Barnsley Council

Adults and Wellbeing – Reablement Service

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Author	Linda Richardson – Head of Service Adult Social Care and Wellbeing Sam Watts – Service Manager Hospital and Reablement Services
Approved by	Julie Chapman – Service Director Adult Social Care and Wellbeing
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Introduction

This document provides operational guidance to staff working across Reablement and Adult Social Care services.

Reablement is a preventative service that aims to support people in their own homes to maximise their independence and remain healthier by regaining skills or learning new ways of doing things to develop confidence. Reablement interventions will include the things people can do for themselves, support offered by friends, family, or other community support.

The Reablement Service also works with people who potentially have identified long-term support needs with the aim to try and rebuild confidence and abilities to reduce the level of long-term support being received.

The team will support the discharge of people home from hospital where reablement interventions are identified as part of the discharge plan. Assessments will be carried out in intermediate care and residential home settings when required, where a person is preparing to move into more independent living, such as extra care or returning to their own home.

The Reablement team will also work closely with the Adult Social Care's Initial Response Team to provide support through the community pathway, offering assessments, interventions and signposting in the Care and Support pathway where required.

About the Service

The Reablement service will work in conjunction with existing intermediate care and preventative services, by offering intensive support to the person for a defined period of time, with clearly defined goals aimed at maximising independence. Reablement interventions may also be undertaken by informal carers already involved with a person.

There is no financial charge to receive the Reablement service unless there has been a long-term need identified and there is a problem in securing a long-term provider. The period of support can be from a few days up to six weeks depending on the person's progression. Progress will be reviewed at regular intervals and, if the reablement period is completed and ongoing support is required, users of the service may need to contribute to ongoing care and will need to complete a financial assessment. The amount the user will contribute towards their ongoing support will depend on the outcome of their financial assessment.

Only people thought unlikely to benefit from a time-limited reablement service will be screened out and sign posted to other services appropriate to the identified needs. A person may be provided with appropriate information, advice or guidance, or directed to other suitable services. Guidance criteria can be found in appendix 1.

Following completion of the initial assessment, a person-centred support plan will be developed with the person, which will identify the outcomes they want to achieve, and the steps and goals that the person will work towards to achieve those outcomes. The plan will be evaluated each week by a member of the Reablement team to monitor progress against the steps and goals, this will be shared with the Practitioner.

If at any point during the reablement journey it becomes clear that the person is likely to require on-going support from adult social care, a Care Act Assessment will be completed by the Reablement Social Worker or Assistant Social Care Practitioner. The assessment will be completed to determine whether a person is eligible for and would benefit from adult social care support.

Scope

This guidance should be read and agreed with by all staff who are involved in the assessment, support planning, and delivery of reablement, to an adult with care and support needs, and or carers.

Equality and Diversity

Our operational guidance, policies and procedures support the commissioning and delivery of services that meet the needs of communities, and individuals. Ensuring equity of access and outcomes is central to this. In developing and applying our policies and procedures, we will take account of:

- Equality and diversity
- Anti-discriminatory practice
- Dignity and respect
- Human Rights

What Is Reablement?

1.1 Reablement is about supporting people to do things for themselves, rather than doing things to, or doing things for people.

1.2 Reablement is time-limited; the maximum time that the person can receive reablement support is for a period of up to six weeks. If reablement interventions are required beyond 6 weeks these may be chargeable and will be considered on a case-by-case basis.

1.3 Reablement is outcome-focused: the overall goal is to support people to remain in their own home or community.

1.4 Reablement involves setting and working towards specific goals agreed between the person and/or carer and the Practitioner

1.5 Reablement is focused on a strength-based approach. The support delivered is tailored to the person's specific goals, needs and outcomes they want to achieve.

1.6 Reablement builds on what peoples' strengths are and what they can currently do. This supports them to regain skills to increase their confidence or to learn new ways of doing day to day tasks for themselves.

1.7 Reablement may also involve ensuring people are provided with appropriate equipment and/or assistive technology and understand how to use it.

1.8 Reablement aims to maximise the person's long-term independence, choice, and quality of life.

1.9 Reablement aims to reduce or minimise the need for ongoing support after the period of reablement by supporting people to reconnect to their local communities.

1.10 The Reablement service aims to utilise a strength-based approach, provided in a way that is actively risk managed, not risk averse.

1.11 The Reablement Service will work with people who have an identified long-term need of support with the aim to reduce the level of long-term support

Action for staff:

2.0 Referrals

2.1 There are several pathways into the Reablement service, these include direct referrals from Right Care, the Adult Social Care Initial Response Team, and the Hospital Social Work Team.

2.2 Referrals received into the Reablement Team will receive a secondary triage to identify the most appropriate pathway.

2.3 All referrals will be received via the Reablement Allocation Team Tray or the Community Pathway Trays on Erica or in to the Reablement email inbox. From the information available the practitioner on duty will pass the referral to the relevant Practitioner to start an initial assessment.

