Adult Social Care Policies and Procedures

REABLEMENT

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Contents

REABLEMENT

POLICY VERSION CONTROL

POLICY NAME	**Reablement**		
Document Description	**This document sets out the Council's relevant duties under the Care Act and its response to the Care Act 2014 in regard to Reablement.**		
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Document Author(s)	**Kate Burgess/Val Knight/Kate Hemple /Kieran Curran**	**Date**	**11 July 2017**
Status **(Draft/Live/Withdrawn)**	**Draft**	**Version**	**0.2**
Last Review Date		**Next Review Due date**	
Approved by		**Position**	
Signed		**Date Approved**	

DOCUMENT CHANGE HISTORY			
Version No	**Date**	**Issues by**	**Reason for change**
0.2	**July 2017**	**Various**	**Final updates and additions from Programme Manual.**

1. POLICY STATEMENT

"People using Reablement experience greater improvements in physical functioning, health-related quality of life and social care outcomes compared with people using standard home care."

Social Care Institute for Excellence

Reablement is a short-term service designed to help people develop the confidence and skills they need to live as independently as they can. Reablement can help to prevent or delay the need for health and social care by supporting people to develop, retain or regain the skills necessary for independent living and active involvement in their local community.

Reablement should be the first choice for any service user to get them back to or better than their "baseline level" of independence.

Where reablement is provided to those who require it, it must be provided free of charge for a period of up to six weeks. This is for all adults, irrespective of whether they have eligible needs for ongoing care and support. Although reablement will usually be provided as a preventative measure under section 2 of the Care Act, it can also be provided as part of a package of care and support to meet eligible needs. In such cases, the regulations also provide that reablement cannot be charged for in the first six weeks, to ensure consistency.

While reablement is a time-limited intervention, it should **not have a strict time limit,** since the period of time for which the support is provided should depend on the needs and outcomes of the individual.

It is important that people are not removed from the reablement "process" too early. Early or targeted interventions such as a period of reablement, or providing equipment or minor household adaptions, can delay or even prevent an adult's needs from worsening. The first contact with the county council, which triggers the requirement to assess [LINK], may lead to a pause in the assessment process to allow such interventions to take place and for any benefit to the adult to be determined. County council staff should be sufficiently trained and equipped to make the appropriate judgements needed to steer individuals seeking support towards information and advice [LINK], preventative services or a more detailed care and support assessment, or all of these. They must also be able to identify a person who may lack mental capacity and to act accordingly [LINK].

The Care and Support (Personal Budget Exclusion of Costs) Regulations 2015 sets out that the provision of reablement services, for which the county council cannot or chooses not to make a charge must be excluded from the personal budget. This will mean that where reablement is being provided to meet needs (i.e. under section 18, 19 or 20 of the Act) the cost of this must not be included in the personal budget.

In cases where reablement is provided to meet needs under section 18 or 20(1) or under section 19(1) or 20(6), either in isolation or combined with longer-term care and support, the care and support plan should describe what the package consists of and how long it will last. This will help the person understand what is being provided to

meet their needs. However, the person should not receive a personal budget, unless there are other forms of care and support being provided under these sections. In these cases, the personal budget amount must not include the cost of intermediate care/reablement which are provided free of charge.

As always under the Care Act, it is never appropriate to take a one-size-fits-all approach, and local authorities need to ensure that individual needs are met appropriately.

Therefore to fulfil its duty under sections 18, 19 and 20 of the Care Act, the county council will, working with its statutory, voluntary and private sector partners, comply with the duty to provide reablement services.

The county council will make all reasonable adjustments to ensure that all disabled people have equal access to participate in the eligibility decision in line with the Equality Act 2010.

The geography and population of Lancashire is diverse and our Adult Social Care Policies and practice will aim to deliver services and supports that are representative of the communities in which we work.

The county council will follow the Care Act and other relevant legislation, policies and guidance to ensure our practice is of high quality and legally compliant. Where our customers or those we come into contact with wish to challenge or raise concerns in regard to our decisions, regarding eligibility the county council's complaints procedures will be made available and accessible.

2. KEY DEFINITIONS AND PRINCIPLES APPLICABLE TO THIS POLICY

2.1 Intermediate Care

Intermediate care is an umbrella term describing different types of care provided for a limited period of time to assist a person to maintain or regain the ability to live independently. These types of care provide a crucial link between hospitals and people's homes, and between different areas of the health and care and support system such as community services, hospitals, GPs and social care.

