REABLEMENT SERVICE FOR NORTHERN IRELAND

REGIONAL REABLEMENT PATHWAY

(for use by Health and Social Care Trusts)

July 2016

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SECTION 1: INTRODUCTION

A Review of Health and Social Care in Northern Ireland (2011) recommended that the Health and Social Care Board introduce a Reablement Model of Care across Northern Ireland from 2012. In light of this the Health and Social Care Board in its Joint Commissioning Plan back in 2011/12 committed to:

"*Introducing a Reablement Model which would enhance self-management, increase the capacity of the voluntary and community sector and promote healthy ageing; reducing the number of people who require support on a long-term basis.*"

Introduction of a Reablement service across the region has underpinned several of the key proposals within Transforming Your Care, including:

- ensuring home is the hub of care for older people, with more services being provided at home and in the community.

- encouraging independence and helping to avoid unnecessary admissions of older people into hospital.

From 2012 each Health and Social Care Trust has taken steps to establish, implement and roll-out the Reablement service, the purpose of which is to provide older people with intensive and time-limited support with daily living tasks, the aim being to enable the individual to do the task as independently as possible at the end of the process. In other words the **Reablement ethos** is considered to be a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. These goals are further defined in the Regional Definition for Reablement.

Regional Definition for Reablement:

Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability, and necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, deterioration in health or injury.

The aim of Reablement is to help people perform their necessary daily living skills such as personal care, walking, and preparing meals, so that they can remain independent within their own home.

> *"Reablement will help you to do things for yourself rather than having to rely on others".*

In achieving these goals it is acknowledged that the introduction of Reablement is a significant cultural change and service redesign affecting the expectations of Service Users and Carers and staff and staff roles and responsibilities. Hence, leading to the reconfiguration of services and the development of a Regional Reablement Model for Northern Ireland (2015). **(see Appendix 1)** The regional Model will be underpinned by the regional adoption and roll-out of the following:

- ✓ Regional Reablement Pathway;
- ✓ Service User's Goal-Setting Plan;
- ✓ Learning and Development Framework for Reablement Support Workers;
- ✓ Regional Performance Management and Information Dataset;
- ✓ Evaluation of the Service User's Experience of the Reablement Service.

Regional Reablement Eligibility Criteria:

The Regional Reablement Eligibility Criteria must be applied to all those referred to the Reablement service:

- ✓ The Reablement service will be accessible and available across Northern Ireland to all Older People (65+) who are on the threshold of requiring a Domiciliary Care package.

- ✓ Where the assessed needs are identified as Critical and/or Substantial then the "Fair Access to Care Services" criteria must be applied. **(see Appendix 1).**

  AND

- ✓ Requiring assistance of a single member of staff.

  *In exceptional circumstances a Service User may require the assistance of two members of staff as the Reablement episode commences. However, this must only be required in the initial phase of the Reablement episode.

- ✓ The referral to the Reablement service is from either the hospital or community pathways.

- ✓ Has a social care need that affects their daily living activities rather than a therapeutic need.

- ✓ Is medically stable (ie there is no immediate change or deterioration expected in the Service User's health/condition).

- ✓ Lacks confidence and/or requires support after a health or social care crisis, such as illness, deterioration in health or injury.

- ✓ Has difficulty in performing their essential daily living activities (eg personal care needs, mobility, medication management, meals management).

- ✓ Is motivated to actively engage with the Reablement service.

- ✓ The Services Users have the cognitive ability to relearn daily living activities.

Exclusions from the Regional Reablement Eligibility Criteria:

Service Users who would not be considered eligible for a Reablement service:

- ⌦ Service User with complex needs requiring assistance of two members of staff.
  (unless in exceptional circumstances see above*).

- ⌦ Palliative End of Life Care.

- ⌦ Advanced/late stages of Dementia.

- ⌦ Service User whose condition is liable to immediate deterioration or where the risk factor is such that it would hinder participation in the Reablement service.

- ⌦ Service User is not motivated and not prepared to actively engage in the Reablement process.

- ⌦ Service User who is at the early stage of a fracture or illness and is not symptom free.

- ⌦ Service User who has recently completed a period of Community Rehabilitation and has reached their maximum potential.

SECTION 2: PURPOSE AND OBJECTIVES

2.1 Purpose:

The Reablement Pathway will outline the service user's journey – from Referral to Discharge.

2.2 Objectives:

- ✓ To adopt a person-centred approach ensuring that service users are treated with dignity and respect taking account of their unique and diverse needs.

- ✓ To embed a partnership approach involving the service user, family and/or carer, statutory and non-statutory organisations.

- ✓ To ensure that the Reablement Pathway is clearly established and embedded to support and deliver the **"Right Service in the Right Place at the Right Time"** thus ensuring continuity of service.

- ✓ To adopt and roll-out the regional Reablement Pathway to ensure a convergence of approach and equity across the region for all service users.

- ✓ To optimise service delivery within Reablement, therefore, maximising the potential to promote independence rather than unnecessary dependence on services.

- ✓ To effect the best outcomes possible for the service users.

