based activities; driving, shopping and visiting friends. Medically, Mr. & Mrs. Luccio were restricted in their activities by shortness of breath and dizziness respectively, experiencing fatigue when completing home care tasks, particularly when vacuuming. They felt they were a priority for service and were disappointed not to be assessed as such.

Mr. and Mrs. Luccio were using a cumbersome vacuum cleaner and shared the task over the course of a week. They could only complete one room at a time. Mrs. Luccio also had difficulty mopping the floor and cleaning the shower. Following task analysis and equipment assessment, a light, motorized carpet sweeper was provided on trial and alternative techniques were demonstrated. The carpet sweeper replaced the vacuum cleaner and the microlite mop replaced a squeeze sponge mop. They commenced using a non-scrub spray and a long handled scrubber, taking away the need for harsh scrubbing and bending in the shower. They were encouraged to space the completion of all house cleaning over the week.

At review, they no longer felt a need for general home care service and managed tasks without difficulty; Mrs. Luccio was able to complete the tasks on her own. Mrs. Luccio commented;

"I don't get puffed out anymore….I never thought I'd be able to do it. I used to hate the thought of doing the vacuuming".

Case Study Two: Mr. and Mrs. Cooper
Mrs. Cooper (aged 67) was referred by her General Practitioner (GP) for a home care service. On assessment it was found that Mr. Cooper (aged 76) used to complete the majority of cleaning tasks prior to his recent hospital admission for a fall and other complicated medical issues. On discharge Mr. Cooper had reduced mobility (using bilateral elbow crutches) and wasn't able to participate in vacuuming or washing the floor. Mrs. Cooper was on 24 hour oxygen and experienced shortness of breath on minimal exertion during cleaning tasks. Their daughter was assisting them with these tasks following discharge, but was not able to continue long term.

Mr. and Mrs. Cooper had a heavy barrel vacuum cleaner and used a squeeze sponge mop with a bucket. Following assessment, a plan was put in place to increase both their physical capacity as well as strategies to facilitate their ability to resume cleaning tasks. Mr. Cooper was referred to physiotherapy for an ongoing exercise group to increase his mobility following hospitalisation and Mrs. Cooper was engaged in home care tasks with alternative techniques and equipment.

A one off bathroom clean was provided by Moreland City Council to bring it up to a level of cleanliness that the Coopers could maintain. The couple purchased a non -scrub spray on cleaning product that they applied daily to the shower eliminating the need for scrubbing and reaching down low. The ILP assistant visited and provided a motorised carpet sweeper on trial, reinforcing the need to pace activities.

On review, Mrs. Cooper had purchased her own motorised carpet sweeper and was completing a few rooms at a time. She had purchased a microlite mop and was managing washing the floors well. Mrs. Cooper's only limitation was reaching into corners with her carpet sweeper. Moreland City Council instituted a reduced ongoing service of 0.5 hours per month to vacuum the corners. Mrs. Cooper commented:

"There's a big difference………the gadgets you've recommended have made cleaning a lot easier….now I can last longer".

Case Study Three: Mr Black

Mr. Black was referred by a community occupational therapist (OT) and was assessed by a team leader a month later as being a low priority for a home care service. At 72 years of age, Mr. Black had a variety of chronic medical conditions including angina, poorly managed diabetes, glaucoma affecting his vision and anaemia requiring continuing medical investigation. He was experiencing deterioration in his function and mobility.

On assessment, Mr. Black was experiencing pain following vacuuming. He would get down on his hands and knees to clean the shower base and slide down the sides of the kitchen cupboard to sweep up dust from the floor. He reported distress at his deteriorating vision. An alternative vacuuming technique was demonstrated and he was encouraged to spread the task over the week. Mr. Black was shown a motorised carpet sweeper, along with alternative mop, long handled pan and broom, cleaning products and equipment for the shower. He agreed to a referral to Vision Australia for advice on increasing his independence in cooking tasks.

At review 3 months later, Mr. Black's medical status had stabilised and he was using the alternative vacuuming technique demonstrated, as well as the shower products. He felt that he was able to manage his home care activities with occasional assistance from his daughter to get to the shower grouting.

Eight months later, Mr. Black was re referred for a home care service after being hospitalised and discharged following sciatica and hip pain. He was mobilising with a frame and unable to complete any home care tasks. On returning home, Mr. Black's daughter linked him up to weekly physiotherapy at the local community health centre. The ILP re engaged with Mr. Black again.

Mr. Black was extremely frustrated at not being able to undertake his home care tasks. He wanted to continue being independent and was progressing well with his physiotherapy. A short term home care service was put in place at 1 hour per fortnight for 3 months whilst he improved. Mr. Black was open to implementing recommendations made during the initial involvement with ILP. The ILP assistant organised the purchase of a microlite mop and took out a carpet sweeper on loan, demonstrating the use of both.

Mr. Black reported using the carpet sweeper in between visits from the home care staff. He felt more in control of his environment and was progressing well with re-engaging in tasks.

Three months after the second engagement with the ILP, Mr. Black was able to walk for 15 minutes and no longer using a walking stick in the home or around the village. He no longer required assistance with the floors and was only having trouble bending to clean the toilet and shower base. The home care service provided by Moreland Council was reduced to 0.5 hours a month for these tasks for another three months. Mr. Black continued to restore his physical capacity and resumed all home care tasks independently ten weeks later.

Case Study Four: Mrs. McDermott

Mrs. McDermott was an 89 year old woman who lived on her own and was referred by a hospital social worker for a home care service after hospitalisation for unstable diabetes. She received short term hospital funded services upon discharge and these were coming to an end when the ILP assessment was conducted.

Mrs. McDermott was previously independent in home care tasks and was known to cook a meal for up to 20 family members. Her hospitalisation affected her confidence and on returning home she found her energy levels were reduced and she was concerned that she would never return to her previous level of functioning.

Mrs. McDermott's daughter was present during the assessment. A consensus was reached that a capacity building approach, where Mrs. McDermott would be supported in returning to normal activity, would be the best approach. Mrs. McDermott lived in a small, fully tiled house. She used an old heavy vacuum cleaner and a string mop, which she wrung out with her hands. Alternative equipment was demonstrated and Mrs. McDermott decided she'd like to trial a carpet sweeper and purchase a microlite mop.

The ILP assistant was to provide fortnightly assistance to Mrs. McDermott in completing some of the home care tasks and working alongside her providing training in how to engage in those tasks that she could undertake, using the recommended alternative equipment and techniques.

On the first visit from the ILP assistant, Mrs. McDermott was found dusting the house, having swept all the living areas already. Her daughter had purchased the mop, but she had not trialed it yet. Mrs. McDermott expressed that she was no longer satisfied with the care plan agreed on. She reported that if a worker was going to come fortnightly to her home, then the worker might as well complete all the cleaning tasks herself. She reasoned that a niece who was younger than her and living in a neighboring municipality received an ongoing home care service, and felt that she was more worthy herself because of her age. She refused to engage with the assistant, and felt that unless she was going to do the cleaning, she should leave.

During the process of trying to negotiate a new care plan, Mrs. McDermott's energy and functioning improved. Despite this, she continued to request a passive home care service.

"I have my own way, have been doing it this way for a long time……… are you going to send someone or not?"

Case Study Five: Mr. and Mrs. Morello
Mr. and Mrs. Morello were referred by an occupational therapist following Mrs. Morello's hospitalisation and rehabilitation, having sustained spontaneous vertebral fractures. She had been gradually deteriorating and Mrs. Morello (aged 79) had significant difficulties with her mobility, using a walking frame. Mr. Morello (aged 81) had arthritis in his knees and hypertension, but walked without difficulty.

At the assessment, Mrs. Morello strongly advocated that they required an ongoing home care service. Both their daughter and an interpreter were present. It was difficult to engage Mr. Morello, as he felt that the cleaning had nothing to do with him. As the assessment progressed, it transpired that Mr. Morello was involved in the heavier tasks of vacuuming and washing the floor. They had a range of lightweight compact vacuum cleaners which Mr. Morello had started using as the need for his involvement in the housework increased. The techniques he used could have been improved upon to lessen his fatigue levels and the need to split the tasks up throughout the course of a week was indicated, as he tended to vacuum the whole house in one day and wash the kitchen floor daily.

Mrs. Morello was at a high risk of falling and had not taken up bathroom adaptation recommendations made by the hospital OT. She had stopped attending outpatient physiotherapy, as she disliked using the taxis and found the drivers rude. With her agreement, a referral for community transport was made with an aim to link her back into her therapy program. The value of rails in her shower was reinforced, and an offer was made for the recommendations to be reactivated. Mr. and Mrs. Morello were advised that they were not a high priority for a home care service.

Mrs. Morello was non-committal to the recommendations and said she would consider the action she wanted to take. At a follow up phone call, Mrs. Morello repeatedly asked when she was going to get a home care service and reported that she didn't understand the concept of prioritisation. She refused to discuss it any further and advised me to talk to her daughter. Repeated attempts were made to communicate with Mrs. Morello's daughter, with no response.

4.6.5 Focus Groups

Out of the thirty people invited, seven English speaking and eight Italian speaking participants attended the two groups on the day. Reasons for non-attendance ranged from disinterest and other commitments, to poor health. An external facilitator conducted the sessions and produced a report outlining their findings.

The two groups were very different in terms of their responses to the focus group questions. The first group was generally able to think broadly and consider and comment on the questions being posed. The second group (possibly due to language, the impact of interpreters or their understanding about why they were invited to participate in the focus group) was less able to discuss the concepts and were very focused on individual situations and their `right' to access Council home care as they had worked hard and paid taxes. They used the focus group as a forum to air their issues and complaints, in the hope it would somehow improve their access to service. They felt Council (including reference to Council as "father") had a responsibility to look after them that was not being fulfilled to their satisfaction. The difference between the two focus groups indicates the diversity of expectations from the people requesting assistance from Council's home care. For example, Group 1 tended to reflect that their attitudes to housework had relaxed as they had aged whereas this was less apparent in Group 2.

The key themes from the focus groups can be summarised as follows:

- that perceptions about satisfactory levels of cleanliness in the home are very personal and influenced by upbringing and personality traits, and differ greatly between individuals;
- some people's attitude to housework relaxes as they age and they accept that they are less able to complete tasks to the same standard;
- the desire for periodic assistance with bigger or more difficult tasks such as cleaning curtains and moving furniture (to clean behind or underneath);
- that a clean house has a psychological and emotional impact (of varying degrees) on how people feel and their attitude to aspects of life (such as socialising, mood, sense of achievement, sense of well-being etc);
- part of the psychological and emotional impact of a clean house is being able to maintain the house through their own efforts; a sense of powerlessness ensues when they can't prevent deterioration in their property;
- a sense of inequity in relation to access and allocation of home care services;
- a lack of understanding about how home care is funded (i.e. arrangement between Commonwealth, State and Local Government) and limitations of funding; and,
- the visits from the occupational therapist were generally seen as positive and useful, although some participants would have preferred an ongoing homecare service.