Reablement is a particular type of Intermediate Cate but there is a tendency for the terms 'reablement', 'rehabilitation' and 'intermediate care' to be used interchangeably. The National Audit of Intermediate Care categorises 4 types of intermediate care:

- Crisis response – services providing short-term care (up to 72 hours)
- Home-based intermediate care – services provided to people in their own homes by a team with different specialties but mainly health professionals such as nurses and therapists
- Bed-based intermediate care – services delivered away from home, for example, in a community hospital

- **Reablement** – services to help people live independently which are provided in the person's own home by a team of mainly care and support professionals

Intermediate care services – which *includes* reablement – are provided to people, usually older people, after they have left hospital or when they are at risk of being sent to hospital.

Three of the 4 types of intermediate care (crisis response, home-based intermediate care and bed-based intermediate care) have historically been clinician-led and provided by health staff, with reablement being provided by local authorities.

However, these are not concrete, mutually-exclusive categories and, furthermore, with greater integration and co-operation between health and local authorities there should be greater use of qualified staff from health and social care working together to provide all forms of intermediate care.

2.2 Reablement

Reablement is a particular type of intermediate care, which has a stronger focus on helping a person return to a "baseline" by enabling them to regain skills and capabilities, reduce their care needs and promote levels of independence, in particular through therapy intervention or via the provision of aids and adaptations.

Reablement works across four key areas to improve a person's independence:

Performance: Improving someone's ability to meet their needs e.g. assisting someone with mobility exercises or meal preparation.

Confidence: Building someone's confidence to do things in a safe way e.g. making sure they are confident getting in and out of the shower safely.

Occupation: Using other techniques for doing everyday tasks e.g. learning to get dressed with limited mobility.

Environment: Adapting someone's environment so it meets their needs better e.g. providing equipment like transfer boards or a bath lift.

3. PROCEDURES

3.1. Thinking "Reablement First"

People function best when they are in an environment they are familiar with and happy in. For most people, that environment is at home. Reablement is a unique opportunity for someone to improve their independence while living at home. Importantly, it can prevent reliance on longer-term packages of care. Reablement also helps:

- Prevent deterioration
- Prevent hospital admission
- Prevent admission to residential care
- Support timely discharge from hospital
- Assist with management of long term conditions
- Prevent or reduce the need for long term domiciliary support.

Reablement should be seen as the first choice for any individual to return them to (or exceed) their baseline level of independence.

3.2 Who can be referred for Reablement?

Reablement is for people who have Care Act eligible needs [LINK] or who are at risk of developing them.

3.3 Who may not be suitable?

People with severe cognitive impairment. However, if they have been assessed in an unfamiliar setting or immediately after returning home, the person should be referred so they can be assessed at home. Reablement can still be appropriate if the person is able to meet their needs when prompted.

People who need end of life care, unless there are identifiable goals to improve their independence: People who are in the final few months of life (i.e. in the "Increasing Decline" stage of the End of Life Care Model. People at earlier stages of the model should still be considered for Reablement).

People who need specialist therapeutic intervention For example, specialist rehabilitation, or Acquired Brain Injury (ABI) rehabilitation.

People who do not intend to engage with the service who have had reasonable opportunity to understand its benefits.

If you are not sure whether the service is suitable for someone, get in touch with one of the points of contact for your area (East: ICAT, North & Central: LCC Reablement team)

3.4 How to talk to service users about Reablement

Use these simple explanations to help someone understand what Reablement is and how it can benefit them.

What is Reablement?
Reablement is a short term service to improve independence and confidence living at home. It is about helping the individual do things for themselves and not having them done for the individual. The initial assessment [LINK] will determine whether or not Reablement is right for the individual.

How long does it last for?
Typically 2-3 weeks. The actual length of time depends on the individual's assessment and progression towards their goals.

But I heard that I'll get six weeks of support at home.
It's possible, but only if it's right for the individual. Service length depends on individual needs and progression towards specific goals.