2.4 A Staff huddle is held 3 times a week. The purpose of the huddle is to gather an update on current cases that may require review or input from the Practitioner, and review current reablement capacity against new referrals being received.

3.0 Assessment

3.1 The purpose of the initial assessment is to identify the persons desired outcomes and goals drawing on their own strengths and their informal support networks.

3.2 The initial assessment should be proportionate and holistic taking account of what the person can do, their strengths, abilities and aspirations, social context, and support networks.

3.3 The initial assessment will be undertaken by the Practitioner and the person requiring the service. Where appropriate the customer can have family members or an advocate to provide support during the assessment if required and/or necessary. Assessment are completed face-to-face in the person's own home whenever possible.

3.4 As part of the assessment process, the Practitioner will also complete any relevant risk assessments, for example falls risk assessment, medication screening tool, and environmental assessment, associated with the proposed reablement interventions.

3.5 We will support people to manage their own risk where possible and keep safe within a framework of recorded risk assessments, compiled with the person and/or carer representative.

~~3.6 In some circumstances it is not possible for the Practitioner to undertake an environmental assessment, for example the assessment has taken place in hospital and the person is not expected to be discharged until the weekend. In these circumstances the duty worker working that weekend will arrange for support workers to commence support, accept a trusted assessment from a therapist and allocate the case for a visit to be completed on the first working day following the weekend by the Practitioner.~~

3.7 Following the completion of the assessment, the Practitioner, with the person will write a support plan. Any long-term services such as major adaptations, maintained equipment, telecare will be added to the support plan as a signposting task.

4.0 Reablement Planning

4.1 Reablement planning is the formulation of an support plan based upon a range of interventions including informal support and community resources aimed at maximising a person's independence, increasing confidence and/or wellbeing. This is usually centred on goal setting and working toward the outcomes the person wants to achieve.

4.2 The support plan should detail the things that are important to the person, their preferences, likes and dislikes. It must be personalised to the person.

4.3 The support plan will also include the interventions to be undertaken by the Reablement support worker and other relevant people involved in the support plan for example an informal carer, neighbour, or friend.

4.4 The support plan will also detail what to do if the person's health or wellbeing changes and what to do in emergencies.

4.5 The support worker will work closely with the Practitioner to ensure that the support plan is delivered, and the outcomes are achieved for the person. The support worker will provide weekly feedback to the Practitioner on the progress of the person against the goals within the plan and the overall outcomes. How this feedback is received will be determined by the

Practitioner and the support worker, for example it could be done by email, face to face or as part of the review where significant changes have occurred.

4.6 Regular evaluation of the goals and plan will be undertaken by the reablement support worker and will be recorded in the person's record in their home. Any barriers to reablement for example a change in circumstance or a period of illness should be communicated to the Practitioner at the soonest opportunity. The evaluation reports will be used by the Practitioner at the point of the review to determine what should happen next.

5.0 Review and Evaluation

5.1 Each support plan should have clearly identified goals and the interventions aimed at meeting these goals.

5.2 As part of regular update between the Practitioner and the reablement support worker consideration should be given to whether the person is likely to have any medium- or longer-term care and support needs. Where this is the case the Practitioner must seek consent from the person to request a Care Act Assessment.

5.3 The person, informal carer, or anyone else the person wants to be involved must be fully involved in any decision making as far as they are able.

5.4 Following a period of reablement if a package of care is required, but a provider cannot be sourced it should be made clear and the person informed that this would be a chargeable service.

5.5 Where the person would benefit from medium to longer term care and support the Practitioner will arrange a final review meeting.

5.6 If the person does not agree with the transfer of care other alternatives should be explored and discussed with the person and informal carers during the final review.

5.7 Where the period of Reablement has ended, we will seek to capture feedback from users of the service via a customer satisfaction questionnaire.

6.0 Mental Capacity

6.1 Mental capacity must be considered as part of any referral. Where the person has capacity consent must be sought.

6.2 Where the person lacks capacity, the appropriate procedures must be followed to determine whether reablement interventions would be in the person's best interests and a clear decision is recorded.

7.0 Commissioning Services

7.1 In some circumstances a period of reablement would not be beneficial for example where the person has sustained a break or fracture and is in plaster cast or splint and unable to attend to their personal care, however they are expected to make a full recovery. In these circumstances the Practitioner should consider if the person has access to other informal support that they can use until such time the person is ready for reablement. If the person does not have any other support or is not able to commission their own services, the team can commission a short-term package of support completing a needs assessment followed by an eligibility determination that identifies the person is eligible for support from the local authority. Any commissioned services will be chargeable. At the end of this period the person may be eligible for reablement and/or services provided by the NHS for example physiotherapy.

