Implementing reablement in dementia care

Catalogue of tools, interventions and models

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Introduction

Dementia

Dementia is an increasingly significant global health issue. In 2023, over 55 million people had the diagnosis ‘dementia’, and every year, more than 10 million new cases are identified, according to the World Health Organization (World Health Organization, 2023). Dementia includes various diseases that affect memory, thinking, and the capacity to carry out daily tasks (World Health Organization, 2023). Unfortunately, there is no specific treatment or medicine that can completely cure these diseases. Therefore, the focus of care is on slowing the disease, managing the symptoms, and supporting the patients with the activities of daily life (Mishra & Baratt, 2016).

As dementia decreases people’s functional independence, there is a need for informal care if people with dementia want to stay at home as long as possible (Klapwijk et al., 2016). Taking care of people with dementia is often associated with mild or severe caregiver burden for the informal carer (Collins & Kishita, 2019). Care consists of e.g. personal care, housekeeping, and administration of medications, but also support with financial transactions or other administrative tasks (Lindeza et al., 2020). This can lead to physical and mental stress for carers. On the other hand, delivering care to a person living with dementia can also strengthen the relationship with their relative and make people feel more closely connected (Lindeza et al., 2020; Collins & Kishita, 2019).

Individuals with dementia often receive formal care in addition to informal care. This includes assistance with activities such as bathing or showering, getting out of bed and taking their medications. Research by Kang and Hur (2021) demonstrated that the complex care needs combined with symptoms of dementia such as aggression, hallucinations, and an elevated fall risk, leads to an increased workload and negative emotions by formal caregivers. Reablement is an approach that can help people gain more functional independence and reduce caregiver burden.

What is reablement?

Reablement is an approach in which older people can be supported with activities of daily living, such as ensuring a person can shower on their own or help someone to stop forgetting keys when leaving the house. Typically, in current systems of care delivery staff provide care *for* the person, while in the reablement approach care is

provided *with* the person (Metzelthin et al., 2020). The goal of reablement is to support people in maximizing their skills to manage their everyday life as independently as possible (Metzelthin et al., 2020). It helps older people in (re)gaining skills and confidence in maintaining or improving function or adapting to the consequences of declining function(s) (Mishra & Baratt, 2016). At the same time, it ensures that individuals stay connected with their community in a safe and adaptable way (Mishra & Baratt, 2016).

A trained and coordinated reablement team makes several visits to a person, starting with a comprehensive assessment, followed by ongoing reassessments. They formulate goal-oriented support plans, which help to achieve an individual's goals by engaging in daily activities or using assistive devices (Metzelthin et al., 2020). A goal might be to be able to bake their favourite cake when family comes to visit. Together with the reablement team, a strategy is thought of on how a person with dementia can do this. For example, write down the recipe step by step, make a grocery list, get all supplies ready before starting, ask spouse for help, if necessary, etc. When formulating goals, it is important to understand the person's abilities to make the goals realistic, achievable as well as meaningful to the person (Poulous et al., 2017).

For people living with dementia, the reablement approach has three main purposes: maintaining function as long as possible; regaining lost function when there is potential to do so; and adapting to lost functions that cannot be regained (Poulous et al., 2017). Reablement encourages people with dementia to function at the best possible level, given the degree of cognitive disability experienced and is relevant in each stage of dementia (Poulous et al., 2017).

Why is reablement important?

In 2017, the World Health Organization (WHO) launched the Global Action Plan for the Public Health Response to Dementia (World Health Organization, 2017). According to the WHO, rehabilitative approaches like reablement should be offered to people with dementia and their family caregivers to support them in preserving their autonomy and capability (Jeon, 2022). This aligns with the message from the International Federation of Ageing. In 2016, they articulated two compelling reasons for reablement in dementia care: sustainability and human rights (Mishra & Baratt, 2016). Reablement is sustainable as it can improve the functioning of

older people and in the process reduce the need for costly health and social care measures (Mishra & Baratt, 2016). The right of people with dementia to have access to comprehensive rehabilitation services, including reablement, is further stressed by the UN Convention on the Rights of Persons with Disabilities (United Nations, 2024).

Over the last two decades, reablement has been acknowledged as a promising health and social care approach in many high-income Western countries (Rostgaard et al., 2023). Although not developed for people with dementia, in recent years a steady number of approaches for this population group has been documented. Studies show promising results regarding outcomes in people with dementia and their family caregivers, cost-savings, and cost-effectiveness (Metzelthin et al., 2024). Nevertheless, reablement in dementia care has spread slowly and has been poorly adopted, despite implementation efforts.

Goal and motives of catalogues

The goal of this catalogue is to summarize and give an overview of interventions and models that currently exist for people living with dementia. Tools were incorporated in the catalogue if they were utilized in reablement interventions for people living with dementia.

This catalogue can be used to provide inspiration and as a guide for sharing knowledge and experience amongst healthcare providers, policy makers and researchers on how care for people living with dementia can be transformed.

Reading guide

In the upcoming chapters reablement tools and strategies for people living with dementia were summarized. All the tools are colour coded into one of five categories. The green category represents all assessment tools, which can be used to assess a person's abilities. Goal setting tools are displayed in the blue category. In purple all strategies to support meaningful social and daily activities can be found. The grey category exhibits all training and implementation tools, that can be used for staff or organizations to train care providers and implement interventions successfully. Lastly, the orange category summarizes all materials that are available for people living with dementia and their caregivers to learn more about the reablement approach and how to implement it in their daily life.

The appendix contains additional information concerning interventions in which the tools or strategies have been employed.

The tool:

The QSC Pool Activity Level checklist (PAL checklist) is an evidence based too, used by practitioners and caregivers, to determine an individual's cognitive capacity to participate in activities. It provides reablement therapist, caregivers, and activity providers with the resources to identify the cognitive functional ability of the person with dementia and to produce a guide to support therapy, care and activity planning and delivery. QSC PAL is available in several languages.

How does it work?

The checklist identifies four levels of activity: Planned, Exploratory, Sensory and Reflex (table 1). For nine everyday activities, e.g. bathing/washing; eating; contact with others, four descriptive statements are provided corresponding with the activity levels. Please find an example of a question in figure 1.

A caregiver chooses the statement which is most accurately describing the activity level of the person for each of the everyday activities. A sum score of the selected statements for each activity level is calculated. The level with the highest score determines the individual's activity level.

The PAL checklist incorporates an Activity Profile for each activity level. These profiles outline the expected abilities and limitations of a person at that activity level. Additionally, they offer guidance to caregivers on the most effective ways to involve and empower someone at a specific activity level. This includes details as optimal positioning of tools, verbal instructions, and non-verbal cues. An example of the guidance for a person with sensory activity level can be found on the next page.

1. Bathing/Washing	P	E	S	R
Can bathe/wash independently, sometimes with a little help to start.	●			
Needs soap put on flannel and one step at a time directions to wash.		●		
Mainly relies on others but will wipe own face and hands if encouraged.			●	
Totally dependent and needs full assistance to wash or bathe.				●

Figure 1: Example question of the QSC PAL

Completing the Checklist

Thinking of the last 2 weeks, tick the statement that represents the person's ability in each section.

If in doubt about which statement to select, choose the level of ability that represents their average performance over the last 2 weeks.

You <u>must</u> select one statement for each section.

P = Planned level of ability

E = Exploratory level of ability

S = Sensory level of ability

R = Reflex level of ability

Figure 2: Instructions for completing the checklist

QSC Pool Activity Level Instrument

Table 1: Explanation of the different activity levels

Activity level	Explanation
Planned activity level	A person can engage in goal directed activities. (S)He looks in obvious places for tools and objects but may encounter challenges in solving problems that arise during the process. The person with planned activity level, can perform activities with tangible outcomes (e.g. baking and cooking) as well as engaging in group discussions.
Exploratory activity level	A person can execute highly familiar activities within familiar surroundings, placing more emphasis on the experience of engaging in the activity than the end result. At this activity level, the person can participate in creative pursuits (e.g. painting, pottery etc).
Sensory activity level	A person is primarily focused on the sensations being felt and responds by moving their body. With this activity level, a person is able to complete simple, one-step activities to provide a range of sensations (e.g. simple ball games, dancing etc.).
Reflex activity level	A person is no longer aware of their surrounding environment and their own body, so movement is being a reflex reaction to stimuli. Direct sensory stimulation is needed to raise the person's self-awareness. Sensory overload should be prevented, so activities should focus on single sensations. At this activity level, the person can participate in experiences such as music, massage, touch, and multi-sensory stimulation.

Below are examples of guidance for a person with sensory activity level.

My Likely Abilities

Is likely to be responding to bodily sensations such as the warmth of the water, the smell of the toiletries or the feel of the soap or cloth.

Can be guided to carry out single step activities such as wiping face or rubbing hand cream onto hands.

Can carry out more complex activities if they are broken down into one step at a time.

My Likely Limitations

May not have any conscious plan to carry out a movement to achieve a particular end result so will need prompting to raise arms etc.

Care Giver's Role

- Enable me to experience the effect of the activity on my senses
- Break the activity into one step at a time
- Keep directions simple and understandable
- Prepare the bathroom and draw the water for me
- Make the bathroom warm and inviting for me - play music, use scented oils or bubble bath, have led safety candles and themed ornaments.
- Give me simple directions: "rub the soap on the cloth", "rub your arm", "rinse your arm", "rub your chest", "rinse your chest"....