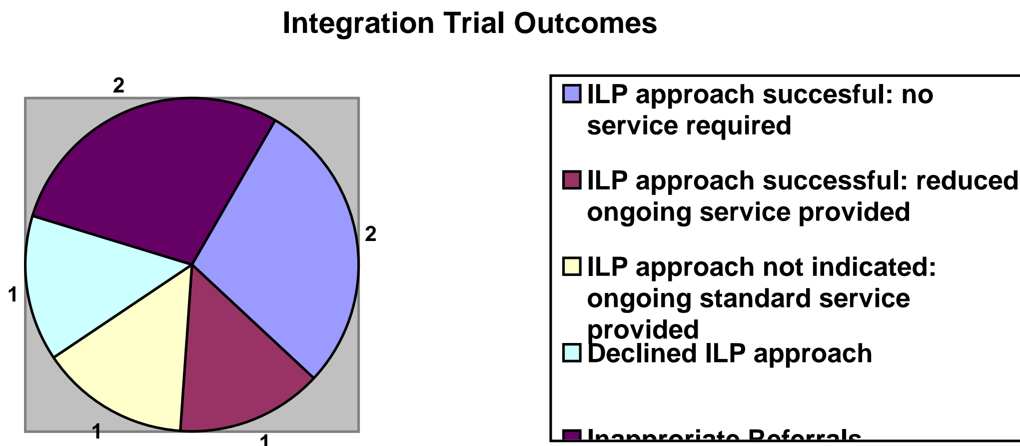
4.7 Integration Trial (Stage 3)

Between July and September 2006, ten households allocated an 'urgent' status at the Intake stage of referral were approached for assessment using the ILP model of service by the chosen team leader, falling short of the targeted twelve. Of these:

- two households did not undergo a full assessment, advising they no longer required a service at the commencement of the assessment visit. In both these cases, an orthopaedic condition and its' surgical treatment resulted in a temporary decline in function. One client experienced a 2 month delay from referral to assessment, and had recovered function, whilst the other household was receiving short-term assistance from a family member and was happy with this arrangement;

- One household required a more complex needs assessment with referral to the local Aged Care Assessment Services (ACAS) and,
- Seven households underwent full assessment and some engaged in further intervention, the results being;
  - two households did not require or receive a home care service following the ILP focused assessment and intervention process;
  - one household required a reduced ongoing service of 0.5 hours a month of home care ;
  - one household had high needs and was at risk of being placed in residential care and the household received a standard ongoing home care service;
  - carer stress triggered the referral rather then difficulty completing home care tasks resulting in respite rather than home care being provided for one household;
  - one household was resistant to a functionally based assessment and capacity building framework and was provided with a standard service; and,
  - one household had a care recipient and two residents who had no difficulties engaging in home care tasks. The original referral was based on a belief of entitlement. They declined to participate in an ILP approach.

Chart 18: Outcome of Clients seen on the Integration Trial



During the same period, the following outcomes were recorded for other teams in the service not applying an ILP approach to assessments for people deemed urgent at the Intake level. Thirty three households were approached for assessment by 5 team leaders with: 19 households (57.5%) were assessed as a high priority and received a standard ongoing home care service; 13 households (40%) declined an assessment upon contact stating they no longer required a home care service; and one household was ineligible for Home and Community Care services.

No households were assessed during this period as having a moderate or low priority for home care services, indicating that these tend to be identified as “standard” rather then “urgent” referrals at Intake. The majority of households who did not require an urgent service, had waiting times from referral to assessment anywhere between two and ten months.

4.8 Costs

The project cost for direct staff service delivery and salary on –costs based on the actual hours of service per client (but excluding non-direct service hours, and corporate on -costs) including occupational therapist assessment, general home care, home maintenance, interpreters plus equipment amounted to an average of $ $204 per client. Nearly two thirds of this cost was in the occupational therapist’s time spent with clients i.e. assessment and interventions (61%).

Table 4: Expenditure by Category

Item	Occupational Therapist	General Home Care	Independent Living Project Assistant	Home Maintenance modifications	Interpreters	Equipment
Percentage of expenditure	61%	5%	3%	18%	11%	3%

The cost of management time, worker training and supervision, corporate overheads and vehicle use was estimated at an additional 18%. This would increase the average cost per client to approximately $240.

Most of the participants in the ILP would not have received an on going standard home care service at Moreland, unless their needs had changed. All had already received, or would have received in due course, a home visit assessment. The direct cost of undertaking the usual home based assessment is approximately $ 54 with out management and corporate costs included. Thus the financial costs of employing the ILP approach with low priority clients, is in fact almost four times greater than the current approach.

Assuming there are current Moreland clients of the home care service who received an on going standard service despite having only a low to medium priority, and that using the ILP approach in future in assessing and reviewing all clients, may reduce the amount of on going home care required, it is worth comparing the costs against the standard general home care (GHC) service costs.

Estimating the average hourly cost of home care, without the management and corporate costs , is in the vicinity of $33 per hour, plus $ 9 per hour for the per hour share of assessment and administrative costs, then an episode of ILP intervention at $204 is equivalent to 4.8 hours of GHC service. On average, clients receive 33 hours of home care a year (or 39 hours per annum for a full year per individual). Thus for every client seen using the ILP approach, with an outcome of not needing an ongoing GHC service, there would be a saving of 34.2 hours per annum, worth $1436. It would only take the savings for 120 clients to fund the 2 additional assessment positions needed to implement the approach. Given a home care service base of about 3,000 clients and 400 new clients starting home care a year, it would take under one third of new clients, or 4% of existing clients to reach 120 clients. Although the numbers in the Integration trial were very small, 2 out of 10 urgent clients were able to use the ILP interventions and not use GHC, and one other only needed .5 hours of home care a fortnight. So 30% of the urgent referrals assessed using the ILP approach did not require the standard GHC service when assisted in other ways.

Although it is not possible to fully argue the cost benefit of the ILP approach, given the sample probably would not have received any home care service, so the direct substitutable cost benefits can't be measured, the indications are that investing more heavily in assessment and capacity building approaches will have some cost offset in the home care costs. The benefits in terms of client confidence, efficacy in completing home care tasks and remaining in control are also not able to be given a direct cost benefit.

Section Five: Discussion

5.1 Goals and Objectives

The project has been able to substantially achieve its objectives, and go someway towards meeting the last three of the five goals.

Goals

1. Assist in managing unmet demand for Home Care services.
2. Improve access to assessment services by the reduction of waiting times.

3. Provide a preventative service to clients with lower, less urgent need for Home Care.
4. Improve individual capacity to function safely at home.
5. Improve satisfaction with Moreland City Council HACC services.

Table 5: Objectives and Outcomes

OBJECTIVES	OUTCOMES
1. CLIENTS	
To assess and enroll initially 30 clients ,later increased to 200 clients, to the Independent Living Project.	256 clients approached, 193 assessed, 147 enrolled and reviewed after three months. 28 reviewed at 12 months.
To identify a range of suitable equipment and adaptive devices to minimize the strain of completing home care tasks.	Lightweight vacuums, vacuum modifications e.g. handle extensions, motorized carpet sweepers, light weight and extendable mops and spray on cleaners identified and trialed. Attempts to identify and develop affordable robot/remote controlled vacuums less successful. Most households adopted at least one item of the alternate equipment suggested to them.
To trial a range of techniques, equipment and modifications with assessed clients to determine whether they can maintain or increase their ability to safely complete home care tasks.	Energy conservation and work simplification techniques that included strategies specific to household tasks. 48% of households either maintained or improved functioning in 3 task areas after 3 months. 63.5% improved in at least one area. 31.3% had no improvement. 3% declined in capacity. 70% maintained the level they achieved after 3 months at 12 months, 85% of these still following most or all recommendations. Only 24% of households took up all the recommendations made -of these 65% improved in 2 – 3 task areas. 21% of those who took up less than 50% of recommendations, improved in 2 –3 areas.
To increase client confidence in managing their home care tasks safely.	68% of the 147 clients (96 households) reported that participating in ILP had increased their confidence.
2. COMMUNITY	
Identify and assist clients to access community based capacity building activities.	85% households engaged in social and capacity building activities, averaging 1.9, after 3 months, compared with 75% averaging 1.8 at the beginning. 52% of those not engaged in any physical activities commenced something suggested by ILP .
Increase client access and knowledge of other community services to meet their identified need	63% households using other community services at 3 months (18% increase), averaging 1 per household. 71% of households using community services at 12 months averaging 1.6 services.
Provide opportunities to share the learnings and strategies with other service providers, referrers and the broader Moreland community.	Presentations re ILP to Steering Committee, Moreland Aged Care Forum, Moreland Council Aged Care branch staff, Melbourne Health Discharge Expo, LGPRO Aged and Disability Services Interest Group conference, Launch of HACC tri – ennial Priorities, DHS Active Service Models Pilots. Sessions with seniors groups and at Healthy Living Expo for Moreland Seniors.
3.PRODUCTS	

Develop an Intake screening criteria tool to identify clients who may be more suited to the Independent Living Project rather than core service delivery.	As there were no clear indicators of who would benefit most from the ILP approach, no final screening tool was developed.
Develop an Independent Living Manual translated into appropriate community languages.	Completed (see Appendix 8)
Provide training to a pool of 5 home care staff so they can promote and reinforce independent living techniques with assessed clients on the program.	Training provided to 6 home care staff.
4.IMPACT ON HACC SERVICES	
To identify and trial alternative models of HACC services to sustain clients living at home	Flexibility in home care service most commonly needed e.g. short term, one off heavy clean, occasional grout or corner clean to supplement what client can do; working alongside to build confidence and improve capacity. Access to physiotherapy, and referrals to other capacity building activities. Assessment of all clients using ILP approach to ensure capacity building approach and that services are supplementing not substituting.
Minimize the client need for ongoing HACC services through implementation of the Independent Living Project.	Most clients seen in the ILP trial were not and would not have received a home care service at Moreland, at the time of assessment. 23 received a GHC service during the trial – only six had the standard 1.5 hours per fortnight – the others had less – e.g.; once off, short term or reduced service. Those that got some home care assistance did better in improving capacity in all three tasks. Although the numbers were too small to be reliable, a smaller percentage of clients with a higher priority received a standard home care service from the integration trial (3%) than other urgent referrals assessed in the usual way during the same time period (30%).
To develop a model of service that is sustainable and able to be integrated into the mainstream local government and community based HACC services.	To integrate the ILP approach would appear to have benefits for both individual's retention and development of capacity. It will require changes in assessment practice and skills, staff training and development, linkages with MCHS to better access allied health services in referral, assessment and treatment, improved communication with referrers and potential clients and their families about expectations of home care.

It is clear in both the qualitative and quantitative data that most of those households who were assessed as a low or medium priority who engaged with the ILP were assisted to continue to manage their own home care, to varying degrees, and that this was a more beneficial process than remaining on a waiting list for a service they were not likely to get until their needs increased. Of those that went on to a home care service, 75% required less than the standard service.

Whether the ILP approach substantially impacts on reducing the demand for mainstream home care services, or frees resources for more assessment, is more difficult to conclude as the clients

involved in this project were tracked for three months to one year only. However the approach of focusing on functional ability to perform core household tasks and ways of improving capacity stands to benefit a wider range of clients other than just those assessed as too low a priority to get any service, and it is likely that in responding more flexibly, many could require less hours of service than the standard 1.5 hours per fortnight. We estimated that approximately one third of referrals for home care could be a low priority and thus likely to benefit most from the ILP. During the project period, about half of the low priority clients were actually referred to, or agreed to be referred to ILP.

5.2 Clients

5.2.1 Client and Other Characteristics as Predictors of Suitability and Success of ILP Approach

It was assumed at the commencement of the project that the data would assist in identifying characteristics so that clients would be able to be screened and identified at Intake, as either needing a standard home care service, or not needing it and benefiting from the ILP capacity building approach. The data suggests that there are no particular client characteristics that consistently indicate the likelihood of success or better outcomes.

Age alone does not appear to be a strong predictor of outcome , although the ILP participants had a younger age profile than existing HACC service users in Moreland, and those aged 65 -79 years did better than older participants. Living alone was a significant factor in improving in all tasks.

