Derbyshire County Council Adult Care Practice Guidance
Homecare Reablement Service Operational Guidelines

Name	Job Title	Date
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Approved by:	Quality and Compliance	July 2017

Change History

Version	Date	Name	Reason
V 1	January 2014	Jane Parke	Development of new practice guidance
V1.1	June 2016	Jane Parke	Reviewed no changes
V1.2	May 2017	Rob Moore	Review and update
V1.3	July 2107	Rob Moore	Review and update to reflect changes to Reablement

Derbyshire County Council Adult Care publishes a range of Practice Guidance documents to support workers managing individual cases. They are written in plain language and give clear and precise guidance detailing how professionals and other relevant parties should respond when dealing with clients in need of reablement services.

Aim of the Service

The aim of the reablement service is to support people aged 18 and over to maximise their independence to achieve a level of self-caring appropriate to the individual client. The service will be provided predominantly to older adults which is in line with the population growth but does not exclude other client groups. The service would normally be provided in the client's own home but there are a number of specialist community beds in the older adult's residential services. These beds are supported by the community reablement team and therapy/nursing staff where appropriate. The main focus of bed based reablement is to facilitate early hospital discharge or prevent admission into hospital, long term residential or nursing care.

The reablement service shall:

- Be based on an assessment that the person will benefit from a period of reablement and has consented to a programme that involves setting joint goals to maximise independence and function
- Focus on practical outcomes within a specified timeframe; normally up to a maximum of six weeks, apart from exceptional circumstances; to assist individuals, to regain/gain skills to live independently
- Be appropriate and responsive to the needs of the individual, with a flexible approach to spend more or less time with people, if necessary
- Ensure preferences of the individual and/or their advocate are taken into account
- Encourage individuals 'to do for themselves' rather than 'doing it for' them
- Have access to a range of multidisciplinary specialist skills and support, including support for people with dementia and other mental/cognitive problems
- Provide the optimum level of support for individuals.

Eligibility Criteria

All new and existing clients (including hospital discharges) assessed as needing personal/ practical assistance to support them at home will be eligible to receive an initial support package from the reablement service where it is identified there is reablement potential. If this service is not used the reason must be identified using the outcome 'reablement not used' which is available in most fieldwork episodes. There is a drop down list to choose the appropriate reason.

The service is free from co-funding for **up to** 6 weeks.

National Care and Support Eligibility Criteria will be applied at the end of the service to determine the need for ongoing services.

Where a significant change in circumstance is identified with existing home care clients (whether provided by Direct Care or the Independent Sector), such as admission to hospital, etc, resulting in increased need, reablement must be offered prior to agreeing any increase in the care package.

For some clients reablement will achieve a return to full independence with no further need for ongoing services, whilst for others the potential may be limited to maintaining an optimum level of independence with the need for ongoing care and support.

Personal/practical support may include the following:

- get out of bed to dress or undress, and go to bed
- to wash, shower or bath including hair washing, shaving and oral hygiene
- toilet requirements
- meal preparation
- to eat or take a drink
- medication and health related activities in accordance with agreed policy
- identify possible small aids/equipment that will support independent living
- practice using aids/equipment e.g. telecare
- domestic tasks e.g. cleaning, laundry
- shopping
- exercise regimes as identified by an OT or other relevant professional
- movement in different environments
- confidence building and re-engaging with the local community.

There will be some people for whom a short term intensive service may not be appropriate. Decisions about the appropriateness of the service must be based on individual assessment and not according to assumptions about a person's diagnosis or disability. This must still be recorded in the 'reablement not used' outcome as above.

Outcomes for Clients

- Helping people to achieve their maximum independence
- Helping people achieve a healthy lifestyle
- Helping people feel in control of their life
- Improving people's quality of life
- Helping people to maintain the level of independence that they gained through reablement
- Having a positive effect on carers.
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Links with Intermediate Care/Access to Therapy

Reablement teams will work in partnership with health colleagues including OT's and Physio's to deliver short term home based services.