Supporting Me

Position of Objects:
Ensure that I become aware of the soap and cloth by placing them in my hands.

Verbal Directions:
Limit your requests to me to carry out actions to the naming of the action and of the object involved eg. "lift your arm", "hold the cloth".

Demonstrated Directions:
Add extra meaning by showing me the action on the object.

Attention and Concenration:
Use touch and my name to sustain my focus on the activity.

Activity Characteristics:
The goal of bathing/showering or washing is achieved by using it as an opportunity for a multi-sensory experience. Repetitive actions are appropriate.

Environmental Tips

- Colour contrasting objects help a person with perceptual difficulties (and visual difficulties) to recognise them. Coloured towels and soap are easier to see against a white or pale background.
- A plain floor helps a person with perceptual difficulties to be able walk on it. Patterns and lines, such as on tiled flooring, can create visual barriers.
- A coloured toilet seat can help a person with perceptual difficulties (and visual difficulties) to be able to recognise the toilet bowl against the background of the pedestal and a paleoor. This can reduce 'missing the target' and falls.
- Removing clutter on shelves will help a person with perceptual problems to be able to find objects.
- Even lighting that reduces shadows helps a person with perceptual problems to make sense of the floor surface.
- Rduced glare from windows or strong lighting on polished surfaces helps a person to be able to recognise objects and move more safely.
- Bath games, such bubble machines will add to the sensory enjoyment of bathing.

Sources:

- *Digital Pool Activity Level (PAL) Instrument | QCS*. (2024, January 5). QCS. https://www.qcs.co.uk/digital-pool-activity-level-pal-instrument/
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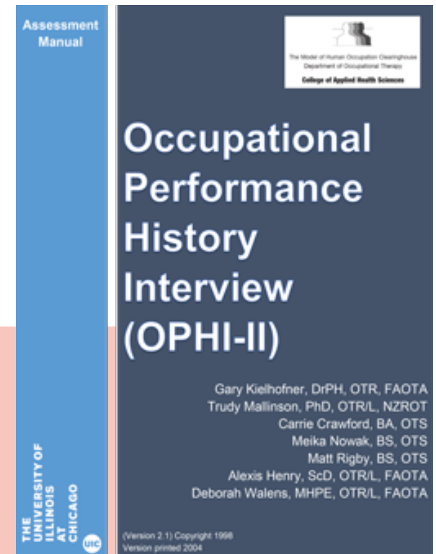
Occupational Performance History Interview II (OPHI-II)



The tool:

OPHI-II is an interview tool used to map the life history based on the story of the older individual with dementia. By sharing experiences, the occupational therapist is able to explore activities, goals and interventions that align well with the life history and personality of the person with dementia. Furthermore, OPHI ensures that the occupational therapy is as client-centered as possible.

The OPHI-II comprises the following components:

1. A semi structured interview aimed at uncovering the client's life history
   It focuses on five themes: organization of daily routines; life roles; interests, values, and goals; perceptions of ability and responsibility and environmental influences (table 2).
2. A narrative of the life history
   Data from the interview are described in a story format, spanning from the past to the present. Thus, it captures the qualitative features of the occupational life history.
3. Score scales
   The scores are intended for the interpretation and quantification of the actions of older individual. It measures the client's occupational identity, competences, and impact of the client's occupational settings.

The tool is predominantly used in the COTiD intervention but can also be used during occupational therapy.

Occupational Performance History Interview II (OPHI-II)

Table 2: Explanation of the theme's in the OPHI-II

Theme's	Explanation
Organization of daily living routines	How is the time spent? How does this pattern affect the functioning of a person? How are work, play and daily living tasks balanced? How satisfied is someone with this balance?
Life roles	What pattern of role involvement emerges from the interview and how well does the person fulfil the expectations of the roles?
Interests, values, and goals	How well does the person identify and act on personal interest, values, and goals, and to what degree does he/she achieve satisfactions and enjoyment?
Perceptions of ability and responsibility	What is the awareness of his/her own control over everyday life and his/her ability to perform behaviours required of everyday life.
Environmental influences	What is the influence of the interviewee's present human and nonhuman environments on his/her adaptation? What was it in the past? What is it likely to be in the future?

Part of the OPHI-II questionnaire

Instructions: Circle the number that best characterizes the individual's adaptive status for each key item in both past and present according to the following scale: 5—*Totally Adaptive* (high level of function); 4—*Moderately Adaptive* (basic ability to function); 3—*Marginal* (questionable/at-risk ability to function); 2—*Moderately Maladaptive* (substantial problems that interfere with function); 1—*Totally Maladaptive* (complete inability to function).

	Individual	Past	Present
Organization of Daily Living Routines	Maintenance of organized functional daily routines	5 4 3 2 1	5 4 3 2 1
	Achievement of a balance in work, play, and daily living tasks	5 4 3 2 1	5 4 3 2 1
Life Roles	Maintenance of involvement in life roles	5 4 3 2 1	5 4 3 2 1
	Fulfillment of expectations of life roles	5 4 3 2 1	5 4 3 2 1
Interests, Values, and Goals	Identification of interests, values, and goals	5 4 3 2 1	5 4 3 2 1
	Enactment of interests, values, and goals	5 4 3 2 1	5 4 3 2 1
Perception of Ability and Responsibility	Acknowledgment of abilities and limitations	5 4 3 2 1	5 4 3 2 1
	Assumption of responsibility	5 4 3 2 1	5 4 3 2 1

Sources:

- Graff, M., Van Melick, M., Thijssen, M., Verstraten, P., & Zajec, J. (2010). Ergotherapie bij ouderen met dementie en hun mantelzorgers. In *Bohn Stafleu van Loghum eBooks*. https://doi.org/10.1007/978-90-313-7874-6
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The Bangor Goal-Setting Interview tool

The tool:

The Bangor Goal-Setting Interview (BGSI) is a tool which can be used to identify the goals of a person with dementia in the context of an intervention. Both full (BGSI) and short (BGSI-S) versions are available, where the long version contains more questions and a deeper analysis of the goals. The short version would be more suitable for routine clinical use.
'Goals are brief statements about a behaviour that the participant wishes to carry out, achieve or manage better.'
The tool offers a structured format for collaboratively identifying an individual's goals, a standardized method for evaluating the interviewee's current capability in relation to the identified goals, and a system for assessing progress towards goal achievement over time. It consists of four steps: Identifying areas to work on; Setting goals; Assessing current goal attainment, motivation to achieve the goal, and indicators of success and; Evaluating the progress, which are further explained on the next page.

The tool can be used in a structured interview between a person (with dementia) and a therapist/caregiver (reablement practitioner), in which they set goals collaboratively. A caregiver can also be involved in this process if available.

The BGSI has been used effectively as an outcome measure in the GREAT CR trial (full version), GREAT-iP implementation study (short version), and in the I-HARP intervention, However, it can be used to set goals in routine practice or in the context of other intervention approaches.

STEPS 3 & 4: RATINGS OF READINESS TO CHANGE AND ATTAINMENT

Use the Visual Rating Scales to explain and complete the ratings. Write down the ratings here.

Readiness to change: the person's perception of his/her readiness to make a change to achieve the goal
1 = not ready to work on the goal 10 = extremely ready to work on the goal

Attainment: how the person is currently performing in relation to the goal
1 = cannot do or am not doing successfully 10 = can do and am doing very successfully

	Person with dementia	CR Practitioner	Care partner
Readiness to change			
Attainment Initial			
Attainment Re-assessment 1			
Goal attainment reached (%)			

Figure 1: Rating scale used in step 3 & 4 of BGSI

The Bangor Goal-Setting Interview tool

Step 1: Identifying areas to work on

A detailed conversation is held about the person's situation and expectations. It focuses on pinpointing problems or needs within each domain of interest. The conversation may revolve around activities the person wishes to either initiate or enhance. Motivation to change is crucial, and identifying areas where the person is willing to make an effort helps set meaningful goals in the upcoming steps.

Step 2: Setting goals

Each domain is revisited to identify specific issues that will become goals. The goals should present a challenge but be realistic and potentially achievable considering the person's capabilities. Furthermore, the goals should be SMART: Specific, Measurable, Attainable, Relevant/Reasonable and Time-bound.
Barriers, facilitators, and resources are discussed, and a problem-solving process is initiated to evaluate options and implement strategies to achieve the goal.

Step 3: Assessing current goal attainment, motivation to achieve the goal, and indicators of success

The individual assesses current activities and rates goal performance, motivation, and readiness to change on an accessible numerical scale.

The person with dementia, carer if available, and practitioner decide what changes would indicate that the goal was partially or fully achieved.

Step 4: Evaluating progress

The person with dementia, carer if available, and practitioner repeat the goals attainment rating at subsequent time-point and identify changes. If progress is limited, the intervention approach can be adapted. If the goal has been achieved, a new goal can be explored.