It is likely that improving capacity to undertake household chores will be more successful with younger older people (under 80 years) and those living alone, but not exclusively, and individual circumstances and other factors have an impact.

Those assessed as having a lower priority need for home care services had a slightly higher rate of improvement with all tasks. We are not able to draw any strong conclusions as to how effective the ILP approach is for clients who present as having an urgent or high priority need for service as only 3 high priority clients were included in the ILP sample. The Integration Trial with 10 people was also too small to draw any strong conclusions, but the differences in outcomes between that group of urgent clients and those assessed in the usual way over the same time period, suggests that the ILP assessment and approach leads to fewer people getting a standard home care service response, and a wider range of outcomes.

Current methods of assigning a low priority level status to clients as an indicator of lower need for services, has some predictive value for improving capacity in household tasks.

The clients who accessed physiotherapy during the project commenced at a lower functional level that the general ILP sample but made greater improvements across all the three major areas of vacuuming, cleaning the floors and bathroom. These clients or households had improved their function to a level where they would not require ongoing home care services and although the numbers are small (11) 82% sustained this level at 12 months.

It is important to ensure that people requesting home care services are screened and referred for physiotherapy assessment and treatment as needed, to regain maximum possible physical functioning, before being offered an ongoing home care service. Moreland Council and Community Health Service will need to further develop screening and referral protocols.

Clients' interest in continuing to do tasks for themselves and willingness to try new techniques and equipment is also very significant for success. When considering vacuuming ability, the number of people who could vacuum independently following intervention more than doubled from 19 to 50 households. There seemed to be a reluctance to take up some equipment recommendations and this may have been associated with cost which averaged about $90.

Cost can be a barrier to taking up recommendations. Options for trialing and loaning equipment at low cost are important strategies for ensuring take up of recommendations.

As with vacuuming, the number of households who were able to complete floor washing increased by over 50% following intervention, from 27 to 65 households. Although the greatest improvement in any individual task was in cleaning the bathroom where the number of people who were able to complete the task independently increased from 20 to 55.

In all areas, there was a strong association with the uptake of recommendations and the increase in function. Overall the confidence of clients increased and their self rated need for assistance decreased. 82% rated an increase in their confidence after ILP intervention and 71% rated that their need for assistance with home care had decreased.

Other client perspectives revealed during the reviews at 3 and 12 months were appreciation for the limited waiting time, the clarity of the service response, the follow up and review. Clients stated things like ***" the most rewarding aspect of the ILP was having someone take an interest and care".***

Clients felt if their needs changed and they needed the service, it was going to be available to them ***"we know we've got someone to fall back on if we need it".***
One of the main reasons why clients do not relinquish services when they don't require them is the length of waiting time for assessment and service provision to commence.

Council services need to continue working towards being able to respond to all requests in a more timely, engaging and re –assuring ways.

The ILP has successfully demonstrated the effect of an active service model approach with a low and medium priority HACC target group, and the possibilities and logic of success with others in a higher need category. The data indicates that the interventions were most successful with three activities of daily living, namely vacuuming, washing floors and cleaning the bathroom. These are the items that are commonly the precursors for people to want and request a home care service.

The main factors impacting on more successful outcomes were the ability to assess the client or household from a functional perspective using a task analysis and problem solving approach specific to the client, and access to capacity building supports such as physiotherapy or an interim home care service, and clients willing to take up and sustain the recommendations on equipment and technique.

5.2.2 Sustainability

The project measured how well households sustained the interventions and their functional capacity to undertake home care over a12 month period for 28 households(29%). These households were generally older than the core ILP sample with the majority recruited in Stage One. These households reflect the fact that the differences made in functional capacity are sustainable for at least one year after intervention as 71% had sustained their overall function, with 29% declining in at least one area. One of the factors that appears to influence this is the maintenance of uptake of recommendations where 61% had maintained all and 80% had maintained at least 50% of the recommendations.

There was also little change in the households' self reported rating of the impact the ILP had had on their confidence to continue to function at home and their need for a home care service. This substantiates that they were able to sustain their confidence and independence from a home care service for at least 12 months.

In the individual tasks, there was a high association between those that maintained their level of function and maintained the uptake of recommendations. Cleaning the bathroom proved to be the area that was most difficult to assist people to change their habits and sustain this change.

The data indicates that over 65% of clients took up the recommendations made to them for cleaning bathrooms and between 17 and 34% maintained these 12 months later.

Improvement in confidence and capacity appear sustainable, if recommendations continue to be followed.

5.2.3 The Meaning of Home Care

The two focus groups conducted as part of the ILP revealed some key themes in the participants' perceptions about the meaning of home care and their view on the current system of assessment and allocation in Moreland. There were three themes to the comments, which have implications for Moreland's services.

Entitlement and equity
There is a view of entitlement to these services, not a lot of knowledge about how they are funded, or why they are prioritized, and that there is some inequity about who gets them and who misses out. This is particularly true of the Italian born participants.

Council needs to review its communication strategy about community care services, in consultation with Italian and other ethnic community organisations, and provide more information about what the services aim to do and what the assessment process and prioritizing entail.

If introducing a capacity building approach across all the home care services, in the interests of equity and better use of resources, Council would need to re – assess existing clients receiving an on going service, and only continue for those for whom other interventions to improve capacity were not suitable. It would make sense to start with those clients who are aged under 80 years, live alone, and had an original priority status of 2 or 3, and whom their care workers identify as having poor equipment and capacity to do a range of other activities.

The importance of maintaining a clean and ordered environment.

Perceptions about satisfactory levels of cleanliness are very personal and influenced by upbringing and personality traits, and differ greatly between individuals. A clean house generally has a psychological or emotional impact on how people feel and their attitude to aspects of life (e.g. having visitors). A clean environment can have a positive impact on one's health and wellbeing. Part of the psychological and emotional impact of a clean house is being able to maintain the house through one's own efforts and a sense of powerlessness can ensue when one can't prevent deterioration in the property. Some people's attitude to housework relaxes as they age and they accept that they are less able to complete tasks to the same standard, and can let it go without fretting about it. Most participants did not have an expectation that their family would or should help with the cleaning and none of the participants had paid for a regular private service stating it was too expensive, although no one had explored the cost.

These views seem to re-inforce the need for an approach to assessment and care planning that is flexible, able to acknowledge individual differences and preferences, and provides support without undermining independence.

Moreland residents also need to be assisted to understand some of the limitations on publicly funded services, and to look creatively at what resources they can also bring to bear for the results they want.

Type of assistance required

The participants expressed the desire for periodic assistance with bigger or more difficult tasks such as cleaning curtains and moving furniture (to clean behind or underneath). Many were readily able to identify the tasks that they regret not being able to manage as well as they used to and expressed a preference for help from Council to be available for the less frequent, bigger tasks that include washing the curtains and doing a detailed clean, getting into corners and hard to get to places.

Given these participants were a low priority for services, Council's home care service needs to consider what resources it can direct to support this lower level of need and how to organise to be able to offer a wider range of more flexible services, including one off or periodic, spring cleaning. Some households could pay a higher rate for occasional spring cleaning rather than the on –going fortnightly home care.

5.3 The Integration Trial

The Integration trail was an attempt to understand how we could transform the whole service to an active service approach.

Although the number of clients involved in the trial was small, the variation in outcomes for this group compared to those being assessed with other teams under the traditional model is notable. Only 20% of the Integration trial clients received a standard home care service, compared with 57.5% of those assessed by other team leaders, in the same time frame. In both cases a high percentage of referrals no longer needed the service when seen, (30% and 40 %) highlighting that inappropriate referrals are made, and either not being screened out at Intake or not being assessed quickly enough to provide the care when needed. If assessment time was not taken up seeing people who didn't need the services, then others could be seen in a more timely and effective way. This warrants further examination to try and prevent inappropriate referrals.

Council's assessment and intake service to review referral practices and outcomes from other services with view to improving timely responses for urgent and short term requests, and reducing the number of referrals that are inappropriate, or unrealistically raise expectations of receiving a service.

The process of assessing and engaging with clients under an ILP model required greater resources in terms of assessor's time. The 'standard' assessment conducted within Moreland City Council's Aged and Disability unit takes on average 1 hour, with a further hour for travel and follow up. The ILP model requires on average 1½ - 2 hours of assessor's time and a further hour for travel and follow up input, with the occasional additional visit. Given that Moreland hasn't had enough assessment staff to respond to all referrals in a timely way, this is a critical factor to resolve in considering how the approach could be implemented across the service. On current referral rate, ability to respond and time taken on average per visit and follow up, 2.75 EFT are required to conduct assessments. To undertake all assessments without delay would take 3.5 EFT assessment officers, and Moreland is in the process of re – structuring assessment to achieve this. To increase assessment time by using the ILP approach would take approximately an extra 2 EFT.

The issue of how additional assessment time is to be resourced to introduce an active service approach, will need to be considered by Council with the Department of Human Services.

The other critical issue is what additional skills and training are required for both assessment and home care staff. The ILP decided to use the skills and knowledge that comes with having qualified as an occupational therapist, given the functional focus and capacity building approach, and then tried to pass on the skills required to use the approach to other assessment and home care staff through in service training.

A review of the client files and assessments conducted as part of the Integration trial was undertaken. In addition, an evaluation questionnaire was completed by the team leader involved, followed by a meeting to discuss and clarify responses and perceptions. This was done in an endeavor to:

- evaluate training methods provided,
- evaluate the transference of a new model of assessment and service provision, and,
- draw inferences from this about training required for a shift to an active model of service delivery.

The team leader involved rated both the training and her confidence around assessing and suggesting alternative equipment and adaptive techniques as excellent. No feedback was provided on the different training modalities utilized, although they were all 'informative'. Instead, it was suggested that the training program be 'significantly simplified' to the level of a "concise briefing document", along with access to previous ILP client assessment documentation, advice and equipment samples. In addition, it was firmly expressed that the ILP process is "*conceptually an extension of the standard assessment process".* Further, it was suggested the assessment required a greater exploration of the client's communication status, falls prevention/risk assessment, mobility/transfer status, PADL status, community transport and support needs of primary carers and other family members.

A review of the assessments during the integration trial indicated the need for future training to include the assessment of a client's psychosocial, physical and medical status on function. Not only the effects of these, but a thorough examination of these to be the starting point of an assessment.

- How long have they had the condition?
- Which of these factors have the biggest impact on function?
- When did the decline in function occur?
- What were the precursors?
- What was their premorbid functioning?
- How can we intervene at these various levels to maximize their function?

A thorough knowledge of the above forms the backdrop to the task analysis that follows. The subsequent focus is on targeting the health, environmental, technique and equipment based factors that contribute to dysfunction, with the aim of minimizing the impact of each of these to create an increase in function. The risk of such clinical reasoning being surpassed, with the 'active service model' being simplified into generalised prescriptive recommendations about changing equipment and technique, is high. Adaptation to dysfunction should become the course of action only when the potential to build capacity has been exhausted. This approach requires an assessor to be able to identify where capacity can be built, the knowledge base of how this can be done and the resources by which to do it. In addition, it is essential to allow time for this to occur before determining an individual's priority for and level of passive service required.

The differences seen between the outcomes and interventions experienced by Integration trial clients and those assessed under the remaining teams, reflect marked differences in practice, as also observed 'on the ground'. As a result, it is difficult to give weight to the assertion that the model proposed serves as an extension of a core standard assessment that maximises independence and already aligns itself with an active service model paradigm.