How could it help me?
Reablement areas of support include:

- Personal care, like getting dressed and washed
- Practical support, like help with meal preparation, making beds, and washing the dishes
- Medication management, to help ensure the individual is taking the right dose at the right time
- Ensuring a safe home environment
- Reducing the risk of falls around the home
- Helping people to learn to use equipment and assistive technology
- Mobility and transfers
- Improving confidence with everyday tasks like grocery shopping
- Exploring what is available in the local community, like lunch clubs
- Supporting exercise plans to help regain mobility and strength
- Providing information about other services that can support the individual

3.5 What does a good referral look like?

There are six key elements of a good Reablement referral.

1. The individual meets **referral criteria** (see Section 3.2, above).
2. The individual and their family understands **what Reablement is**, and isn't.
3. Clear goals have been set and agreed with the individual.
4. The number of visits is appropriate for the level of need.
5. The referral has the right level of detail
6. The service user has been given a copy of the Reablement Guide [LINK]

Staff should also be aware of the following guidelines regarding Reablement referrals:

• Use a strengths-based approach. Identify what is important to the individual, what they would like to improve and what they can do already.

• Identify goals, based on eligible needs or areas where the person is at risk of developing an eligible need.

• Understand the specifics – what are the tasks involved with meeting those needs? Can the individual perform some of the task but not all of it? Is it confidence or capability?

• Identify the steps to reach the goal.

• Capture the detail in the referral. e.g. “improve ability to transfer from wheelchair into arm chair. Goal to improve confidence during transfers when there is no one to supervise the transfer” rather than “improve ability transferring”.

• There is limited capacity within the service and demand must be managed. Putting in a package of Reablement that is too high deprives someone else of the support they need.

• Where possible, match each goal to a visit (e.g. getting dressed would be the morning visit).

• Requests for a specific gender for a visit must be understood in terms of whether the request is a necessity or a preference, and which visits it applies to (e.g. female Reablement Assistant required for personal care visits due to history of domestic abuse).

• Only specify the exact time of the visit if the individual requires assistance taking their medication at a specific time of the day, and make this clear in the referral. Otherwise use the booking slots.

• Ensure the service user and family understand that not all requests can be guaranteed.

3.6 The referral process

3.6.1 Referrals in the East

Referrals will be sent to ICAT (triage) who will act as the single point of access for the Reablement Service in the East. Referrals will be triaged for Reablement potential, with an Occupational Therapist (OT) responsible for ensuring that all referrals are appropriate.

If a referral does not have Reablement potential, the referral is rejected and the referrer notified within 2 hours of the referral being made.

If a referral does have Reablement, potential, ICAT will pass the referral onto Care Navigation who look to source a Reablement provision by contacting the area provider with the individual’s requirements. The provider has 1 hour to respond to the request.

If the provider does not have capacity to start Reablement within the expected time frame (1 day for urgent referrals, and 3 days for non-urgent referrals) the provider has to reject the referral with a future start date offered and the individual will receive an alternative service until there is Reablement capacity.

If the provider is able to accept the Reablement provision, Care Navigation updates LAS and sends a case note to ICAT who will send a case note to the referral source and send the Case and Reablement plan to the Reablement team.

3.6.2 Referrals in North and Central

There is no triage point in these areas so the referrer will need to complete the Reablement plan with clear, achievable goals (as set out in section 3.3) and send to Care Navigation to source the Reablement provision. The provider has 1 hour to respond to the request.

If the provider does not have capacity to start Reablement within the expected time frame (1 day for urgent referrals, and 3 days for non-urgent referrals) the provider has to reject the referral with a future start date offered and the individual will receive an alternative service until there is Reablement capacity.
If the provider is able to accept the Reablement provision, Care Navigation updates LAS and sends a case note to the referral source. The case and Reablement plan will be sent to the Reablement team by the referrer.

3.7 Case Allocations

The Business Support Officer (BSO) in the Reablement team receives the case and the Reablement Plan pending review task in the Reablement work tray. The BSO adds the case to the allocation tracker. The number of allocations for each Social Care Support Officer (SCSO) will have been agreed with the OT Team Manager. The BSO will allocate the agreed number of cases to each SCSO taking into account the areas worked (these will be predefined) unless the Senior OT/OT Team Manager specifies otherwise.