Sources:

- Bangor Goal-Setting Interview – Short Version – Manual (2016). https://medicine.exeter.ac.uk/v8media/facultysites/hls/healthandcommunitysciences/documents/The_Bangor_Goal-Setting_Interview_-_Short_Version_Manual_v116_03_2020.pdf
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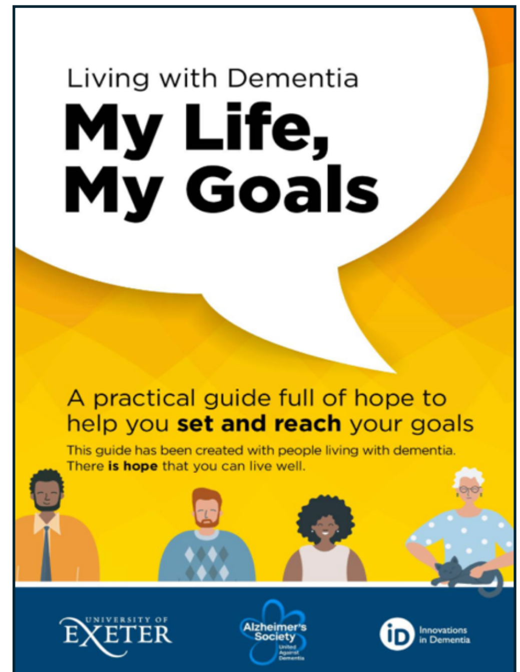
My life, My Goals

My life, My Goals is a guide created by people with dementia with input from the researchers who developed the GREAT Cognitive Rehabilitation approach. It aims to help people living with dementia think about their goals and take steps towards achieving them by creating their own plan. Its creators wanted to give people hope that there are always ways of managing difficulties, finding solutions to problems, and living a good life with dementia. People with dementia can use the guide on their own or with support from a family member, friend, or healthcare professions. Some memory services and dementia support groups are introducing people to My Life, My Goals and are encouraging them to use it.



My Life, My Goals is freely available on the Living with Dementia toolkit and can be found in the section 'Keep a sense of purpose' along with other resources.

An example of a completed My Life, My Goals personal plan

Background: I would like to go out more and meet other people who live with dementia. I would like to learn how others cope with poor memory and hopefully have a good time chatting and laughing at our forgetfulness.

Date:	28 June 2021
My Goal:	Attending my local dementia support group meetings

This goal is important to me:	Yes	✓	No	
I feel motivated to work on this goal:	Yes	✓	No	

Who will support me to work on this goal?

My neighbour could help sometimes

What do I need to do before I start working on my goal? What will help?

1. I need to know the venue and date
2. I need to check how to get there
3. I need to remember about the meeting on the day

What could make it hard for me?

1. I might feel too anxious or sad to leave the house
2. I might forget about the meeting or mix up the date
3. I might get lost on the way there or back

What could I do to get around any difficulties?

1. Make sure in advance that I know my way to the venue meeting. Perhaps my neighbour wouldn't mind walking with me once or twice until I feel more confident
2. Have a back-up plan to make sure I know the way - I do my shopping myself in a local shop, so I know the area and can find my way around, but need something just in case. Ideas: drawing a map, writing down the landmarks for the way there and back, practising the route a few times with my neighbour
3. Make sure the meeting is my calendar so that I know when to go

My commitment - this is what I will do

It is helpful to work through your task step-by-step. It might not take many steps, or it might take lots.

- **Step 1** Find out the date and venue details (ring the phone number given by GP)
- **Step 2** Write down the meeting in the calendar – I commit to go at least four times to give myself a chance to learn the route and see if I actually like the meetings
- **Step 3** Plan the route using a map
- **Step 4** Have a practice walk with my neighbour to check the route is correct and note the landmarks
- **Step 5** Write a step-by-step instruction how to get there and back using the landmarks noted
- **Step 6** Leave early to avoid feeling rushed and anxious
- **Step 7** Take a few deep breaths and count to 10 if feeling anxious

Sources:

- Clare, L., Kudlicka, A., Collins, R., Evans, S., Pool, J., Henderson, C., Knapp, M., Litherland, R., Oyebode, J. R., & Woods, B. (2023). Implementing a home-based personalised cognitive rehabilitation intervention for people with mild-to-moderate dementia: GREAT into Practice. *BMC Geriatrics*, *23*(1). https://doi.org/10.1186/s12877-022-03705-0
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Dementia-specific Goal Attainment Scaling

The dementia-specific Goal Attainment Scaling (GAS) method can be used to measure meaningful outcomes from reablement programs. It consists of three steps: choosing therapy goals with clients using the Reablement Goal List, Defining the goals using a dementia-specific adaptation of SMART and scoring using the GAS-Light to record and evaluate program outcomes. A broader explanation of the steps is provided on the next page.

The method has a practitioner guide and a client workbook. The practitioner guide provides background information and explains the method, while the client workbook is a practical application of the method which can be used together with the person with dementia.

1. Choose – From the Reablement Goal Lists
Identify personally meaningful and desired goal(s) in partnership with the client

2. Define – SMART Goals using the Framework
Define identified goal(s) as Specific, Measureable, Achievable, Relevant, and Time-bound (SMART)

3. Score – using GAS-Light
a) Prior to beginning the reablement program, rate the client's current level of functioning towards their SMART goal
b) At the end of the program (or another pre-specified time), rate the client's level of attainment towards that goal

Figure 4: Steps in GAS method

Leisure

- Community and social life e.g.
  - Recreation and leisure e.g. playing an instrument, dancing, singing, playing sport
  - Community life e.g. outings, visiting the café
- Maintaining relationships e.g.
  - Social e.g. socialising, meeting with friends
  - Family e.g. 'visiting' grandchildren using the iPad

Thinking, planning, and coping

- Thinking about and planning activities e.g.
  - Organising activities e.g. plan and remember to attend an appointment, plan the shopping
  - Undertake a task e.g. making a cup of tea
- Coping e.g.
  - Manage fatigue e.g. manage own activity level
  - Reduce carer frustration e.g. strategies to cope with stress or pressure associated with caring role

Everyday activities

- Activities at home e.g.
  - Preparing meals
  - Doing housework
  - Taking care of plants
- Mobility e.g.
  - Lifting and carrying objects e.g. laundry, shopping, vacuum
  - Fine hand use e.g. writing, making a cup of tea
  - Hand and arm use e.g. making the bed, gardening
  - Indoor mobility in the home e.g. in the kitchen to make a meal, in the bathroom
  - Outdoor mobility e.g. in the garden, in the community to do the shopping
  - Using transportation e.g. catching a bus, train
  - Driving
- Self-care activities e.g.
  - Washing self e.g. showering, bathing
  - Caring for body e.g. doing hair, shaving
  - Dressing e.g. managing buttons, putting on shoes
  - Transferring yourself e.g. on/off the toilet

Figure 5: Examples from the Reablement Goals List

Dementia-specific Goal Attainment Scaling

Steps of the method explained:

1. Choose – from the Reablement Goal Lists
   The practitioner guide provides three programs of 'Reablement Goal Lists', which can be used to guide a discussion about the desired goals of a person with dementia. During the process, people with dementia and their family are encouraged to explore potential goals that they find important. Health practitioners should apply the principles of supported decision making to support the clients in identifying the objectives (figure 5).
2. Define – SMART Goals using the Framework
   When the goals are identified, the practitioner needs to define it as a SMART goal. Specific – the goals need to be defined as explicitly and clearly as possible. Measurable – how will the outcome be measured? Attainable – is the goal attainable, considering the intrinsic capacity and environment of the person. Relevant – the goal should be meaningful to the client. Time-bound – what is a realistic timeframe for the goal to be reached?
3. Score – using GAS-Light (figure 6)
   This scoring system can be applied to determine the client's level of attainment at the end of the program. It will be determined whether the goal was achieved as anticipated (0), slightly exceeded (1), significantly exceeded (2), or if it was not attained, whether it was partially achieved or remained unchanged (-1) or if it worsened (-2) (Figure 6).

The workbook also provides a 'My Reablement Plan' which can be completed by the practitioner and client. This helps to keep a record of the goals and the plan to achieve these goals (figure 7).

Baseline date:			✓	Scoring
Regarding the reablement goal, do they have		No function (as bad as they could be)		-2
		Some function		-1
After reablement program – date:				
Was the goal achieved?	Yes	A lot more		+2
		A little more		+1
		As expected		0
	No	Partially achieved		-1
		No change		-1/-2
		Got worse		-2

Figure 6: GAS scoring table used in step 3

MY REABLEMENT PLAN

Name: Date:

Therapist/ clinician:

This is what I want to work on (my goal):
My program involves: e.g. building strength in my legs, practicing using a timer while cooking a meal
My supporting team: e.g. allied health team members, family members
I am aiming to achieve this goal in: _____weeks (time frame) (add date)
At the beginning of my program, I have (circle): • No ability towards my goal • Some ability towards my goal
At the end of my program, I have (circle): • Achieved my goal: as expected, a little more, a lot more (circle one) • Partially achieved my goal • Not achieved my goal: no change, less ability towards my goal (circle one)

Figure 7: My Reablement Plan

Sources:

- Hammond Care. (2022a, December 13). *Setting goals and evaluating meaningful outcomes for people living with dementia who are participating in reablement programs: Client Workbook*. Retrieved February 26, 2024, from https://www.hammond.com.au/hubfs/HammondCare/HC%20Resource%20Library/Resources/Reablement-Client-Workbook.pdf
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Exercise strategies

Exercising holds potential benefits for individuals with dementia, aiding in maintaining or enhancing everyday functioning and independence. The exercises someone executes should be tailored to the person's goals and, most importantly, abilities. Everyday activities can be mainly supported by exercise programs that improve physical fitness, stamina, and balance.