To continue with an active service approach, Moreland's assessment team will need to be working within an agreed assessment policy and practice framework, have a greater multi disciplinary mix of base skills, some additional training, and on going leadership and support, to develop the necessary clinical reasoning skills to identify the causes of dysfunction and the interventions most appropriate to improve capacity. Links with the HACC funded allied health team at the Moreland Community Health Service needs to continue to be strengthened and streamlined. Further work on appropriate and common assessment tools that can be integrated into the electronic data collection systems used by HACC service providers is necessary.

5.4 The Model of Service

The model of service employed during the project contributed significantly to the delivery of the project and the subsequent outcomes. Following is a discussion of the model of service and a comparison to the HACC model current when the ILP commenced at Moreland City Council (refer to Appendix 7: Comparison of ILP and HACC model of service.

5.4.1 Service Engagement

It makes sense that the clients involved in Stage Two of the project were more likely to take up and complete the ILP, than those clients recruited during Stage One. The Stage One clients had experienced significant delays in assessment and or service delivery, and were not always clearly informed, or had not accepted, that the likelihood of receiving a service was very low unless their needs increased. The clients who had been assessed were told at that time that they were on a waitlist for home care and thus believed it was just a matter of time before they would receive a service. These clients were frequently disgruntled with Council and did not welcome the ILP as it did not offer them what they believed they were entitled to or needed, namely a regular home care service. They were a much more difficult group to engage and sustain.

Recruitment for the second stage involved new referrals to home care. As the project progressed it became increasingly obvious that directly recruiting participants through phone discussion at Intake was a difficult and disengaging process. The main issue was in trying to explain the ILP to clients and gain their explicit consent. The majority of clients had already predetermined (whether through their own doing or through external agents) that home care was the service that they needed and wanted. Attempting to engage them with an unfamiliar alternative prior to meeting and assessing their situation often proved futile, however beneficial it may or may not have been.

As a consequence, although Intake continued to identify people most likely to benefit from the ILP approach and refer, the discussion with the client about the ILP approach took place at the home based assessment. The client was not initially aware that the assessment for access to HACC services at Moreland City Council, would also include ILP options. The ILP offered an integrated assessment so clients could access services based on their need. This change had a significant impact on the uptake of the ILP and the confidence of the ILP staff approaching clients about an assessment. It also revealed to us that engaging all referrals, whether they appeared as ILP appropriate or not, in this way was a better approach for all referrals for home care. This is consistent with the model provided by Silver Chain in Western Australia whereby they assume that all referrals for home and personal care can benefit from a capacity building and problem solving approach before services are engaged.

There was a higher decline rate amongst those clients who had been assessed by team leaders and then referred to ILP as a follow up, than for clients coming directly through Intake. For these clients they had already received an assessment and been told they were not a high priority for a home care service and that ILP could be of some benefit. The two part process of assessment complicated the process for these clients. This approach also assumed that the ILP was not a legitimate service type but rather an “add on” service for clients who were not a high priority. It was perceived as a way of dealing with these clients.

The ILP approach is likely to be better taken up by clients and provide a more consistent service if it is the approach for all referrals rather than offered as a stand alone or alternate service type. Referrers also need to be encouraged to explore capacity building approaches themselves before suggesting home care, or to at least refer their clients for a home based assessment rather than for a pre determined service outcome.

5.4.2 Assessment

The standard HACC assessment for home care at Moreland Council is generally conducted by social or welfare workers as a service specific assessment, in response to other health and welfare agencies specifically requesting that service, or the resident themselves requesting it. This involves

the completion of HACC eligibility, an Occupational Health and Safety checklist, the Service Coordination Tool Template (SCTT: a screening tool mandated by the Victorian State government) and the asset declaration form. The functional assessment is based on the client's reporting of difficulties and the assessor's observations, and more on the need for assistance, rather than the potential to regain capacity, and is not as thorough or detailed as the functional assessment undertaken for the ILP.

The ILP assessment process provided an integrated broad service specific assessment involving the mandated elements of a HACC assessment (SCTT tool); components that covered the Councils occupational health and safety obligations; as well as, the functional assessment using the ILP data collection tool including community and capacity building activities. The functional assessment involved observing the client demonstrate each of the tasks, including accessing and using equipment, technique and interaction with the environment, in the context of their medical history and discussion about when and why the tasks have become more difficult.

Although the ILP process took up to twice as long as a standard Moreland HACC assessment, it did include care planning and intervention elements. Most of the ILP clients had their issues dealt with at the initial assessment and approximately 50% required a further phone or visit follow up, either by the OT, or ILP assistant, to reinforce or demonstrate recommendations.

5.4.3 Care planning

The care plan developed for the ILP detailed the strategies that were recommended to the client and those that the client had agreed to implement to minimise the difficulties they were having with home care tasks. Complementary to this was information about and connectivity to other support services, discussion with GPs when this was appropriate and consented to, and details about any proposed service provision. This included capacity building strategies.

5.4.4 Intervention

The standard service response by Moreland HACC services has usually been either the provision of a home care service, or not. Depending on assessed priority there can be a significant delay between assessment and service provision. The standard service is 1.5 hours per fortnight. For those clients who were assessed as not being a high priority, generally no interventions were provided, although needs for other Council services would be responded to, and referrals or suggestions about other services made.
As previously described, the ILP took a very different approach and undertook to provide interventions to minimise the need for an ongoing home care services. The ILP model had a variety of service options immediately available including: training and guided support to learn new techniques or adapt to new equipment; one off cleans to establish a good baseline for the client to continue from; short term service and support; and/or reduced ongoing services. A combination of staff were used to follow up with these clients including the occupational therapist, student occupational therapists and/or home care staff who had been specifically trained in the ILP techniques.

Essentially interventions included:

- Advice about safe body movements;
- Advice about equipment, cleaning methods and products;
- Purchase or loan of suitable equipment;
- Completion of home modifications, using MCHS occupational therapist and Council's home maintenance service.
- Client training, skill development, confidence boosting;
- Encouragement and assistance to attend health promotion, fitness and strength building activities and improve social connectedness;
- Referral and connection to other existing support services; and/or
- Provision of a spring clean or intermittent home care.

The interventions were kept simple and affordable to maximise the possibility of clients being able to integrate these into their home care routine. The recommendations were generally focused around patterns and habits and specifically about equipment and techniques for individual tasks. Environmental factors were also taken into consideration such as storage or floor surfaces, although they were not as significant a barrier as the equipment and techniques.

When analysing the task of vacuuming for instance, the major barriers were:

- Poor equipment, for example: older style heavy barrel vacuums with poor suction, short electrical cords, short hoses that were fixed at the connection to the barrel and were very heavy to maneuver around;
- Poor technique, for example: the majority of people vacuumed in a stooped position and strenuously pushed the vacuum cleaner back and forth across the floor surface;
- Poor storage, for example: people frequently stored their vacuum cleaners in rooms at a distance from the main living areas or in the original boxes in closets broken down into its component parts; and,
- Poor energy conservation, for example: it was surprising how many people still continued to vacuum the entire house in one session despite the pain and fatigue this caused them afterwards.

It was unusual for the issues around vacuuming to vary from those listed above. The recommendations made to clients are listed in the ILP Manual (refer to Appendix 8: ILP Manual) and were discussed and demonstrated to the clients. If equipment recommendations were made to clients, we frequently loaned the equipment to the client for them to trial before making a decision to purchase.

Interventions also focused on the client's functional capacity and strategies to maximise this such as referral to physiotherapy and other capacity building options. The uptake of these by the ILP population was lower than anticipated. Clients cited factors such as motivation, cost, transport, confidence and valuing these activities as important, as barriers to their participation. This is an area that needs more focus than the ILP anticipated and managed to influence. Other programs (e.g. Silver Chain's HIP, over came this by having initial home based physiotherapy and exercise programs, but the ILP was not well resourced enough to introduce this option.

Discussions were also held with each household about other services that may be beneficial to assist with their presenting needs, such as home maintenance, occupational therapy and carer support services. Recommendations were made to 64 households with 56 taking them up. The majority of these were facilitated by the ILP in referring to the agreed services.

> To achieve the take up for capacity building, more home based exercise options, lower cost and transport assisted programs are required.

5.4.5 Capacity Building

It was identified early in the project development that to maximise outcomes it would be most beneficial to assist people to link to capacity building and health promoting opportunities. Many of these opportunities exist in various organisations across the community such as the local community health service, neighborhood houses and leisure centres. It was not the aim of the project to duplicate these programs but rather to facilitate interest and access to these when participants showed an interest. For the ILP this involved building knowledge and relationships with these programs.

We initially identified existing service directories and gathered information on programs including costs, availability and access. The two main potential connection points emerged as the leisure centres and community health services. Both of these posed barriers for potential participants. The community health service ran appropriate programs and were able to meet the demand generated by the ILP but had difficulty moving people on to community based options when clients

no longer needed the specific support provided by the community health service. For example, participants were referred to physiotherapy for support and advice on appropriate exercise options such as hydrotherapy. The participants were assessed and integrated into the community health service hydrotherapy group which ran for six weeks. At the completion of this program most were ready to pick up a program at the local leisure centre. The challenge then became the increase in costs and the transition into a new program with more participants and less direct staff support..

The leisure centres in Moreland offer a good variety of programs that were of interest to many of the participants looking for activities. Participants identified several barriers with using the leisure centre facilities:

- To participate in an ongoing gym program you had to pay an initial joining fee and the first month's fee up front. Most of the ILP participants were on a fixed income and thus struggled to pay these costs in one go;
- The ongoing costs of the programs were higher than the HACC assisted programs so for those who were transitioning from a physiotherapy to a leisure centre run group their weekly costs increased by about 20%;
- The groups operating in the leisure centres were substantially larger and less intimate which complicated the transition process.

Further discussions are required on developing, funding and pricing transition programs between the health services and leisure centres.

5.4.6 Reviews

Reviews are rarely completed routinely and are often generated when a client has a negative change in circumstances and requests an increase in service provision in the standard Moreland HACC service. Clients tend to remain on an ongoing service unless they, another service or their home carer, report a significant change in circumstances.

The ILP provided a standard three and twelve month review. The review process was to establish: what strategies they had adopted; whether the support provided was appropriate; whether a change in the care plan was required; whether any other referrals were required; any required changes in home care service delivery; and further problem solving if needed. This continued to allow the ILP to provide a flexible service response and ensure that the client was getting the right support when they required it. Clients also rang in when they had a change in circumstances and reviews were completed to adjust their care plan as needed.

5.4.7 Essential Elements from the Learnings of the ILP Model

1. Assess all referrals using same approach.

Even the clients who had high support needs were able to make functional gains and take on some of the strategies although they may have been in receipt of some service.

2. Use an assessment tool that measures functional ability, such as the one developed for the ILP.

This provides a measurable way of assessing clients and prioritising accordingly.

3. Respond to post acute and other short term needs quickly, and with a restorative focus.

The ILP was able to meet clients' needs in a more flexible and timely manner. For example, when someone had a hip replacement, we were able to put in an interim service and work with the client in returning to completing their own home care with support and adaptation as needed.

4. Requires a multi disciplinary approach.

Moving from providing support services to restoring capacity requires different skill sets such as physiotherapists' involvement for the capacity building approach and occupational therapists for functional training, and the cross learning that develops when people work in multi – disciplinary teams. Given that the HACC funded allied health is predominantly located in community health services, this presents the challenges of achieving strong cross agency processes for team work, referrals, joint assessments and care planning.