7.2 Where the person is assessed and is not eligible for support from the local authority the Practitioner should consider and explore with the person what other solutions are available to the person until such time, they are ready for reablement.

7.3 The transfer of care should be well co-ordinated and the person receiving care and support should be involved as far they want or are able to in the transfer. Ideally the person should be introduced to the new Practitioner from the appropriate Adult Social Care team.

8.0 Disagreements

8.1 Where there is limited or no capacity within the reablement delivery service this should be escalated to the service manager to determine how best to meet the needs of the person. In the absence of any informal care and support, this may involve commissioning a package of support which will be chargeable until such time that reablement delivery can provide reablement interventions.

8.2 In these circumstances the Practitioner must review the package of support at a minimum of every two weeks, liaise with the Reablement Manager to identify when reablement delivery will be available to discuss the case as part of the DHM.

8.3 When it becomes clear that reablement delivery is not going to be available within six weeks the Practitioner must review whether the person has on-going eligible care and

support needs, where this is the case arrange for the transfer of the person to the appropriate Adult Social Care team in the usual way.

9.0 Safeguarding Adults

9.1 Reablement will follow the South Yorkshire Safeguarding policies and procedures and report to the CQC and Adult Social Care Management.

10.0 Operational Hours

10.1 The Reablement team will operate 7 days a between 0700hours to 2200hours.

11.0 Data Recording and Quality Assurance

11.1 The service is regulated by the Care Quality Commission who carry out inspections of the service as well as monitoring to ensure that the service is delivering a safe, effective, caring, responsive and well-led.

11.2 Internal sub-group meetings are held for health and safety, policies and procedures and record keeping that are brought together under the Quality and Governance meeting.

11.3 Information for users of the service is recorded within the electronic ERICA system. All related documentation from partner agencies will also be stored under the individual's ERICA record to ensure that it is kept safe and secure.

11.4 User assessments and reviews are also recorded on the system and, where required and appropriate, can be accessed by Adult Social Care staff to reduce duplication.

12.0 Performance Monitoring

12.1 As part of the monitoring of service delivery, the service will monitor:

- Number of people accessing the service
- Outcomes of individuals completing a period of Reablement, including those completing with no ongoing care and support needs
- The stages at which individuals complete their period of Reablement

Legislation and Guidance

The Care Act 2014

Regulations made under the Care Act:
The Care and Support (Disputes between Local Authorities) Regulations 2014

The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014

The Care and Support (Assessment) Regulations 2014

The Care and Support (Eligibility Criteria) Regulations 2014

The Care and Support and Aftercare (Choice of Accommodation) Regulations 2014

The Department of Health, *Care and Support Statutory Guidance* (23 October 2014) https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

Housing Grants, Construction and Regeneration Act 1996

Section 2 of the Chronically Sick and Disabled Persons Act (CSDPA) 1970

Children and Families Act 2014

Health and Safety at Work etc Act 1974 (HSWA) Manual Handling Operations Regulations 1992 (MHOR) (as amended 2002) Management of Health and Safety at Work Regulations 1999

Other key legislation and guides:

Human rights legislation:

European Convention on Human Rights (ECHR)

Human Rights Act 1998

Reablement: A guide for frontline staff

http://www.opm.co.uk/wp-content/uploads/2014/01/NEIEP-reablement-guide.pdf

CQC Regulated Service

NICE guidelines

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Appendix 1

Access Determinants to the Reablement Service with Reablement Teams

Reablement Service

GUIDANCE ON CRITERIA FOR ASSESSMENT

1. General Criteria for Assessment for Social Care referrals – applicants should
Ordinarily be a resident of Barnsley, aged 18 and over **and** a physical or mental health condition, disability, impairment, sensory loss **or** be carer as defined by the Care Act 2014.

ELIGIBILITY Criteria

People who meet the **General Criteria for Assessment** and request assistance with one or more of the following are **eligible for assessment** to ascertain their **needs** which might include:

- Getting in and out of the home or reaching the essential rooms within the home and using essential facilities within the home
- Managing personal care activities such as washing, feeding dressing and toileting
- Transfers on/off the chair, WC, or bed
- Managing essential daily domestic tasks (such as preparing and consuming a hot drink and a snack)
- Lack Confidence e.g. after a fall or period of illness
- Medically stable
- Previously Independent and have the potential to regain previous level of function
- Potential for Improvement
- Motivation to engage in reablement
- End of Life care – assessed case by case
- Advanced Dementia – will be assessed case by case

PEOPLE WHO MAY NOT BE SUITABLE FOR REABLEMENT

- Palliative care
- Emergency care
- Urgent care/Crisis in Care Arrangements
- People who are not medically stable
- People who are at the early stage of a fracture or illness and are not symptom free e.g. plaster of paris
- People who have recently completed a period of Community Rehabilitation whilst in receipt of a free 6 Week Care package

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