By increasing strength and endurance flexibility and mobility, balance and coordination, the mobility and physical function of a person with dementia can be improved as well.

Plan stages (continued)	2.1: A home based plan (for the dyad)	2.2: A gym or community based plan (for individuals or small groups)	2.3: A residential care based plan (for small groups)
Exercise components	• A personally prescribed multicomponent exercise program with a range of aerobic, strength, balance and functional exercises, or a recognised, pre-designed program involving functional and progressive exercise done at home (usually not requiring specific gym equipment). • Individual (or family member) is also trained in exercise techniques, and provided with an illustrated written program of all the exercises (e.g. photographs or videos of exercises).	• For group settings, exercises are based on recognised pre-designed programs, incorporating aerobic, balance, strength and functional exercises. • Personally prescribed multicomponent programs can also be used. • Exercises may incorporate bikes, treadmills, weights, balls, balance pillows and outdoor areas (e.g. neighbourhood walking). • Programs often feature warm up and cool down protocols.	• Programs are designed to meet the capabilities of the group. May involve multi-component sessions with music to support the exercises: - walking - strength/resistance - balance - flexibility/joint mobility - coordination - functional exercises. • Alternatively, this plan could include an aerobic component (below) or be focused around aerobic exercise: - moderate-high intensity walking sessions for 30 minutes either with support person/s or professional carer, within the residential care home or outdoors - individual or paired cycling sessions monitored by the facilitator. • Programs often feature warm up and cool down protocols.

Figure 8: Examples from the Hammond Care Handbook of components of effective exercise interventions

Exercise strategies

The frequency of doing exercises is dependent on the abilities and goals of the person with dementia. Together with a health professional, the duration and frequency will be determined.

Exercise strategies can be overseen by various allied health professionals such as physiotherapists, occupational therapists, exercise therapists.

It is also possible that an informal caregiver does the exercises together with the person with dementia and thus oversees the program.
Therefore, it is possible to conduct exercises in different settings. Training with a physiotherapist can be done at a gym or in a residential care setting. But when an informal caregiver oversees the majority of the program, training can also be done at home.

Elements from effective exercise interventions for improving/supporting physical function in people with dementia:

Exercise intervention features	• Individually tailored exercises to the person's abilities.
	• Small group or one-to-one.
	• Range of exercises including:
	  o Aerobic e.g. walking, cycling, cross trainer
	  o Strength/resistance e.g. squatting, repeated stand-ups from a chair
	  o Balance e.g. one or two leg balance exercises
	  o Coordination e.g. tossing/catching a ball
	  o Functional exercises e.g. sitting/standing from a chair.
	• Intensity increased over time.

Supporting features of the program	• Exercises led by PTs, physical therapists, exercise scientists, professional trainers, EPs, OTs, RNs, or by carers (family or paid carers). • Music. • Equipment e.g. weighted belts, treadmill, cross trainer, bike, balls, foam ground mats, elastic bands. • Support strategies to match cognitive abilities of the person e.g. tailor communication, 1 or 2 step instructions, visual cues.
Exercise locations	• Home, residential care home, gym, community (e.g. neighbourhood walking).

Sources:

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Fall prevention strategies

Falls are a major cause of loss of independence, and they are more likely to occur in older people living with dementia. Therefore, implementing fall prevention strategies can help reducing the risk of falling and thus reducing the risk of a decrease of functioning independently.

The strategies consist of exercises which are tailored to the person's abilities and functionality. They can be directed by physiotherapists or occupational therapists. Additionally, a supports person or other care giver can be trained to improve the sustainability of the results.

Several strategies and habits in home reducing the risk of falling are taught to the person with dementia. For example, keep the floors clean and not leave any bags on the floor, as this is something you might fall over.

Exercise	Home safety	Technology
• Individually tailored strength and balance exercises prescribed by a PT or EP.	• An assessment of the home, followed by individualised recommendations to improve home safety, conducted by an OT or other practitioner with suitable home safety assessment skills. • Providing education on potential home hazards and how the environment impacts the person living with dementia.	• Assistive technology is implemented as required, such as sensor lights to light pathways at night, or wearable tele-assistance systems (e.g. a device to call for help if a person falls).

Figure 9: Features of a multicomponent plan to reduce falls delivered at home, provided by the Hammond Care Handbook

Fall prevention strategies

Fall prevention strategies can consist of multiple components, including exercising and increasing strength and balance. However, they can also be only focused on reducing the risk of falling and not consider any other aims or effects.
The duration, frequency and intensity of the strategies is therefore dependent on the focus of the strategy. Most often, strategies are tailored at increasing strength and balance, while simultaneously increasing the home and environment safety of a person.

Plan phase	OT	PT
Assessment	• Assesses functional cognition, physical abilities, home safety and potential home hazards.	• Assesses physical performance and reviews cognitive function for ability to engage with tailored exercise plan.
Active phase	• Joint problem solving strategies for the person with dementia and their support person to address any functional changes and home safety hazards. • Tailored home safety recommendations detailed in written information/booklet and may include: - explanation and description of hazards - recommendations in context of person's cognitive abilities, e.g. removing a dark mat that may appear as a hole - identifying habits that can contribute to trip hazards, e.g. removing bags usually left in the hallway - identifying any assistive technology that should be acquired, e.g. sensor lights in bathroom, wearable falls monitor - implementing strategies such as double-sided tape to secure floor mats - recommending home modification strategies, e.g. rails in the shower. • The OT also supports the family member by providing general management strategies, e.g. conversations about behavioural and cognitive changes that might occur, tips to modify the environment or ways to simplify tasks to promote independence.	• Individualised strength and balance exercises tailored to the person's cognitive and physical abilities. • Exercises may include: - strength-training exercises, e.g. calf raises, sit-to-stand, block step-ups - static balance exercises, e.g. scaled stance positions with diminishing bases of support - dynamic balance exercises, e.g. sideways walking, step-ups, stepping over an object. • Exercises are made progressively more difficult through changing: repetitions, frequency, and bases of support. • Providing personalised information/a booklet containing: - strength and balance exercises with illustrations or photographs - instructions that are accessible to someone living with dementia (clear formatting and language, shorter sentences and larger font).

Figure 10: Example of a multicomponent fall prevention plan, in Hammond Care Handbook

Sources:

- Hammond Care. (2019a). *Supporting independence and function in people living with dementia: A handbook of reablement programs for service providers and others with an interest in improving function*. Retrieved January 29, 2024, from https://www.hammond.com.au/hubfs/HammondCare/HC%20Resource%20Library/Resources/Sector-Handbook-Second-Edition-Reablement.pdf
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Communication strategies

Communication is a factor that can be affected by dementia. This can cause a lack of understanding in caregivers and eventually result in the needs of a person with dementia not being met. Communication strategies may improve or support the communication abilities in people living with dementia, their family, and the professionals involved in their care.

A strategy might be for the person with dementia to have various sessions with a health professional, e.g. speech therapist, aiming to increase the communication skills. There are different options for equipment that can be used to stimulate a conversation or discussion or can help memorizing words or to help clarify the needs.

Training is not only possible for the person with dementia. Family members or health professionals can also follow a training that can help them better understand what a person with dementia means or how to help someone when their communication is unclear.

Elements from effective interventions for improving/supporting communication in dementia:

<table>
<tr>
<td>Communication intervention features</td>
<td>Interventions focused towards the person with dementia (small group or individual – person with dementia or dyadic):

Cognitive stimulation strategies: theme-based sessions involving creativity, word games, current affairs.
Life storybook/memory book: developed in discussion with the person with dementia and used as a conversational aid.
Walking and conversation: personalised conversation tailored to the person with dementia.
Snoezelen multisensory care plan used during care interactions.
Montessori personalised activities.
Lexical semantic stimulation: lexical tasks designed to improve semantic verbal processing.
Paro companion robot to stimulate interaction.
Dyadic intervention covering topics such as dementia education, effective communication, building on existing effective strategies, compensatory techniques, coping with memory changes, social and family relationships, daily living skills, stress management, future planning.

Interventions focused towards the family member:

Family member training: education and skills training, antecedent-behaviour-consequences (ABC) problem-solving, behaviour management plans, communication strategies, memory strategies, pleasant events, coping strategies, support for the future.

Interventions focused towards care workers:

Training program: effective communication (verbal and non-verbal), understanding dementia and the effects on social participation, strategies to support social abilities, behaviour management, understanding emotional expression, using multisensory stimulation.
Person centred care + person centred environments.
Care worker support: relaxation techniques and coping strategies to manage work-related stress.

</td>
</tr>
</table>

Sources:

- Hammond Care. (2019a). *Supporting independence and function in people living with dementia: A handbook of reablement programs for service providers and others with an interest in improving function*. Retrieved January 29, 2024, from https://www.hammond.com.au/hubfs/HammondCare/HC%20Resource%20Library/Resources/Sector-Handbook-Second-Edition-Reablement.pdf
- Hammond Care. (2019b). *Supporting independence and function in people living with dementia: A technical guide to the evidence supporting reablement interventions*. Retrieved January 29, 2024, from https://www.hammond.com.au/hubfs/HammondCare/HC%20Resource%20Library/Resources/Technical-Guide-Second-Edition-Reablement.pdf
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Compensatory strategies

Compensatory strategies can help people living with dementia to work towards goals they put in place. It includes adjusting activities or methods of performing tasks which may involve altering the environment or using assistive technology.