If it is identified that any individual supported by the reablement service has a longer term need for ongoing therapy, then a referral must be made to the appropriate health care professionals using the reablement/intermediate care assessment and plan.

Service Model

Following receipt and prioritisation of referrals the Prevention and Personalisation Service Manager will allocate the referral/Decision Required episode to an appropriate care coordinator who will complete the reablement assessment and plan.

All fields in the assessment and plan, except those where health are leading the support (intermediate care) use only, must be completed.

The care coordinator will commission a service from the reablement team and continue their involvement throughout the period of reablement addressing any support needs during the provision of the service and when the service ends.

Reablement should not be purchased from independent sector providers without prior agreement with commissioners. (SLA 6.4 p14).

Once the assessment and plan is completed the care coordinator must send the outcome reablement PSP to the DSO immediately and finish the episode. There is no need for the care coordinator to review the assessment and plan as the outcome from reablement will be recorded in the Reablement PSP and incorporated into the Assessment/Summary of Needs and Outcomes. The review information during the 6 week service will be recorded on the Reablement PSP.

On receipt of the reablement PSP episode the Domiciliary Service Organiser will complete the plan based upon the client's agreed outcomes identified in the reablement assessment and plan and undertake the necessary risk assessments.

The client should be visited before the service starts but if necessary this can be deferred to within 2 working days of the service commencing.

Support will be outcome focused and based on promoting independence including improving self care, domestic skills, building self confidence, social skills and the appropriate use of equipment/aids to daily living including assistive technology to promote quality of life.

Care and support needs will be continually assessed for **up to** six weeks. During this period the communication between the care coordinator and DSO is crucial to keep the care-coordinator updated of the client's progress as appropriate and inform the PSP reviews.

If it is clear that ongoing services following reablement will not be required the DSO will notify the care coordinator who must NFA the assessment episode after completing the narrative scan (this information is confirmed by the DSO sending the outcome 'no ongoing services'). This outcome can be sent early.

Specialist Community Beds (without therapy)

Access to bed based reablement has additional criteria as follows:

- The person must be medically stable and will not require 24/7 supervision of their care by a qualified nurse
- GP is willing to support or appropriate temporary arrangements can be made for medical cover
- Care coordinator must liaise with the Unit Manager or appropriate other prior to admission to discuss the suitability of the client and availability of the bed
- The DSO responsible for the service must liaise with the manager of the home as the provider manager. The service should be led by the home care staff supported by care staff in the establishment.

The admission must be via the DSO and reablement beds must not be used for standard short term care i.e. there must be identified reablement needs.

The electronic client information system process for reablement as outlined in this document applies to the use of reablement beds therefore the person centred PSP used by HOPs is not required.

All documentation including visit record sheets, risk assessments and any MAR sheets must be kept in the person's own room.

The main aim of the service is to enable people to return home therefore it is recommended that the stay in a bed is no more than three weeks and the service completed in their own home.

The DSO should facilitate discharge from the bed by contacting the care coordinator. The service may continue in the person's own home.

Any bed based reablement is included within the 6 weeks reablement offer. Any extended reablement follows the same process as outlined in this document.

Where pre-existing joint health/therapy arrangements are not in place, referrals for therapy and or community nursing assessment and support should be made in the normal way but should indicate that the client is receiving bed based reablement so that referral can be appropriately prioritised.

The identified beds are as follows and are on a dropdown in the electronic client information system which must be completed when beds are used as this information is used to generate the purchase order. The beds can be flexible across all care homes.

South Division:

- Ada Belfield, Belper – 2 beds
- Ladycross, Sandiacre – 1 bed
- Hazelwood, Ilkeston – 1 bed
- Meadow View, Darley Dale – 6 beds
- *(Florence Shipley, Heanor – 8 beds)
- *(Oakland, Swadlincote – 8 beds)

North Division:

- Thomas Colledge, Bolsover – 3 beds
- Staveley Centre, Staveley – 3 beds *(5 beds)
- The Grange, Eckington – 2 beds *(6 beds)
- Goyt Valley House, New Mills – 1 bed
- Whitestones, Chapel-en-le-Frith – 2 beds
- Whitfield House, High Peak – 2 beds
- *(Holmlea, Tibshelf – 1 bed)
- *(Stonelow Court, Dronfield – 8 beds)

*Specialist Community beds with therapy are in brackets.