The BSO will contact the service user to arrange an initial visit that is suitable for them and the allocated SCSO, ensuring it is within 72 hours of the start of Reablement. This initial visit will be booked into the SCSOs Outlook calendar into the predefined slot. The Service User's LAS number will be entered into the time slot so the SCSO knows which service user they are seeing. The Case and Reablement Plan Pending Review task will be assigned to the SCSO's work tray. The BSO will also send a weekly copy of the allocation tracker to the Provider.

3.8 Initial Visit and 2-week review

Once the case has been allocated, the SCSO has 72 hours to conduct the Initial Visit, where the SCSO will explain the service to the individual and hand write the agreed goals onto the first version of the Reablement Plan. The SCSO will leave this hand written plan in the individual’s home.

There may be occasions where the 72 hours target is missed. These cases should be scheduled for an initial visit as soon as possible. These cases will be reviewed by the OT Team Manager to identify the reason why the target has been missed and this will be fed back to the team, the referrers, Care Navigation and the Reablement and Occupational Therapy Manager at the Performance Review Meetings.

While at the initial visit, the SCSO will book in a 2-week review with the service user. There may be some goals that require a review before this time and these should take place. It may be that these are telephone reviews and not face to face. If there are goals that will require a review after 2 weeks, the 2 week review should nevertheless still be booked in as this face-to-face intervention may indicate an unexpected change in the package. The review will be entered into the Outlook calendar into the predefined timeslots.

3.9 Typing up the revised Reablement Plan

The SCSO types up the Reablement paperwork including an updated Reablement plan following input from the OT team if appropriate. Once this paperwork has been completed, the SCSO returns this paperwork to the provider, and the provider ensures that the updated Reablement plan is placed in the individual's home.

Each week the provider should provide feedback to the team mailbox on each individual's progress against their Reablement goals. The provider should return this feedback at least 24 hours before the Case Progression Meeting.

3.10 Daily Catch Ups

The daily catch-up call will take place between the Senior OT and their SCSOs on a one-to-one basis over the phone. The SCSO will briefly summarise their day including the Initial Visits (IVs) planned for that day, any issues and request any support that they feel they may need. The Senior OT should check on the case load of the SCSO and their capacity, allowing more cases to be allocated if appropriate. The Senior OT will also offer guidance on any immediate actions needed. There will also be an update on any service users that the SCSO deems likely to require ongoing support following Reablement. The Senior OT should make a note of these for the Case Progression meeting and the SCSO should bring an update for these to the Case Progression Meeting.

3.11 Weekly Team Meetings

On Wednesdays the team will have their Case Progression Meetings and Continuous Improvement Meetings. This will be the one day that all team members will be required to be in the office. These meetings give the team an opportunity to consider blockers to outcomes for their service users and form solutions to these blockers. It also gives them protected time to consider their own wellbeing as individuals and a team and work together to make changes and improvements where required.

The meeting is also an opportunity to discuss all service users currently on the service that are likely to require ongoing support following Reablement, and to support colleagues to problem solve specific issues and achieve the best outcomes for each service user. Following the weekly meeting, the SCSOs may update the Reablement

support plans and the Provider (present at the meeting) will instruct and guide their Reablement Assistants (RAs) following the decisions made at the meeting. The BSO will keep the action/decision tracker updated at each meeting. The outstanding actions will be reviewed and updated by the Senior OT/OT Team Manager prior to the next meeting.

3.12 Role of the Reablement Assistants (RA) and Reablement Officers (RO)

If a service user's Reablement goals have changed following a Case Progression meeting, it is the responsibility of the RO to ensure that the RA is delivering the revised Reablement goals. It is also the responsibility of the RO to get feedback from the RAs and on occasions this may include calling the RA for feedback.

Once the RAs identify that the service user is achieving their Reablement Goals (written in the support plans that they are following) they inform the Provider Team Manager that the individual is ready to finish with the service. They also inform the BSO via the Reablement team mailbox that the service user is independent. The BSO informs the SCSO that the service user is independent and some action is required. The SCSO must conduct the final review within 72 hours of notification (the provider could also inform the SCSO that the individual is due a Final Review during the Case Progression meeting). If the individual has been expected to be independent following Reablement, and that is still the case, the provider is able to cease Reablement and inform the SCSO and Care Navigation that the service has ended.