Assistive technology encompasses a range of devices, equipment, instruments, or software, specifically designed for use by persons with a disability. For people living with dementia or their caregivers using compensatory strategies can serve multiple purposes. These include facilitating participation in valued activities and roles as self-care, social interactions, and leisure activities, compensating for limitations, providing support or protection for bodily structures or function aiding in activity training or retaining, and preventing bodily impairments or other limitations.

Next to assistive devices, also other aids can be put in place to reach the goals someone has. External aids as shopping lists or using a whiteboard to write things to remember, and internal aids like mental imagery are examples of compensatory strategies that people with dementia might use to reach their goals.

Products that address challenges related to attention, memory, spatial orientation changes, decreased executive functioning, and safety judgements, can help for people with dementia.

Examples are:

- Medication reminder aids
- Stove timers
- Personal locating devices

To facilitate cognitive stimulation and encourage social engagement, robotic pets and digital communication technologies are accessible. For example, Paro the Seal can increase cognitive stimulation (figure 11).

Figure 11: Paro the Seal

Figure 12: Medication reminder

Occupational therapy can also help in advancing compensatory strategies for people living with dementia. They can include simple adjustments to the home environment as providing additional lightning or sensor mats. Moreover, it can also incorporate training to stop forgetting keys when leaving the house. For example, by putting keys in a basket after coming home and picking them up from the basket before leaving the house.

For the person with dementia	For the support person	The home environment
• Assessment of interests and abilities, ensuring a focus on supporting abilities as much as possible. • Practising everyday living activities to support continued everyday functioning, e.g. family member may assist with putting on the washing machine, but the person can then finish the rest of the laundry task (hanging out, bringing in, folding, putting away). • Strategies to compensate for functional changes, e.g. using a timer when cooking or using a list when shopping.	• Highlighting the abilities of the person with dementia. • Education on dementia including symptoms and associated changes. • Understanding the importance and impact of the home environment on everyday functioning. • Skill development such as strategies in problem solving, communication, activity simplification, and coping. • Learning to manage different care situations as they arise, e.g. identifying changes in abilities, and thinking about how tasks can be adapted to support continued participation. • Learning effective communication strategies, e.g. providing options rather than asking an open-ended question, or giving one instruction at a time.	• Modifying the environment to ensure it is more enabling for the person with dementia through changes such as: - decluttering spaces - ensuring appropriate lighting - reducing competing noises - providing assistive technologies (e.g. falls monitor, electronic bidet) and environmental modifications (e.g. clearly defined hot and cold taps). • Environmental cues to support independence, e.g. providing daily schedules on a whiteboard with a clock in a common space to support the person in independently planning their day.
Establishing strategies or supporting effective communication between the support person and the person living with dementia.		

Figure 13: Elements of an effective occupational therapy program

Sources:

- Baas, R. A. (2021, April 15). *Home*. Medido. https://medido.com/nl/
- Farias, S. E. T., Schmitter-Edgecombe, M., Weakley, A. T., Harvey, D., Denny, K., Barba, C., Gravano, J., Giovannetti, T., & Willis, S. L. (2018). Compensation strategies in older adults: association with cognition and everyday function. *American Journal of Alzheimer's Disease & Other Dementias®*, *33*(3), 184–191. https://doi.org/10.1177/1533317517753361
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Cognitive rehabilitation e-learning

An E-learning about the cognitive rehabilitation approach developed and used in the GREAT CR trial and implementation studies is available for dementia care practitioners. It provides a thorough understanding of the principles of CR and of processes and techniques for planning and delivering GREAT CR. This will be helpful for practitioners who wish to expand their repertoire of strategies and techniques for promoting independence and confidence in people who use their services.

The e-learning course consists of nine modules. It includes a series of webinars on which two trainers explain the principles of GREAT CR and how to apply these in practice with individuals and integrate them into service provision, accompanied by written information. The first six modules provide the underlying theory and evidence and introduce the approach, and the final three modules focus on practical application. Learner can check their understanding through quizzes after module 6 and module 9.

Practitioners taking the course gain access to a handbook describing GREAT CR and a booklet explaining how various types of therapy goals can be addressed. These are described in the upcoming sections.

The course is available through NHS platforms in the UK and through the GREAT CR website.

Trainers share their extensive experience of delivering CR, and practical examples help to illustrate how the approach works.

Practical examples illustrating how the CR approach works, provided in the e-learning.

3

GREAT CR plan: developing a personal therapy plan

To plan GREAT CR, you will need to understand the person's current level of ability, and what makes a particular activity difficult. Then you can decide which GREAT CR strategies might be most suitable for that person and the goal. Key areas to consider are:

- Are there any problems that need attention before you can focus on the goal?
- What activities are involved in achieving the GREAT CR goal?
- What exactly makes the goal-related activities difficult?
- Can the GREAT CR plan build on the person's usual ways of coping?
- Could the care partner help in applying the GREAT CR plan?
- What GREAT CR methods could help in achieving the goal?

There are several common barriers to wellbeing that can impact on activities and make the experience of dementia worse:

1. Problems with mood and motivation
2. Difficulty concentrating
3. Limited understanding of dementia within the family
4. Tension in family relationships

It is important to take care of such issues. This can be done either as a separate element of GREAT CR or as part of the plan to address the goal. As discussed earlier, if the problem is of a more serious nature you need to seek specialist help before it is appropriate to start GREAT CR.

Use the arrows to explore some quotes from people who had GREAT CR sessions.

"The therapist made you think about things that you thought you perhaps knew but think about them in a different way ... and approach them in a different way."

- Family supporter

Sources:

- Clare, L., Evans, S., Pool, J., Litherland, R., Kudlicka, A., Oyebode, J., & Bob Woods, B. (2022). *GREAT Cognitive Rehabilitation - eLearning course*. University of Exeter. Retrieved January 29, 2024, from https://sites.google.com/exeter.ac.uk/great-cr/for-practitioners/elearning-course
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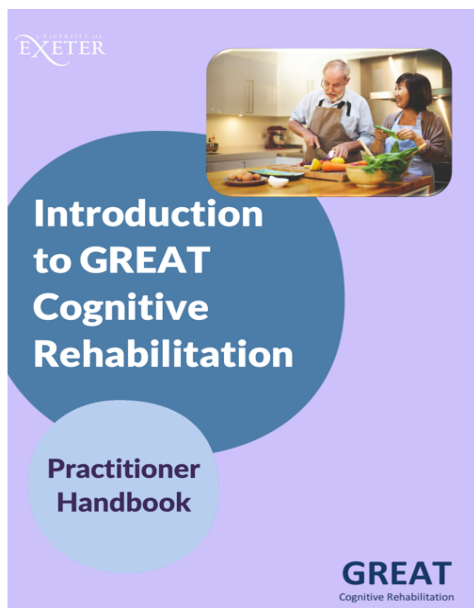

The 'Introduction to GREAT Cognitive Rehabilitation' handbook provides information about the GREAT CR approach. It can be used as a resource to guide intervention planning and delivery.
The handbook covers principles of GREAT CR, assessment, goal setting, planning the intervention, strategies for addressing and achieving goals, and evaluation progress. Practitioners gain access to the handbook when they take the GREAT CR e-learning course.

The handbook is based on years of experience with delivering CR, and includes clear explanations and case examples, as well as strategies for addressing common difficulties that can arise during the CR process and finding solutions. Examples can be found in the pictures below.

To help Joanne achieve her goal of attending the Memory Café, Joanne and the CR Practitioner could try the following enhanced learning strategies:

They could write down the directions, divide them into short sentences (chunking) and practise each sentence using the expanding rehearsal technique.

Alternatively, rather than learning the whole set of instructions Joanne could focus on key landmarks and turning points only, and learn each of these with a mnemonic, e.g. 'CARL in the café', which stands for 'pass the Church, then Asda, then at the Roundabout turn Left, and the meeting is in the café'. Multimodal elaboration could help the information sink in (e.g. Joanne could visualise the landmarks and associated sounds or smells as she describes the route).

The CR Practitioner could try the following compensatory strategies to help Joanne achieve her goal of attending the memory café:

Joanne could take her written directions and/or a map as memory aids. Photographs of landmarks could potentially be added to help in following the route. She could also use a map on her smartphone that gives verbal commands. However, as Joanne has never used maps on her smartphone before, she would need some help in learning how to use this facility. This may take some time and effort, so would have to be carefully considered. Joanne might want to try it, however, as the skill could be helpful in other situations, not just for getting to the Memory Café.

Figure 12: Case examples of CR approach

Example of a six-session GREAT CR plan

GREAT Cognitive Rehabilitation is flexibly designed around the person's needs and abilities, and so there is no prescriptive therapy schedule to follow. However, it takes some time and experience to feel comfortable designing individual therapy plans.

The example below is provided to give you a better idea of what a six-session GREAT CR plan could look like.