5. Requires training and a conceptual shift from current services.

The training undertaken with one assessment officer as part of the Integration Trial highlighted the fundamental conceptual shift and training required by existing staff to implement this model.

6. Passive service provision is the last, not first resort.

Over a twelve month period the ILP clients would have consumed approximately 3820 hours of GHC if provided with a service. Under ILP they consumed approximately 340 hours or less than 10%. Although this is not a strong argument in Moreland – given that most project clients would not have received a standard home care service – the principle of ensuring passive services are not provided until capacity for improvement is tested, still holds to be a more efficient use of resources.

It was also suggested by Turvey and Fine (1990) that the provision of HACC services to clients, even at low levels appears to reduce the decline in client ability and help them remain stable. It also appears to act as preventative measure for hospital admission and length of stay.

7. Dealing with community expectations and providing clear messages about entitlement to home care and the place of assessment and other options.

Most of the ILP clients had been referred for and thus expected a home care service. They were not prepared for a process of looking more closely how they could do more for themselves. There is a tension between feeling entitled to a service and needing information and receiving advice about how better to manage independently at home. Part of successfully implementing an active service approach, will be convincing other referring agencies to refer for an assessment to determine capacity, rather than pre judging what the service outcome should be, and promoting this as a service to older people as well.

Section Six: Conclusion

The ILP began as a demand management strategy, targeting those with a low level need for home care with an alternate approach focused on improving capacity and confidence. For about two thirds of this group of people, improvement in capacity to perform tasks independently, with some or all household tasks, was possible. There was a drop in perceived need for assistance and an increase in confidence. Improvements were closely related to the uptake of recommendations, and when recommendations were sustained, it appears that improvements are also sustained, at least over 12 months.

Perhaps the most significant finding of the project, was the realization that the approach of addressing capacity prior to considering support services, had a much wider application, and chance of success, for more of the population requesting assistance with home care tasks, and not just those seen to have a low priority need.

The outcome is thus how to transform the whole service to operate from a different set of assumptions about how independence and capacity in household tasks can be improved and supported. Moreland has already begun to improve its capacity to undertake assessments in a timely way, but will need to continue to develop a progressive implementation plan. This direction should be supported by working closely with the Moreland Community Health Service and other

HACC funded local services and with the Department of Human Services as they implement the wider actions from the Active Service Models project.

Section Seven: Recommendations

7.1 That Moreland Council develop an implementation plan to continue with a capacity building approach to assessment for its' community care services – to cover communication with clients and referrers, a revised assessment, review and priority of access policy, assessment staffing levels and skills, staff development and training.

7.2 That Moreland Council and Moreland Community Health Centre develop inter agency agreements to address how the HACC funded resources can be best utilized to ensure residents can access capacity building options, and how step down or transition programs from the health service programs to leisure centre programs can be supported.

7.3 That the Department of Human Services be asked to address how training programs can be developed and funded for both home care and assessment staff, to ensure the skills to implement active service approaches.

7.4 That the Department of Human Services be asked to consider how the assessment function can be funded, and supported by appropriate tools, given the additional time requirement, and the importance of reviews.

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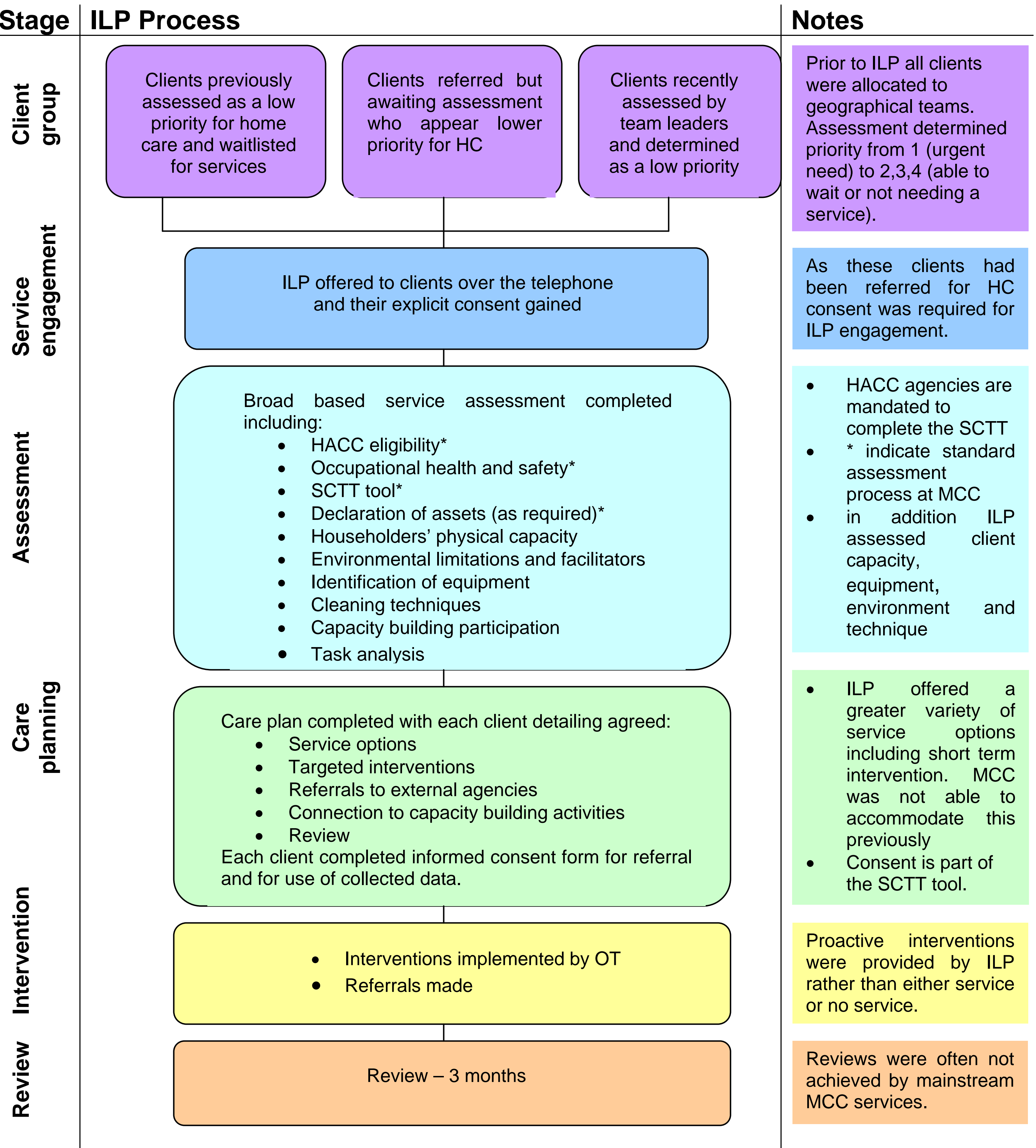
APPENDICES

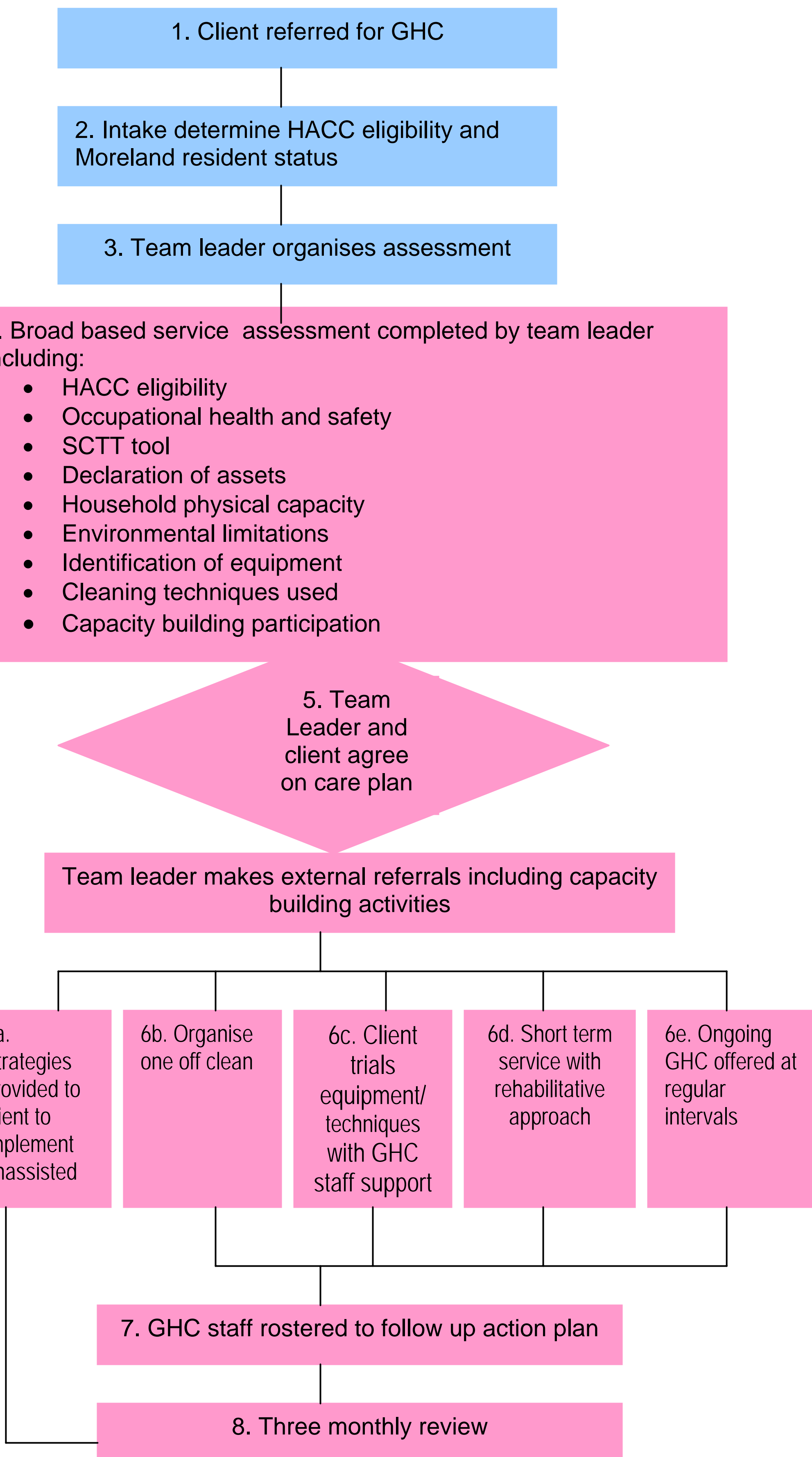
Appendix 1: Stage One Implementation Flowchart



Appendix 2 : Stage Two Implementation Flowchart

Stage	ILP Process	Notes
Client group	Clients referred for HC and identified at intake as a low priority Clients recently assessed as a low priority and consented to ILP	All clients entering the ILP had a recent presentation to intake or recent assessment by a team leader.
Service engagement	Explicit consent to engage with the ILP was not sought for each client as they had already consented to an assessment at intake.	This practice change resulted in a higher uptake of ILP and a greater integration of assessment.
Assessment	Broad based service assessment completed including: • HACC eligibility* • Occupational health and safety* • SCTT tool* • Declaration of assets (as required)* • Householders physical capacity • Environmental limitations and facilitators • Identification of equipment • Cleaning techniques • Capacity building participation	• For clients coming direct to ILP from intake, ILP completed all assessment elements. • For clients being referred by the team leaders to ILP, the assessment elements marked * had already been completed. • Priority of access level for standard GHC service determined as per usual assessment
Care planning	Care plan completed detailing agreed: • Service options • Targeted interventions • Referrals to external agencies • Connection to capacity building activities	Consent procedures continued as before.
Intervention	• Interventions implemented by OT • Referrals made	A home care staff member was trained to provide clients with follow up and equipment delivery.
Review	Review – 3 months	Reviews were often not achieved by mainstream MCC services.