Ongoing Services

If the client requires ongoing services the care coordinator will complete the Decision Required episode and commence the extended assessment episode at least two weeks before the service end date. The ongoing request for service must be with the Brokerage team a minimum of one week prior to the service end date.

The care coordinator must hold reviews at appropriate times with the home care manager to pre-empt any identified longer term needs. This review must be sufficiently in advance in the reablement process to allow the care coordinator appropriate time to complete the extended assessment episode prior to the end of reablement.

A further review must be held at the end of reablement where the National Eligibility criteria must be applied for ongoing services. Signposting may be required where clients do not meet this but would benefit from other support.

The home care service identified at the end of reablement must be the service commissioned.

Clients who choose to take their Personal Budget as a Direct Payment will be responsible for arranging their own longer term support.

Extended Period of Reablement

Reablement may be extended as an exception where it is has been identified that the client will benefit from a further few weeks, up to a maximum two weeks, to achieve maximum independence. This must be agreed with the appropriate Service Manager/Group Manager and reviewed.

It is clearly written in the Assessment and Plan the need for co-funding once reablement has ended.

Where this has been agreed the DSO must:

- Send task 'Notify PST (Purchasing Support Team)' - reablement extended by agreement. N.B. Co-funding will apply after the end of 6 weeks.

If reablement is extended because the assessor has not arranged ongoing home care as required the DSO must follow the process outlined below:

At 6 weeks

- Complete the 'Summary of Ongoing needs at end of reablement' in the PSP

- Send the task 'Notify PST (Purchasing Support Team) - reablement exceeded - delay in transfer of care – co-funding to commence. Add trigger date to note field'.

- During the extension period maintain home care services at the level noted in the summary of ongoing needs.

- Once the service transfers to the appropriate provider send the task 'Notify PST extended period of reablement ended'. Add end date to note field.

- Once the task is completed by PST you can then end the reablement PSP episode.

PST (Purchasing support team) will use the start and end dates of the extension period and summary of persons ongoing needs to calculate the charge to fieldwork teams.

Ending the Reablement Service

Complete the PSP episode at end of reablement by selecting one of the following outcomes:

1. **No ongoing services – assessor to end involvement** (to be used where ongoing home care is not required)
2. **No further action** (to be used where ongoing home care is required and has been arranged by the assessor and no other outcomes have already been sent)
3. **No further action and other outcomes** (to be used where ongoing home care is required and has been arranged by the assessor but other outcomes have been sent e.g. BS to send plan and monitor return).

For options 2 and 3 the field 'Persons ongoing needs at the end of reablement' **must** be completed.

Appendix 1 Possible Situations which would Indicate Consideration for Admission to the Reablement Beds

This list is not exhaustive and a common sense approach should always be adopted if an acute hospital admission can reasonably be avoided.

Lower urinary tract infection	
Upper urinary tract infection	The proposed use of IV antibiotics needs to be fully discussed with local district nursing and intermediate care teams
Falls	If significant head injury is suspected (i.e. neuro-obs required) an A&E assessment is appropriate
Deteriorating mobility (with the expectation that the patient will be returning to their own home)	Social admissions should be avoided
Fractures: wrist ankle ribs	Following treatment at A&E where appropriate
Retention of urine	Monitor urinary output throughout the day and night (max. hourly observation throughout the night)
Constipation	
Cellulitis	
Dehydration from known cause	Oral dehydration
Complex wound management (e.g. pressure ulcers, leg ulcers)	
Symptom control in chronic illness(e.g. analgesia in chronic arthritis, N&V in cancer)	End stage palliation **cannot** be provided
Lower respiratory tract infection, Exacerbation of COPD	Oxygen, if needed will have to be prescribed on a named patient basis
Heart failure	Optimisation of treatment may prevent acute hospital admission
Diabetes	Unstable diabetes involving changes in treatment regimes.