Session	Example of a 6-session protocol
1	Explaining GREAT CR and problem-solving Evaluating the person's current level of functioning and needs Identifying areas to work on and setting Goal 1 Reviewing current adaptations and compensatory strategy use
2	Planning to address barriers to wellbeing (if relevant) Confirming Goal 1 Planning GREAT CR for Goal 1 and completing BGSI-S attainment ratings Explaining between-session tasks for Goal 1
3	Reviewing the person's wellbeing Reviewing between-session tasks for Goal 1 Working on Goal 1 Discussing compensatory strategies Confirming Goal 2 and completing BGSI-S attainment ratings
4	Reviewing between-session tasks and progress with Goal 1 Planning GREAT CR for Goal 2 Explaining between-session tasks for Goal 2 Discussing enhanced learning techniques
5	Reviewing between-session tasks and progress with Goal 1 and Goal 2 Working on Goal 2 Reviewing activity levels Reviewing carer's wellbeing and referring to sources of support, if needed Preparation for ending weekly sessions
6	Evaluation of goal achievement for Goal 1 and Goal 2 Completing BGSI-S attainment ratings Ending the therapy sessions

Figure 13: Example of a six-session GREAT CR plan

John who lived with dementia wanted to know the date without asking his wife Patricia. They had a daily newspaper delivered every morning, but John did not use it to check the date. The CR Practitioner suggested using prompts to gradually develop a habit of checking the date in the newspaper. The CR Practitioner visited weekly and Patricia supported John between the CR Practitioner's visits.

When John asked about the date in the morning Patricia pointed to the newspaper and suggested checking the date there. It was important to do it every time John asked, and to do it in a calm and friendly way to make it a positive experience. Later on, when John wanted to know the date, it was enough to simply ask 'How do you find out the date?' instead of pointing to the newspaper. They kept the newspaper where John could easily see it at breakfast time.

The plan worked very well. Within three weeks John started to check the newspaper in the morning without prompts from Patricia and in the following three weeks he remembered to check the newspaper throughout the day. John and Patricia were both very pleased with the achievement and used the same strategy to help John with checking appointments in the diary. The result was that John knew the date and was aware of any appointment independently, which reduced tension in their relationship and improved John's confidence.

Figure 14: Example of addressing a therapy goal – knowing the date

Expanding rehearsal procedure

Step 1: The person repeats the information straight after hearing it

Step 2: The person recalls the information after a short interval, while he or she still remembers it, e.g. after 15 secs

Step 3: The recall interval doubles in stages (e.g. 30 secs, 1 minute, 2 minutes, 4 minutes and so on), 'stretching' the memory

Correction procedure: if the person forgets, the information is given and repeated again, and the next interval halved.

Achieving an interval of 20 minutes is normally a good sign that the information has been learnt, but the length can be extended (e.g. recalling after a couple of hours, or a day)

Figure 15: A strategy that can be used to learning or re-learning information

Sources:

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GREAT Cognitive Rehabilitation: Addressing therapy goals

This booklet provides examples of how to successfully address the goals that you collaboratively identify when providing GREAT Cognitive Rehabilitation (GREAT CR) for people with dementia. The examples are real-life scenarios encountered in the GREAT trial. The examples are grouped into categories and show the wide range of goals that practitioners can help to address. Each example is illustrated with a short case study. Practitioners gain access to the booklet when they take the GREAT Cognitive Rehabilitation e-learning course.

For each goal, the text explores:

- Why a person might want to work on this goal
- What difficulties might be interfering with ability to do the activity
- Whether and how the activity itself could be simplified
- What kinds of strategies would be helpful for addressing the goal
- How the practitioner could use these strategies
- What other support might the person need when working on the goal

Vera lives alone in the village where she grew up. Neighbours have rung Sheila, her daughter, twice to say Vera has been out in cold, wet weather without a coat or umbrella, leaving Sheila worried about her mum's safety. Vera doesn't want Sheila to worry and wants to prove she can still manage. The CR practitioner and Vera sort out her accumulation of coats, putting most away upstairs, giving some to charity, and only leaving her current winter coat on the stand in the hall. They decide her umbrella will hang next to the coat rather than being put out of sight in the hall cupboard. The CRpractitioner puts a vivid sign on the inside of the front door saying: 'Coat, Coins, Keys'. They use modelling, action-learning and expanding rehearsal to help her learn to follow a checking routineso she takes her coat, money and keys when going out.

Figure 16: Case example provided in the booklet

GREAT Cognitive Rehabilitation:
Caring for oneself

GOAL: I will select my own clothes each day, appropriate to the weather

What are the possible motivations underlying this goal?

- Independence.
- Maintaining identity.
- Safety, for example, being warm enough in cold weather.
- Comfort.

What difficulties might be interfering with being able to do this activity?

- Difficulty remembering to check the weather.
- Being unable to locate appropriate clothes.
- Unable to use judgement to pick the best clothes for the weather.
- Difficulty getting the clothes out and ready to put on.
- Difficulty concentrating.
- Perceptual problems leading to difficulty recognising particular clothes from different angles.

Could this activity be simplified?

- The person, with a family member, could take out-of-season clothes out of the bedroom.
- Drawers could be labelled with their contents using a word and picture.
- A see-through door could be used on a wardrobe or cupboard to allow sight of what is inside (or a door could be removed/sliding wardrobe door left open).
- A light could be fitted inside the wardrobe to support visual access.
- Organising the wardrobe by placing skirts and trousers, tops and shirts in specific clusters on the rail; these could be further identified with colour markers between categories on the rail.
- The person could always dress as if for a cool day first and then consider whether extra or fewer layers are needed.

Which strategies would be helpful for addressing this goal?

- Enhanced learning techniques: action-based learning, fading prompts, expanding rehearsal.
- Compensatory strategies: simplifying the activity; memory aids; managing the environment.
- Other CR elements: problem-solving.

Figure 17: Case example provided in the booklet

Sources:

- Clare, L., Kudlicka, A., Collins, R., Evans, S., Pool, J., Henderson, C., Knapp, M., Litherland, R., Oyebode, J. R., & Woods, B. (2023). Implementing a home-based personalised cognitive rehabilitation intervention for people with mild-to-moderate dementia: GREAT into Practice. *BMC Geriatrics*, *23*(1). https://doi.org/10.1186/s12877-022-03705-0
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Organisational self-assessment tool

With the organizational self-assessment tool an organization can assess reablement in their service delivery. The tool provides an overview of organizational elements that support organizations to embed reablement in practices and service delivery. It can help kick-start a discussion in the organization, measure the current level of readiness, help in identifying areas of focus and improvement and it can provide a baseline for future assessments.

The assessment consists of 23 questions, which have to be rated between 1-5 (table 3). Rating 1-2 indicates a low maturity level, requiring significant focus, particularly from the executive level. A rating of 3-4 suggests moderate development in maturity, yet further efforts are necessary to fully integrate it into the organization. When a question is rated 5 it indicates successful integration of wellness and reablement in the organization effectively.

Table 3: Rating scale used in the organisational self-assessment tool

Rating	Explanation
1-2	The maturity is low and requires significant focus, particularly from the executives
3-4	The maturity is somewhat developed, but work needs to be done in embedding it.
5	You have embedded wellness and reablement into your organisation effectively. Consider celebrating the success internally and externally to further reinforce the good work.

The elements an organization can assess itself include:
Training and coaching – Does the leadership team possess a comprehensive understanding of wellness and reablement, and do they actively advocate for these concepts throughout the organization?
People – Are the employees sufficiently supported and trained to effectively integrate wellness and reablement into their service delivery?
Process – Do organizational policies and procedures clearly outline the approach to wellness and reablement, offering adequate support and guidance to employees on how to implement the principles?
Systems – Are the organization's systems oriented towards supporting and promoting wellness and reablement, with employees receiving appropriate training to utilize them effectively?

Organisational self-assessment tool

The questions of the organisational self-assessment tool

Leadership & Culture	Rating							Comments
Senior leadership understands wellness and reablement and how it relates to their business model	Not at all	1	2	3	4	5	Completely	
The principles of wellness and reablement are reflected in our organisation's vision and mission statement	Not at all	1	2	3	4	5	Completely	
The principles of wellness and reablement are reflected in our Human Resources policies (including recruitment information, position descriptions and performance metrics)	Not at all	1	2	3	4	5	Completely	
Leadership regularly endorses and promotes wellness and reablement stories within our organisation	Not at all	1	2	3	4	5	Completely	
Our leadership team champion good practice and actively support ongoing learning to support wellness and reablement	Not at all	1	2	3	4	5	Completely	
Our organisation is ready and able to offer short-term support	Not at all	1	2	3	4	5	Completely	
	Average Score							(Score 1 + Score 2 + Score 3 + Score 4 + Score 5 + Score 6) / 6 = Average Score
People	**Rating**							**Comments**
Managers and support workers are educated on wellness and reablement philosophy	Not at all	1	2	3	4	5	Completely	
Managers and support workers are trained in embedding wellness and reablement in their service delivery	Not at all	1	2	3	4	5	Completely	
Employees are encouraged and empowered to adopt wellness and reablement practises from training, when working with their clients	Not at all	1	2	3	4	5	Completely	
Employees are enabled to deliver wellness and reablement in all aspects of their service delivery	Not at all	1	2	3	4	5	Completely	
Opportunities for learning and development for wellness and reablement are integrated into employee professional development plan	Not at all	1	2	3	4	5	Completely	
There are clearly defined and well-communicated feedback channels for employees to seek advice on wellness and reablement approaches/strategies	Not at all	1	2	3	4	5	Completely	
	Average Score							Score 1 + Score 2 + Score 3 + Score 4 + Score 5 + Score 6) / 6 = Average Score