Appendix 3 : Stage Three Implementation Flowchart



Notes

1-3 No variation on current practice required

4. Training required:
- Use of assessment tool
- Assessment protocols
- Capacity building framework
- Service options

ILP OT can complete joint assessments

5. Training required on how to select best options with the client.

6. Is the service able to respond flexibly on a larger scale? Do we have the resources to administer this?

7. Training required for GHC to facilitate independence

8. Is it possible with current resources?

Appendix 4 : Client Consent

Consent to Participate in the Independent Living Project

The Independent Living Project is being trialed at Moreland Council aiming to assist residents maintain their independence in home care tasks. Residents being offered the project have been assessed as eligible for home care but are a low priority being waitlisted for services, often for long periods of time.

The project aims to:

- assist these residents to safely continue to manage their housework and other tasks of daily living;
- provide a suite of services to support the residents' capacity to manage household tasks;
- evaluate how effective the strategies used in the project are at assisting residents; and
- to assist in managing the demand for home care services.

The project is planned to run for approximately 12 months and residents will be offered an initial assessment, a home care management plan, support to implement the plan, follow up and evaluation. It is anticipated that at the end of the project a report will be written.

As a participant in the project your consent is required to be able to use your information in the report. All information collected will remain confidential and will not identify you in anyway.

I do / do not give my consent for to participate in the Independent Living Project.

I do / do not consent to my information being included in the project report in a confidential manner.

Signed: ________________________________

Name: ________________________________

Date: ________________________________

Appendix 5 : ILP Assessment Tool

Independent Living Project Information Collection Tool

Client Name: **Date:**

Background:

Medical background:

Current community services:

Current community activities (physical and social):

Current family/friends support (incl. no. of hours):

Perceptions of Ability

1= Not at All 5 = Strongly agree						
How strongly do you feel you need help to do house hold tasks?	1	2	3	4	5	
How confident do you feel you can						Total
prepare a hot meal?	1	2	3	4	5	
do the shopping?	1	2	3	4	5	
do housework?	1	2	3	4	5	
do the banking?	1	2	3	4	5	
pay bills?	1	2	3	4	5	☐
walk around the house?	1	2	3	4	5	
get dressed/undressed?	1	2	3	4	5	
take a bath/shower?	1	2	3	4	5	
getting in/out of bed	1	2	3	4	5	
access leisure activities?	1	2	3	4	5	☐
REVIEW						
Has the independent living project helped you to feel more confident?	Y	N				
Has the independent living project helped you to access other services/activities? (List)	Y	N				

Permission to contact GP to discuss suitability for project? Y N

Task	Client Function	Equipment Used	Description
Vacuuming			
Lounge			
Bedroom			
Bedroom			
Dining			
Kitchen			
Bathroom			
Sweeping			
Lounge			
Bedroom			
Dining			
Kitchen			
Bathroom			
Washing floors			
Lounge			
Bedroom			
Dining			
Kitchen			
Bathroom			
Toilet			
Bathroom			
Bath			
Shower			
Toilet			
Hand basin			
Dusting			

Task	Client Function	Equipment Used	Description
Clothes washing			
Loading machine			
Unloading			
Hanging out clothes			
Bringing in clothes			
Ironing			
Dryer			
Meals			
Preparing a meal			
Reheating a meal			
Preparing a snack			
Shopping			
Getting to/from shop			
Selecting items			
Carrying items			
Banking			
Bill paying			
Telephone use			
Community access			
Washing dishes			

Task	**Client Function**	**Equipment Used**	**Description**
Change bed linen			
Cleaning windows			
Blinds/curtains			
Cleaning fridge			
Cleaning oven			
Cleaning gutters			
Cleaning cupboards			
Removal of cobwebs			

Client function: I = independent; W/D = with difficulty; W/A = with assistance; D = dependent; N/A = not applicable

Recommendations

Tasks Identified	**Equipment Modifications**	**Environmental Modifications**	**Technique Modifications**

Other Supports:

Council Support:

Community Services:

Capacity Building Services:

No. of Hours of Intervention:

	Assessment	Care Plan	Intervention	Review	Total
OT/TL					
Home Care Staff					
Home Maintenance					
Interpreter					
Other					

Cost of equipment:

Summary:

Appendix 5 : Integration Trial Training Assessment Tool (Notes)

Client Name: Date:

Medical History

Collect information for both the client referred and significant members of the household.
Ascertain what the current and past treatment regimes are/have been for the main complaints. Their functional capacity may be improved by treating the main cause. Refer appropriately: i.e. physiotherapy referral, discuss with GP management of dizziness etc.

Current community services
Who else is involved in client's care?

Current community activities
How often do they access the community and what for? Look at existing socialization and physical activity involvement with aim to engage client further where there is low involvement. Is transport and issue? Do they need community transport/HATS?

Current family/friends support (incl. no. of hours)

Perceptions of Ability

Task	At present, how motivated are you to:	Total	At present, how confident are you to:	Total
- prepare a hot meal?	1 2 3 4 5		1 2 3 4 5	
- do the shopping?	1 2 3 4 5		1 2 3 4 5	
- do housework?	1 2 3 4 5		1 2 3 4 5	
- do the banking?	1 2 3 4 5		1 2 3 4 5	
- pay bills	1 2 3 4 5		1 2 3 4 5	
- walk around the house?	1 2 3 4 5		1 2 3 4 5	
- get dressed/undressed?	1 2 3 4 5		1 2 3 4 5	
- take a bath/shower?	1 2 3 4 5		1 2 3 4 5	
- get in/out bed?	1 2 3 4 5		1 2 3 4 5	
- access the community?	1 2 3 4 5		1 2 3 4 5	

REVIEW

How strongly do you feel you need help to do house hold tasks? 1 2 3 4 5

Has the independent living project helped you to feel more confident? Y N

Has the independent living project helped you to access other services/activities? (List) Y N

To what extent did the ILP meet your expectations?

Overall what difference did the ILP make?

How satisfied are you with the ILP? 1 2 3 4 5

*** Review questions only.

Task	Client Function	Equipment Used	Description
Vacuuming		*View and take note of weight, manouverability, suction, height, length of hose.*	• *Encourage demonstration of technique & take note* • *How do their medical complaints impact on completing this task?* • *How do they feel during and after task in terms of main complaints; pain, shortness of breathe, fatigue?* • *What is their habit of task completion? All in one day, one room at a time, frequent rests, pushing through pain?* • *How do floor surfaces impact on task completion?* • *Who does what?*
Lounge			
Bedroom			
Bedroom			
Dining			
Kitchen			
Bathroom			
Sweeping		*Note both general item used and type of shovel/dustpan.*	*As above*
Lounge			
Bedroom			
Dining			
Kitchen			
Bathroom			
Washing floors		*Type of mop and bucket used*	*As above* *If a bucket is used, how do they fill it up and how much?* *How do they wring the mop?*
Lounge			
Bedroom			
Dining			
Kitchen			
Bathroom			
Toilet			
Bathroom		Note equipment and cleaning products used.	*How do they do it?* *Which parts of the task are difficult?*
Bath			
Shower			
Toilet			
Hand basin			
Dusting			

Task	Client Function	Equipment Used	Description
Clothes washing		*What do they use to carry out items? Clothes horse?*	*How far to the line? How much do they take at one time? Do they place the basket on the ground or on a chair? Who does what?*
Loading machine			
Unloading			
Hanging out clothes			
Bringing in clothes			
Ironing			
Dryer			
Meals			
Preparing a meal			
Reheating a meal			
Preparing a snack			
Shopping			*Transport taken? Delivery option? Assistance provided by whom?*
Getting to/from shop			
Selecting items			
Carrying items			
Banking			
Bill paying			
Telephone use			*Do they have trouble hearing the phone ring or communicating?*
Community access			
Washing dishes			
Task	Client	Equipment	Description

	Function	Used	
Change bed linen			
Cleaning windows			*Is there a need for Home Maintenance?*
Blinds/curtains			*How do they take them down?*
Cleaning fridge			*Is it done , how often*
Cleaning oven			*Is it done,howoften*
Cleaning gutters			*Who does this for them?*
Cleaning cupboards			
Removal of cobwebs			

Client function: I = independent; W/D = with difficulty; W/A = with assistance; D = dependent; N/A = not applicable

Recommendations

Tasks Identified	Equipment Modifications	Environmental Modifications	Technique Modifications
4.4.3.1 Area they are having problems *i.e.vacuuming*	e.g. *Trial of alternative equipment* • *vacuum, carpet sweeper* • *lighter mops, bucketless techniques* • *long handled equipment* • *change in cleaning products*	*e.g.* *Can they consider changing carpet/shower screen/pick up mats?*	*See manual for further information re techniques. These include, but are not limited to:* • *pacing activities* • *splitting up tasks during day/week* • *respecting pain barriers* • *taking breaks* • *preferred techniques for different tasks, given injuries/physical limitations.*

Other Supports

Council Support
Indicated referrals to be made.

Community Services
Indicate services recommended and whether client has consented. Recommendations are based on the exploration of community activities and capacity in initial stages of assessment.

Capacity Building Services
Make note of any referrals indicated for socialization activities, exercise groups etc and whether client consented to referral.

No. of Hours of Intervention

	Assessment	**Care Plan**	**Intervention**	**Review**	**Total**
OT/TL					
Home Care Staff					
Home Maintenance					
Interpreter					
Other					

Cost of equipment
Note if council funding any as well as items provided on loan.

Summary

Appendix 6: Integration Trial Project Brief and Implementation Timetable

1. BACKGROUND TO THE PROJECT

The Independent Living Project has been piloted at Moreland Council since September 2004. It has operated from the assumption that approximately 30% of all referrals for general home care could benefit from an alternative model of service and assessment than the standard HACC intervention.

Traditional home care services have implemented a service for the client regardless of whether they are able to perform parts of the care provided. Clients commonly commence on a service and remain with that service until they leave their home. Many clients are unable to complete the heavy housework such as vacuuming because of poor equipment, poor technique and/or reduced physical capacity. The traditional model assumes that clients will benefit from having their home care completed for them.

The ILP service model is designed to be a preventative approach. Clients are assessed as to their functional ability and provided with advice and support to: maintain or improve their capacity to complete their own home care tasks; increase or maintain their independence through connectivity to health promoting and/or capacity building services; and increase or maintain the clients' confidence in remaining independent in their own home.

The ILP has been operating separately from mainstream service delivery at Moreland Council. To further understand the barriers, benefits and resources required, a trial of an integrated approach is proposed.

2. GOAL

To test the ILP model of service in an integrated setting with one team leader for 10-12 randomly selected referrals assessed from July 31 until September 15, 2006.

3. OBJECTIVES

1. Trial application of the ILP assessment process and tool;
2. Identify barriers to implementing ILP model of service;
3. Identify areas requiring further/alternative development in model of service;
4. Receive practitioner feedback;
5. To test whether it is feasible to manage multiple service delivery options and what resources and structures would be required to sustain this;
6. To identify potential training needs and resources for integration of the ILP;
7. Refinement of a sustainable preventative model of service delivery in home care;
8. Compare service delivery outcomes for clients assessed by the team leader before implementation of the ILP model with those seen under the ILP model; and,
9. Gain some insight as to clients' perspective on the changes in the model of service.