3.13 The Final Review

Before the Final Review, the individual will have been discussed at the weekly Case Progression meeting and the ideal outcome agreed upon with the rest of the team (if this has not happened, the SCSO must discuss the expected outcome with the Senior OT ahead of the final review).

The final review (conducted within 72 hours of notification) is completed, and any ongoing support is sent to the Senior OT for authorisation. The Senior OT, who has oversight of all cases expected to require ongoing care from the Daily Catch ups and Case Progression Meetings, authorises all packages of care that are as expected. For any packages of care that are unexpected, the Senior OT contacts the SCSO to understand why this was the case. The Senior OT and SCSO must review if the outcome was ideal and, if not, record the reason on the final review tab on the Reablement Plan, and if Reablement could have been better deployed. This is important as LAS collects the issues and these can be addressed in the Continuous Improvement Meeting so that the service can be improved for future service users. It may be necessary to review the package of care with the SCSO, Provider and Senior OT in a specific case review meeting to ascertain the best way forward.

Once the Senior OT has authorised the package of care, it is forwarded to Care Navigation to source the ongoing support. Once support is found, the Provider, individual, SCSO and community team are informed of the Reablement end date and new care package start date and the systems are updated. The BSO will be informed by the SCSO that a case closure has happened. The BSO will then update the allocation tracker.

4. CASE STUDIES

Case Study 1: A 95 year old lady was referred following the onset of an illness affecting her balance. After a short period of Crisis Support she was referred to Reablement, with the aim of getting her back to being fully independent. In particular, she had lost a lot of confidence in following her daily routine. She was struggling to meet her needs in the kitchen, dressing herself, and showering. Starting with a strengths-based approach and functional assessment of her needs, she worked with the Reablement Assistants to gradually regain her confidence and independence over four weeks.

Using regular feedback from the provider, her social care worker ensured that her goals were met, in all areas except showering. At the end of Reablement she had a follow-on package of care of one hour a week to help meet her ongoing needs.

Case Study 2: A 74 year old lady was referred following admission to hospital for an operation on her colon. She had been fully independent previously, but had lost some of her strength and mobility over her time in hospital. When she was referred, she wasn't able to meet her needs for personal care, getting dressed, meal preparation and getting to the shops. But she was very keen to regain her independence. A detailed Reablement plan was quickly put in place, and soon she began regaining confidence in dressing herself and preparing meals. Improving the way goals are identified and support plans are written allows the county council to work more responsively and explore innovative ways of helping service users reach their ideal outcomes. For example, the Reablement Assistants helped this lady to wash in a way that so her wound did not become infected, as well as supporting her going for short walks outdoors. After four weeks on the service, she finished Reablement fully independent and able to manage her own needs.

Case Study 3: Following a bout of pneumonia, a 76 year old man started with two Reablement Assistants for transfers, personal care and bed time visits. In particular he was struggling to transfer to the toilet due to his bulky wheelchair and poor mobility in his arms. While he was on the service the Reablement staff used the new strengths-based approach to help him to learn to use a board for transfers. Over this time, his progress was monitored closely by his social care worker through regular feedback from the provider. After a few weeks he became fully independent transferring from his wheelchair to the toilet. His final package was revised to two visits a day from one care worker, for personal care and bed time support. Before, a complex case like this might not have been referred to Reablement. With a Reablement-first approach, the county council can help service users quickly reach their ideal outcomes where people have more complex needs.

5. DOCUMENT HISTORY

RELATED DOCUMENTS	
OTHER RELATED DOCUMENTS	• Needs Assessment Policy • Continuity of Care Policy • Ordinary Residence Policy • Wellbeing Policy • Financial Assessment and Charging Policy
LEGISLATION OR OTHER STATUTORY REGULATIONS	• The Care and Support (Eligibility Criteria) Regulations 2015 • The Care Act 2014 - Part 1 Assessing Needs Section 13 • Chapter 1 Promoting Wellbeing Statutory Guidance • Chapter 6 Assessment and eligibility Statutory Guidance • Chapter 19 Ordinary residence Statutory Guidance • Chapter 20 Continuity of care Statutory Guidance • National Institute for Health and Care Excellence (NICE): Intermediate care including reablement (coming September 2017) • Factsheets • Reablement Product Manual

[Insert Reablement Guide and Product Manual]

6. EQUALITY IMPACT ASSESSMENT