Process	Rating							Comments
Policies and procedures clearly articulate:								
How wellness and reablement is applied in service delivery (inc. all service types)	Not at all	1	2	3	4	5	Completely	
The ongoing commitment to working with clients, their family/carers to develop individualised goals and care plans that work to people's strengths and abilities	Not at all	1	2	3	4	5	Completely	
Policies and procedures provide guidance and strategies:								
Communicating with clients and their family/carers on wellness and reablement	Not at all	1	2	3	4	5	Completely	
Developing person-centred and goal-directed care plans that focus on clients strengths and abilities and are aimed at maximising autonomy and independence	Not at all	1	2	3	4	5	Completely	
Identifying changes in a clients circumstance/needs and review care plan/goals	Not at all	1	2	3	4	5	Completely	
Reporting on service delivery outcomes to inform continuous improvement	Not at all	1	2	3	4	5	Completely	
Team reporting processes include wellness and reablement metrics	Not at all	1	2	3	4	5	Completely	
	Average Score							Score 1 + Score 2 + Score 3 + Score 4 + Score 5 + Score 6 + Score 7) / 7 = Average Score
Systems	**Rating**							**Comments**
Website (external and internal facing) content focusses on and promotes wellness and reablement	Not at all	1	2	3	4	5	Completely	
Relevant employees are trained on using the Digital Hub to find key wellness and reablement resources	Not at all	1	2	3	4	5	Completely	
Client Relationship Management (CRM) systems / client databases are optimised to capture and track client wellness and reablement goals	Not at all	1	2	3	4	5	Completely	
Systems are designed to be person-centred and encourage employees to embed, record and track wellness and reablement outcomes	Not at all	1	2	3	4	5	Completely	
	Average Score							(Score 1 + Score 2 + Score 3 + Score 4) / 4 = Average Score

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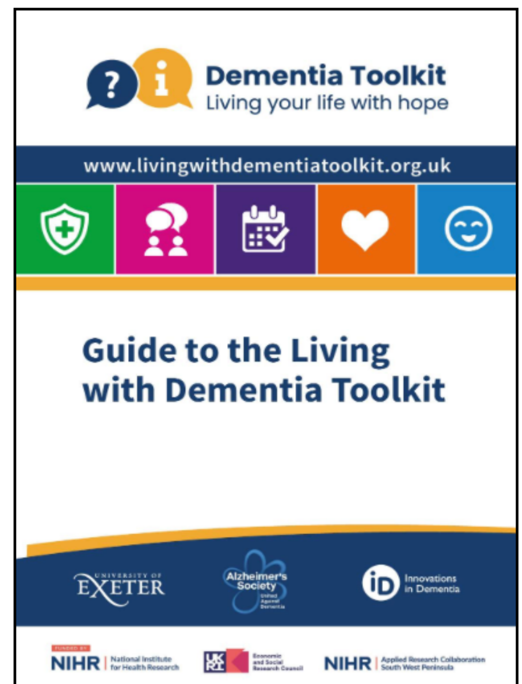
- Australian Government Department of Health and Aged Care. (2021, January 21). *Organisational self-assessment tool*. Retrieved February 22, 2024, from https://www.health.gov.au/resources/publications/organisational-self-assessment-tool?language=en

The toolkit:

The Living with Dementia Toolkit was developed by, with and for people with dementia and their caregivers. It provides resources and insights that can give hope for the future, inspire people through real-life examples and, offers ideas to help a person with dementia live their life as they choose.

The toolkit is organised around five themes: stay safe and well, stay connected, keep a sense of purpose, stay active, and stay positive (table 4). All of these contribute to living a good life with dementia. For each theme, an introductory video with insights from a researcher, caregiver or person with dementia is presented. Suggestions, advice and, tips and are presented along with links to other useful resources. Although this is an online resource, there are some printable pages, and a printed guide has been produced.



5 Top Tips for Keeping a sense of purpose

1. Work out what matters to you, not to other people.
2. Make a plan for the next day every evening, so it's ready for when you wake up.
3. Make a list of things to do and tick each one off when you finish it. Include activities to look forward to as well as tasks you need to get done.
4. Think about what you enjoyed doing which you no longer do – can you take that activity back up?
5. Remember that nothing is too small to have a purpose behind it.

Figure 18: Tips provided in the Living with Dementia Toolkit regarding theme 'Keep a sense of purpose'

The toolkit was initially co-produced by people with dementia, carers, and researchers as a resource to support people during the COVID-19 pandemic but evolved into a more extensive and sustainable resource for living well with the condition, and includes the My Life, My Goals resource described earlier. It was created as part of the IDEAL research programme on living well with dementia – see here.

Table 4: Explanation of the theme's in the Living with Dementia Toolkit

Theme	Explanation
Stay safe and well	Looking after your everyday needs. In that way, a person is in the best position to be able to do the things he/she wants to do.
Stay connected	Creating, maintaining, and enjoying relationships with other people.
Keep a sense of purpose	Staying motivated and finding the things which give a purpose, so someone can feel fulfilled.
Stay active	Keeping active in both body and mind, not just for your health but to feel good overall.
Stay positive	Remaining positive and maintaining a sense of hope amid a sometimes-challenging situation.

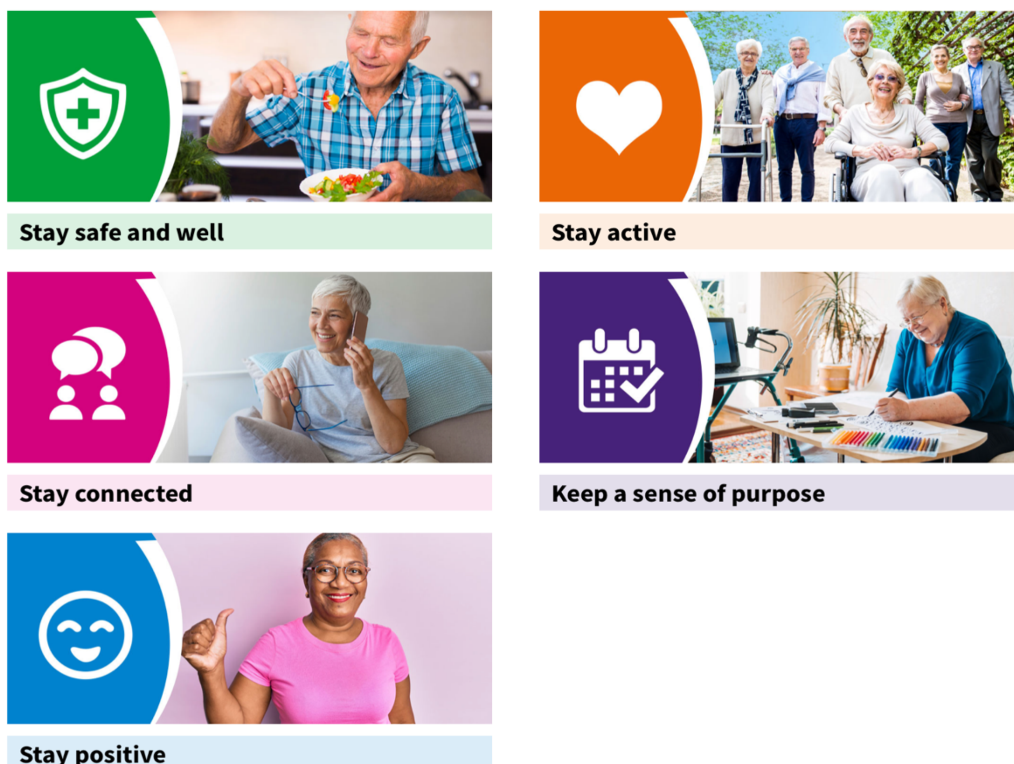


Figure 19: Theme's of the Toolkit

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Appendix

In the appendix, an overview of different reablement interventions that exist and are currently used in dementia care is presented. Per intervention, there is an explanation of the method. Additionally, there are links to the websites of the interventions where more information can be found.

Carecoach

Carecoach is a Dutch intervention aimed at the close relative of a person with dementia. How can a relative meet their own needs and stay healthy while also dealing with changes, uncertainties, and a gradual increase in caregiving responsibilities? It focuses on maintaining a healthy balance in daily life and assisting informal caregivers in coping with changes, sustaining care for longer durations, and finding more enjoyment in their role.

At this moment, the intervention is only available in Dutch: Partner in balans. However, its effectiveness is currently being reviewed in the UK. A caregiver will be enrolled in the program by a healthcare professional. This professional will be the coach during the eight weeks in which the program will take place.

The program consists of twelve modules about which the caregiver can learn more. During the intake, the coach explains all the modules. Subsequently, the caregiver and coach collaboratively select four modules upon which the caregiver will focus during the program. After the intake, the caregiver will go through the online modules independently.