4. DESCRIPTION OF THE PROJECT

The Independent Living Project model of service involves the following elements:

- Comprehensive assessment of the physical and environmental capacity to complete home care tasks.
- Task analysis and identification of areas that were problematic or could be made easier and/or safer.
- Development of a care plan.
- Targeted interventions including:
  - advice about safe body movements in relation to performing household tasks;
  - advice about equipment, cleaning methods and products;
  - purchase or loan of suitable equipment;
  - completion of home modifications necessary to improve safety and improve capacity;
  - client training, skill development, confidence boosting performed by either the occupational therapist or trained home care staff;

    - encouragement and assistance to attend health promotion, fitness and strength building activities and improve social connectedness;
    - referral and connection to other existing support services such as physiotherapy, community transport, etc; and,
    - provision of an initial spring clean or intermittent home care for clients assessed as requiring this.
- Monitoring and follow up predominantly provided over the telephone or via home care staff visits.
- Review.

This role is currently undertaken by an occupational therapist using tools specifically designed for this process that use an occupational performance framework.

This pilot aims to identify:
- whether this model and the associated tools work in an integrated environment;
- what proportion of the clients it works for;
- whether the ILP framework impacts on client outcomes;
- what resources and training is required to support the team leader to implement the model; and,
- the recommendations and learnings the team leader has to inform the ILP.

4.1 Client Group
Two randomly selected clients assessed per week in the geographical Team One from July 24 until September 1, 2006. The lower priority clients identified at intake would still continue to be referred directly through to the ILP leaving those clients that appeared as though they may have a higher need for a service.

4.2 Key Tasks
<u>Preparation</u>
- Identify model of service to be implemented
- Negotiate participating team leader
- Identify key elements of the assessment tool

<u>Training</u>
Provide 4-5 sessions of on site training with team leader and ILP OT with follow up discussion and problem solving.

<u>Pilot Phase</u>
- Team leader to approach all assessments for general home care from the ILP framework
- ILP staff to support team leader to implement strategies as required.
- ILP staff to provide consultancy role on client assessment and care plan as required.

<u>Review</u>
- Team leader completes client reviews
- ILP staff to assist team leader as required

<u>Evaluation</u>
- Pilot project is evaluated against objectives.
- Team leader is interviewed to gather experiential learnings and recommendations.

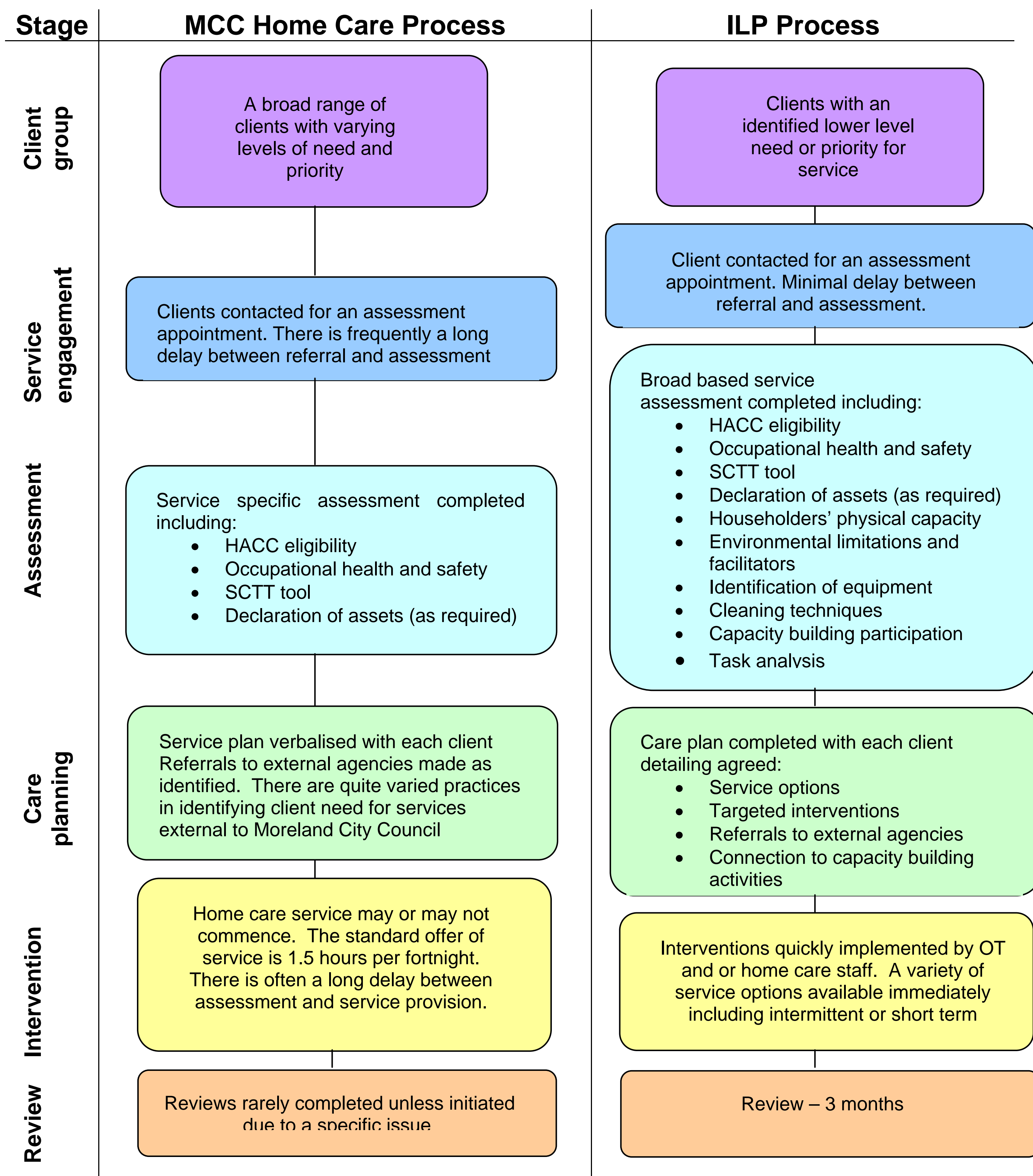
5. EVALUATION
Evaluation of this pilot will involve the following measures:
- Comparison of the service delivery outcomes of those clients assessed prior and post the implementation of the ILP model within the selected team.
- Feedback from the team leader about:
    - The assessment tool;

- Implementation of the service model;
- Changes in their practice;
- Barriers and facilitators;
- Training and resources required; and,
- Process issues and learnings.
- Feedback from clients on their perspective of the alternative model of service.

6. PROJECT ACTION PLAN

TASK NO.	TASK	RESPONSIBILITY	TIMELINES
1.	Identify proposed model of service for an integrated ILP	ILP	03/05/06
2.	Develop implementation plan	ILP	20/06/06
3.	Develop tools, training, protocols and processes to support implementation.	ILP	10/06/06
4.	Provide training to team leader	ILP, team leader	17/07/06
5.	Implement integration pilot	ILP	24/07/06
6.	Provide support to team leader	ILP	30/09/06
7.	Conduct reviews	Team leader, ILP	30/09/06
8.	Evaluate	Team leader, ILP	30/09/06
9.	Document outcomes as recommendations in the final ILP report	ILP	30/09/06

Appendix 7: Comparison of home care and independent living project at Moreland City Council



Appendix 8: ILP Manual (replace with PDF version)

Moreland
Home care tasks made easier

balance
the work
new habits
plan ahead
rest
the right equipment

Contents

1. Plan ahead
2. Balance the work
3. Use the right equipment
4. Do the task the right way
5. Rest

Specific household tasks

Vacuuming
Sweeping
Washing the floor
Cleaning the bath or shower
Dusting
Making beds
Clothes washing
Ironing
Shopping

Home Care Plan

We all get into habits and undertake tasks, such as house cleaning, in a particular way because that is the way we have *always* done it. But, rather than simply repeating a habit, it is important to consider whether you are operating in the most effective way – in the least amount of time and using the least amount of energy. This may mean changing the way you do things or using different equipment.

This booklet has been prepared to help you think about the way you do everyday tasks, assess whether or not you are doing them in the safest and most efficient way, and modify your habits accordingly.

Five main areas need to be considered if you want to conserve your energy and simplify the housework.

1. **Plan ahead**
   - Work out a weekly routine by planning a balance of light and heavy duties spread throughout the week. (Use the table at the back of this booklet to help you plan your week).
   - Ensure you have the right equipment that will make the task easier.
   - Store equipment in convenient places to reduce unnecessary steps.
   - Break each activity down into a series of smaller tasks.
   - Set priorities, identify tasks which may not need doing, such as ironing the sheets, and focus on the tasks you feel must be done.

2. **Balance the work**
   - Break up the task and do not do all your housework in one day.
   - Do not do more than one task for longer than 30 minutes at a time.
   - Spread heavy and light tasks throughout the day.
   - Assess whether you need to do all stages of a given task at once. For example, can the dishes soak before you wash them so that scrubbing is made easier? Let the water do the work!
   - Can you sit while doing some tasks, such as preparing food?

3. **Use the right equipment**
   - Use lightweight equipment to reduce the strain on your body.
   - Can a spray or soaking reduce the amount of work you need to do?
   - Long-handled equipment can reduce strain or twisting your body.

4. **Do the task the right way**
   - Using large muscle groups and joints uses less energy and puts less strain on your body. For example, stand in a lunge position and move your whole body backwards and forwards when vacuuming, rather than just moving your arm.
   - Push rather than pull an object and pull rather than lift an object.
   - Minimise bending and rotating the body, keep your back straight.
   - Work at a steady rate rather than rushing.

5. **Rest**
   - Rest before becoming exhausted.
   - Take 5–10 minute rest breaks during any activity to increase your ability to finish the task without feeling overly tired.

- Rest improves overall endurance and leaves strength for enjoyable activities.
- Pain or soreness is a likely indication that you have worked too hard at one task.

Implementing these principles will help protect your body, minimise pain and the risk of injury, and manage fatigue.

REMEMBER:

- moderation is the key, and
- rest improves overall endurance and leaves strength for enjoyable activities.

Specific household tasks
Following is a break down of the major household tasks using these principles, suggested strategies and equipment to make life that little bit easier. The tasks discussed include:

- vacuuming;
- washing the floors;
- dusting;
- washing clothes;
- shopping;
- sweeping;
- cleaning the bath and shower;
- making the bed;
- ironing;

Using these tips and recommendations can assist in maintaining your independence and health through active participation.

Vacuuming
Plan ahead
- Think about where and how you store your vacuum cleaner to minimise bending, lifting and carrying.
- Vacuum one room only per day to conserve your energy.
- Only vacuum the areas of the house that need it. For example do you need to vacuum the spare bedroom every time if it is not used?
- Vacuum for less than 30 minutes at one time.
- Avoid doing other tasks requiring similar movements (such as sweeping or mopping) immediately before or after vacuuming.
- Work at a steady rate rather than rushing.
- Rest after every five to ten minutes of vacuuming.

Use the right equipment
Features on a vacuum cleaner that will make it easier for you include:

- lightweight and easy to manoeuvre around;
- a pipe that can be adjusted to suit your height;
- suction control that is on the body of the vacuum or on the pipe that is easy to slide (a dial on the body of the cleaner means you will have to bend over to adjust the suction);
- a long hose that is crushproof and rotates a full 360 degrees;
- an on/off switch that you can operate with your foot;
- a long retractable cord so you don’t have to keep changing sockets;
- cloth bags are messier and harder to empty but paper bags are sometimes harder to put into the vacuum and you need to purchase replacements. You will need to consider which will better suit your needs;
- think about attachments that may make vacuuming easier such as a vacuum head with wheels on the side or a cyclonic cylinder that captures the majority of the dirt and dust and is easier to empty;
- adjustable cleaning head with a switch that is easy to flick with your foot to allow you to vacuum on both carpet and lino or tiles; and
- a dust indicator that lets you know when the bag is full.