Each module starts with an introduction video, which includes experiences from other informal caregivers. Then information and tips about the situation in the specific module are provided. Followed by a reflection assignment, that should be made to see what difficulties a caregiver is facing. Last, a step-by-step procedure is devised to guide the caregiver to a more desirable situation. Remotely, the caregiver is guided by the coach.

The program is ended with an end-conversation with the caregiver and coach in which experiences are shared. Additionally, considerations are made regarding how the caregiver can further apply the acquired knowledge in their daily life.

Please click here to find more information about the intervention.

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Care of Persons with Dementia in their Environment (COPE)

Cope is a 4-month, home-based, non-pharmacologic intervention involving occupational therapists and advanced practice nurses. It aims to address adjustable environments stressors and reducing sensorial, physical, and cognitive demands while aligning with patients' capabilities. COPE is focused on re-engaging patients in their daily activities and enhancing overall functionality, with the ultimate goal of relieving caregiver burden.

The program consists of ten sessions with an occupational therapist and two sessions (one face-to-face, one via telephone) with an advanced practice nurse. The occupational therapist identifies patient routines, habits and interests and caregiver's concerns. Additionally, cognitive, and functional tests are done with the patient. Then the caregiver is trained to modify the home environment, daily activities, and communication to support the patient capabilities. Also, a written action plan, which outlines the goals, patient's strengths, and specific strategies, is provided.

The advanced practice nurse will, during the home visit, conduct medical tests and offers health-related information e.g. how pain in a patient with dementia can be detected. Also, medications are reviewed, and dosing is adapted if needed. During the telephone consult, the caregiver is informed over the results.

Please click here for a video's with more information about the COPE program.

Tools used in the intervention:

The COPE program offers a training for people interested in delivering the intervention. In these training sessions, all the ins and outs about the program are learned and professionals are trained to deliver the program effectively. The training is only available in Australia. For more information about the training, please click here.

Key points of the intervention:

- 10 sessions with an occupational therapist, 2 sessions with an advanced practice nurse (1 face-to-face, 1 via telephone)
- Training of the caregiver to support the patient as well as possible

- A written action plan with treatment goals and strategies is provided

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Community Occupational Therapy for people with Dementia (COTiD)

In the community based occupational therapy intervention, people with dementia receive occupational therapy according to a client centred occupational therapy guideline for patients with dementia. The intervention consists of ten one-hour sessions within five weeks, where the focus is on the patient as well as their primary care givers.

In the first four sessions, patients and primary caregivers identify and prioritise meaningful activities for improvement. The occupational therapist assesses potential home modifications, observes daily activity performance, and evaluates the use of environmental and compensatory strategies. Compensatory strategies adapt activities to disabilities, while environmental strategies adjust surrounding to the cognitive disabilities. In the remaining six sessions, patients are taught to optimise the strategies for improvement in their daily performance. Furthermore, primary caregivers receive training in employing effective supervision, problem-solving and coping strategies. This aims to support the autonomy and social participation of both, the patient, and the caregiver.

Tools used in the intervention:

The book called: 'Community occupational therapy for older people with dementia and their caregivers. COTiD programme' explains the theoretical underpinning of the intervention and provides a comprehensive description of how the intervention works. The perspectives of the occupational therapist, informal caregiver, and person with dementia are thoroughly explored and clarified. Real-life examples are shared as well as strategies for effectively addressing these. In the appendices, a compilation of questionnaires and supplementary materials necessary for the implementation is presented.

The book is accessible in multiple languages, including Dutch, English, French and Italian.

The Occupational Performance History Interview (OPHI-II) is an interview tool used to map the life history based on the story of the older individual with dementia. For more information about the tool, please click here.

Key points of the intervention:

- 10 one-hour sessions of occupational therapy within 5 weeks
- Compensatory and environmental strategies to adapt to disabilities
- Training for primary caregivers on how to deal with the person with dementia effectively

Sources:

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Great Cognitive Rehabilitation

The GREAT Cognitive Rehabilitation (GREAT CR) approach inspires and encourages people with dementia to set goals of (everyday) things they cannot do anymore because of the decline caused by the disease. People with dementia do not have to stop doing thing, but they find different ways how to do it. The best way to achieve the goals is to make a plan and then a commitment to carry out the plan.

The reablement practitioner, the person with dementia and the carer agree upon meaningful goal(s), which are collaboratively developed and implemented in a plan to support behaviour change. Goals can be everyday things, things a person wants or needs to do or things that bring joy into life. For example, attending day care every week or cooking dinner for themself. Important factors to consider are that a person with dementia should have a readiness to change and to ensure that selected goal(s) are meaningful and important to the person. This will increase the likelihood of reaching the goals.

The GREAT CR approach involves 6 to 10 one-hour sessions in the home setting of the person with dementia. A GREAT CR practitioner (occupational therapist, assistant occupational therapist, nurses, clinical psychologist etc.) is trained to deliver the approach according to training guidelines.

Together with the person with dementia and the carer, the practitioner finds out the goal(s) of a person, will investigate why this is difficult to do at this moment, suggests strategies that could help reach the goal and eventually keeps enabling the person to make progress and celebrate successes. If needed, additional elements like anxiety management can be integrated into the sessions, potentially enhancing goal attainment.

For a video with more explanation of the approach please click here.

Tools used in the intervention:

The intervention includes an E-learning program designed for health practitioners involved in dementia care, offering comprehensive training on the approach and its implementation. Additionally, a handbook outlines the principles and steps of the GREAT CR approach, supplementing the e-learning. By using the Bangor Goal-

Setting Interview (BGSI) tool, the intervention facilitates the identification of personalized goals for individuals with dementia.
Moreover, the researchers have developed a toolkit for individuals living with dementia, featuring the 'My Life, My Plan' form to help with goal setting and action planning.

Key points of the intervention:

- A trained reablement practitioner, person with dementia and carer set goals together
- On average 6-10 one-hour sessions in which the practitioner and person with dementia are working on a goal
- Additional elements, such as anxiety management, can be incorporated if the practitioner thinks it is necessary
- Incorporate the 'My Life, My Plan' form to help design and reach the goal(s) of the person with dementia

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Hammond Care handbook

The Hammond Care Handbook offers a variety of interventions aimed at enhancing reablement in people living with dementia. It consists of three separate handbooks tailored to various audiences.

The technical guide provides an in-depth outline of reablement interventions, intended for health professionals involved in planning or executing reablement services.

The sector handbook, tailored for aged care providers, allied health and nursing professionals, managers, and care workers, presents information in a concise and accessible manner, focusing on practical implementation of reablement programs.

Lastly, the consumer information booklet serves as a summary primarily for individuals living with dementia, while also offering key insights for family members, support persons, and care workers.

In the handbook, a distinction is made between interventions with three different objectives: supporting everyday living, supporting mobility and physical function, and supporting cognition and communication.

The choice of a suitable program and plan is dependent on various factors: the individual preferences and needs of the participant, the type of functional issues that the person wants to address to maintain independence or to slow decline, the skill level of staff/support people who are available, the access to assistive technology and the financial resources.

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IHARP

The IHARP intervention is a 4-month interdisciplinary model of care, aiming to keep older people with dementia healthy and independent at home. The following components are included in the intervention:

- 12 home visits of 1.5 hour by an occupational therapist (5-6), a registered nurse (3-4) or other care professional (physiotherapist, speech pathologist or psychologist)
- Minor home modifications and/or assistive devices op to the value of $1000
- Three individual carer support sessions of 1.5 hours at the beginning, middle and end of home visits, conducted by a case coordinator

The home visits by one of the I-Harp clinicians include the following:

- An initial comprehensive assessment by an occupational therapist checking functional abilities, strength, balance, and home safety risks. A registered nurse assesses medication, pain, and other existing health issues.
- I-HARP clinicians, the person with dementia and the caregiver identify and set personalized goals and develop action plans to achieve these goals in the upcoming months.
- The plan is implemented during the home visits. Activities as cognitive rehabilitation, tools like calendars and reminders and, techniques to restore memory are used. Also, minor changes to the home environment are made by using assistive devices as automatic medication reminders.

In the carer support session, given by a case coordinator, the impact of dementia, principles of reablement and person-centred care, the goals of the intervention and the role of the carer are discussed. Additionally, the needs and concerns of the carer (e.g. self-care, communication, behaviour of concern and any issues arising from the intervention) are addressed.

If you want to learn more about experiences with the IHARP program, please click here for a video.

Tools used in the intervention:

The Bangor Goal-Setting Interview (BGSI) tool is used to determine the goals of a person with dementia in the intervention. Please click here to read more about the BGSI.

Professionals who want to deliver the intervention receive a training to do so. However, the training resources are not publicly available yet.

Key points of the intervention:

- 12 sessions of 1.5 hour by the occupational therapist, registered nurse, or additional other care professional
- 3 carer support sessions in the beginning, middle and end of the interventions
- Minor modifications or assistive devices in the home of the person living with dementia

Sources:

- *Bangor Goal-Setting Interview Version 2*. (2016). Retrieved January 29, 2024, from https://medicine.exeter.ac.uk/v8media/facultysites/hls/healthandcommunitysciences/documents/The_Bangor_Goal-Setting_Interview_Version_2.2_Manual_(BGSI_v.2.2)_March_2022.pdf
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