Choice magazine has assessed and recommended the following models: Nilfisk GM 100 Sprint Plus, Kambrook Jaguar Turbo Pro, Panasonic MC 4950, LG Turbo X.

A ‘dust buster’ or powered carpet sweeper fitted with an extendable handle may work well for small homes or for predominantly non-carpeted homes. A recommended example is the Black and Decker Stick Dustbuster or Karcher Power Broom.

Do the task the right way

- Adjust the pipe length of the vacuum so you can remain upright..
- Keep your hands high on the pipe.
- Wrap the hose around your back and keep your hands close to your hips so that you are pulling the vacuum cleaner with all your body.
- Put your legs in a forward lunge position in the direction of vacuuming and maintain the natural curve of the spine (‘S shape’).
- Walk back and forward with the hose rather than just pushing the hose while standing in the one position.
- Set the vacuum head to the appropriate surface, for example, have the bristles up for carpet and down for floorboards and tiles.
- Reduce the suction level to lessen the drag on thick carpet.
- Run extension cords along the wall rather than across the room or corridors.
- Avoid excessive bending and standing with your feet together.

Sweeping

Balance the work

- Sweep for less than 30 minutes at one time.
- Avoid doing other tasks requiring similar movements, for example, vacuuming or mopping immediately before or after sweeping.
- Work at a steady rate rather than rushing.

Use the right equipment

- Static mops are easier to use so dust and dirt is kept on the mop and the cloth can be thrown away, for example, Oates Microfibre mop. Most now come with a microstatic cloth that can be cleaned and reused.
- A long-handled pan and broom will reduce the need to bend.

Do the task the right way

- Stand with legs apart and in a forward lunging position in the direction of the sweeping.
- Maintain natural curve of spine ('S' shape).
- Use a handle length appropriate to your height. (Council's home maintenance service may be able to adjust the length if needed).
- Minimise the time spent cleaning under furniture.
- Clear the area of furniture and obstacles to be swept where possible.
- Avoid excessive bending and standing with your feet together.

Washing the floor

Plan ahead

- Store equipment in a convenient place to reduce unnecessary steps.
- Wash one room only per day to conserve your energy.
- Only wash the areas of the house that need it. For example, is every room in the house in need of having the floor washed?

Balance the work

- Wash floors for less than 30 minutes at one time.
- Avoid doing other tasks requiring similar movements, for example, vacuuming or sweeping immediately before or after mopping.
- Work at a steady rate rather than rushing.

Use the right equipment

- Use a mop with an adjustable handle length appropriate to your height.
- A microfibre mop with two cleaning mats is the lightest weight and easiest option, especially for tiles and polished floorboards. They can also be used without the need to carry a bucket around. Examples include the Oates or Sabco Microfibre mop.
- Lightweight mops are better than the traditional cotton tops. Examples of lighter mops include: Oates Strip Mop, Vileda Micro Plus Strip mop.
- A lightweight mop bucket with an in-built ringer is the better option if a bucket is to be used, for example, Vileda, Oates Cone Wringer Mop Bucket.
- A mop bucket can be placed on a mobile pot plant stand to wheel around the home.

Do the task the right way

Mopping without a bucket using a microfibre mop:

- Fill the laundry trough with a couple of inches of water and put in only the recommended amount of detergent.
- Soak one cleaning pad in the trough.

- Lightly wring the cleaning pad and attach to the mop.
- Soak second cleaning pad in the trough.
- Mop floor using a forward lunge position in the direction of the mopping.
- Start mopping in the corner furthest from your point of exit.
- Do not use 'Figure 8' method of mopping.
- When the cleaning pad needs rinsing, return to the trough and remove pad. Lightly wring out the second pad and attach to the mop. Soak first pad until needed.

Mopping with a bucket:

- Half fill the bucket as close to the area to be mopped as possible.
- Use recommended amount of floor cleaner in water.
- Remove the mop from the bucket in one easy movement using your thigh muscles. Legs should be in a forward lunge position in the direction of the mopping.
- Do not squeeze out the mop repeatedly. Let it soak in the bucket for up to five minutes to allow the dirt to disperse before wringing it out.
- Start mopping in the corner furthest from your exit.
- Do not use 'Figure 8' method of mopping.
- Do not hand wring mops.

Cleaning the bath or shower

Plan ahead

- Store equipment in a convenient place to reduce unnecessary steps.

Use the right equipment

- Use of advanced non-scrub products such as Shower Sparkle, Clorox, Windex or Shower Glitz means you can spray the product on and there is no cleaning.
- Long-handled scrubbers can reduce the bending and twisting for you.
- Spray on cleaners need only a gentle wipe and do not create the extra resistance that cream cleansers can.

Do the task the right way

- Spray the bath and tiles with a non-scrub cleaner after each use to reduce the amount of scum which builds up.
- Use long handled scrubbers or the mop on the floor of the shower.
- Avoid awkward postures when cleaning.

Rest

- Rest every 5–10 minutes.
- Pain or soreness is a likely indication that you have worked too hard or done the task incorrectly.

Dusting

Use the right equipment

- Use a long-handled duster for high and low areas.
- Static cloths pick up more dust and reduce the need to wring out a cloth, for example, Oates Enviro Clean dusting mitt, Glitz Microfibre cleaning mitt, Enjo, Vileda, Grab It, Sabco.

Do the task the right way

- Dust only areas that can be easily reached.
- Keep both feet on floor at all times.
- Do not bend over for more than 30 seconds at one time.
- After bending over, reverse the process using back extensions (standing up and bending gently backward).
- Use a folded towel or kneepads when kneeling.
- When rising from kneeling ensure there is something stable to use as support.
- It is preferable to kneel when dusting low rather than bending or squatting.
- Do not stand on furniture or ladders.
- Avoid excessive bending and stretching.

Making beds

Use the right equipment

- It is easier to move a bed on castors to a convenient position. (Council's home maintenance service may be able to assist with installing castors).
- Very low beds could be raised to allow ease of changing linen. (Council's home maintenance service may be able to raise your bed).
- If the bed is not on castors then move it out from the wall permanently. (Council's home maintenance service may be able to move your bed permanently for you).
- When putting sheets away fold them in a way that will let them be unfolded across the bed so they will not need to be shaken.
- Air cell blankets and doonas are lighter than blankets.

Do the task the right way

- Use your knee to move a bed on castors out from the wall.
- Position chairs at the end of the bed so blankets can be striped off the bed by rolling onto the chair to reduce bending.
- Do not lift the mattress. It is better to kneel next to the bed and slide your forearm under the mattress to tuck in the sheet.
- Only tuck in sheets and blankets at the end of the bed.
- If tucking in sides, the preferred method is to kneel, tuck, stand, move to next section of mattress, kneel, tuck, stand and so on until completed.
- Use the bed as support when rising from kneeling.

Clothes washing

Use the right equipment

- A washing basket trolley reduces the need to bend and carry.
- Put the washing basket on a table or chair next to the machine if you do not have a trolley.
- A front loading machine and dryer can be raised to waist level to reduce the need for bending. (Council's home maintenance may be able to assist).
- Long-handled tongs can help you remove items from a top loading machine.
- A clothes dryer will reduce the need to hang out the washing.
- Purchase clothes that are machine washable and require little, if any ironing.
- An apron with a pocket in it is a good place to store pegs.

Do the task the right way

- Place the basket on a bench, chair or trolley to load the washing from the machine.
- Remove items from the machine one at a time.
- Use the gentle cycle for items you would hand wash.
- Use a trolley to carry washing to the line.
- If a trolley is not possible carry small loads to the line.
- Wedge the door open before moving the basket through the door.
- Clothes can be hung on a clothes rack inside to minimise carrying.
- Adjust clothesline to suit height if possible.
- Place a small solid chair or table of reasonable height near the washing line to place the washing basket on if a trolley is not available.
- Clothes can be hung on coat hangers if pegs are difficult to use.
- Fold clothes as you remove them from the line to reduce the ironing.

Ironing

Plan ahead

- Store equipment in a convenient place to reduce unnecessary steps. (Council's home maintenance service may be able to assist with this).
- Only iron items that need it.

Balance the work

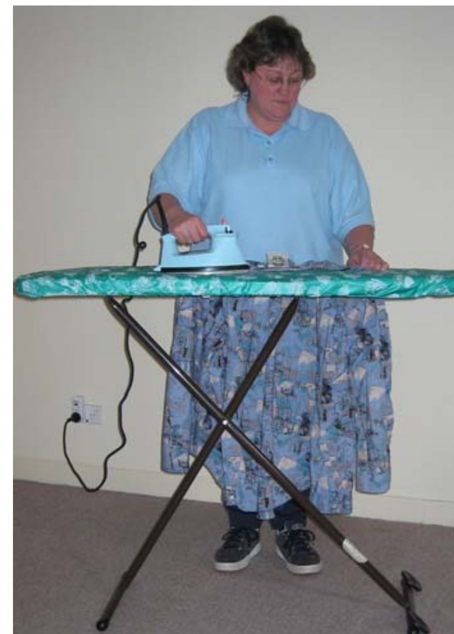
- Iron for less than 30 minutes at any time.
- Avoid doing other tasks requiring similar movements immediately before or after ironing.
- Rest every 5–10 minutes.

Use the right equipment

- Use an ironing board at the correct height. The ironing board should be adjusted so that your elbow is level with the top of the iron handle.
- Leave the ironing board set up all the time if possible.
- Purchase clothing that does not require ironing.

Do the task the right way

- Do not iron on low benches or tables.
- Maintain good posture while ironing.
- When sitting use a high chair with a back support, a swivel seat is ideal.
- Place items to be ironed on a table or bench of similar height, close to the ironing board.
- Do not overfill the iron with water.
- Avoid excessive bending and awkward postures.
- Clothes are more easily ironed if they are damp.
- Remember, it is the heat from the iron that is effective rather than force from your arm, so let the iron do the work for you and don't use undue pressure.



Shopping

Plan ahead

- Make a list of all items required before you shop.
- Try to shop out of peak times so the time taken will be shorter.
- Shop in familiar stores to reduce the walking and time involved.
- Can the shopping be ordered via the telephone?

Balance the work

- Shop regularly rather than doing one big shop, if possible.
- Shop at a steady rate rather than rushing.

Use the right equipment

- Use a shopping trolley.

Do the task the right way

- Do not lift heavy shopping bags. Have the supermarket staff place the items in a number of bags and use the shopping trolley to take to the car.
- Do not lift heavy items for example, pet food or potting mix. Ask the supermarket staff to organise a home delivery if possible.
- Park the car as close to home as possible to unload the shopping.
- Stand front-on to the car when loading/unloading the shopping, hold the items close to your body and bend your knees.
- Only carry small bags of groceries from the car and make several trips.
- Unload the shopping onto a table close to where items are to be stored.
- Stand front-on to cupboards when putting items away.
- Store shopping at a reachable height between the shoulder and the waist.
- Place heavier and glass items at waist height making them easily accessible.
- Place lighter or rarely used items either above/below waist height.
- Avoid awkward postures when loading and unloading or storing shopping.

HOME CARE PLAN

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							