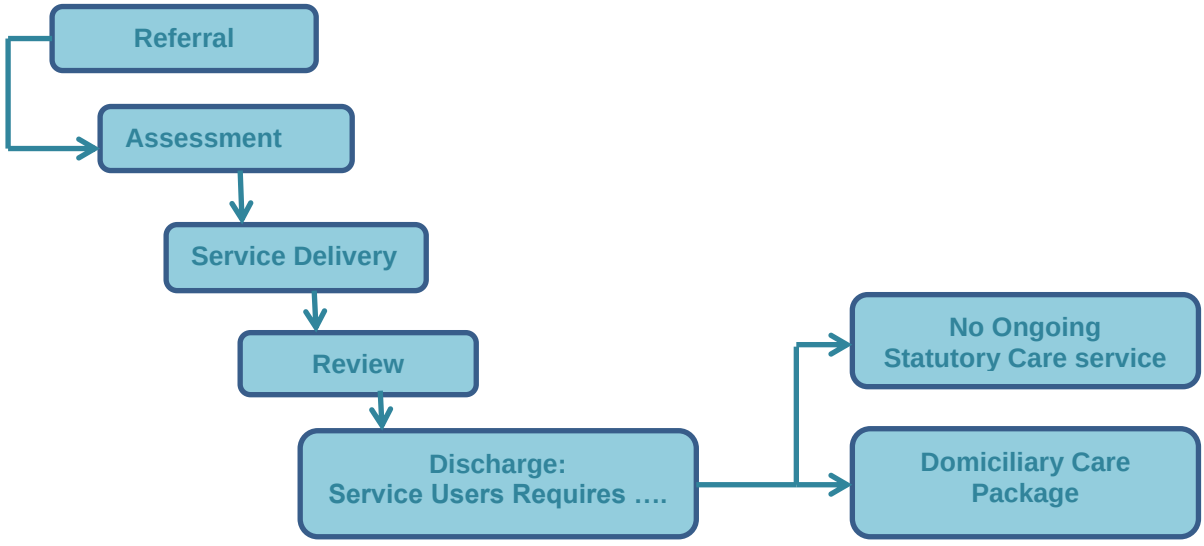
SECTION 3: GATEWAY TO ADULT COMMUNITY SERVICES

In streamlining access to Community services, each Health and Social Care Trust should aim to develop a single point of contact for all adult referrals to community services; this should also be inclusive of those service users within the prison healthcare population who are due for release. [(1)] The purpose of which will be to direct potential service users to appropriate service(s) to meet their need(s). In addition, the single point of access will also provide an opportunity to redirect and signpost those who do not need to access Health and Social Care services to alternative statutory and non-statutory services including Community and Voluntary sector organisations.

3.1 Initial Screening

Where services users are referred and are on threshold of requiring a Domiciliary Care Package or an increase to an existing package the referral will be initially screened to ensure that they meet the Reablement Eligibility Criteria (see page 5 and Appendix 1) and where this is met the Reablement Pathway should be initiated.

3.2 Pathway into the Reablement Service:



Footnote[(1):] Recommendation 21 - In relation to both healthcare and substance use, there should be integrated discharge and care planning between prison and community services, in all health and social care trusts. This should be supported by information-sharing protocols, in-reach and out-reach links and transfer protocols, to ensure continuity of treatment and support after release. (Owers report Oct 2011)

3.2.1 Referring a Service User to the Reablement Service:

→ The process commences with a referral to the Reablement Team from:

- ✓ a hospital when a service user is being discharged; or
- ✓ within the community for a domiciliary care package or an increase to an existing domiciliary care package (this will include a referral from Prison Healthcare on release and where the service user meets the Eligibility Criteria).

→ The service user's referral details and other service specific information is then captured using e-NISAT Contact Screening or a PARIS specific Reablement Referral form.

→ The Reablement Team should take account of the need to complete the NISAT Consent Form **(see Appendix 2)** to accompany the referral.

→ Referrals will be screened to determine suitability for and capacity within the Reablement service. This will be done by the identified officer within the Reablement Team . Following screening the referral should be accepted, triaged (ie categorised as Priority or Routine Referral) and allocated within **one working day** to the Named Reablement Occupational Therapist for assessment.

- **Priority Referral:** Where a referral is triaged as Priority, the service user should be contacted to arrange an initial visit and assessment within ***24 hours (1 working day)** of receipt of the Priority Referral.

- **Routine Referral:** Where a referral is triaged as Routine the service user should be contacted to arrange an initial visit and this should happen within ***3 working days** from receipt of referral.

→ Where a service user is in receipt of a pre-existing Domicliary Care package and/or Self-Directed Support (eg Direct Payment) this should be suspended when Reablement is commenced.

Howevever, cognisance should be taken for the need for flexibiity for cases to be considered on a case-by-case basis (80:20 rule) taking into account the principles of safety and risk.

NOTE:	Where a referral is categorised as **Priority** the Reablement service may commence directly with input from the Reablement Support Worker and in advance of the Reablement Occupational Therapist having carried out the assessment. **(This could occur to facilitate the discharge of the service user from hospital to home).**

3.2.2 Assessment of the Service User for the Reablement Service:

Following allocation of the referral:

→ The Named Reablement Occupational Therapist contacts the service user or family member and/or carer (as appropriate) to arrange a date and time, convenient to the service user to undertake an initial assessment.

NOTE:	***The assessments may not be carried out within the specified timeframes (see Section 3.2.1) as these can be influenced by factors such as: the servicer user's wishes, availability of family…

→ Where the service user is still in hospital the family member and/or carer **may be** contacted by the Reablement Occupational Therapist and in some cases this could be facilitated by the Hospital Discharge Team.
The purpose of this contact will be to facilitate discharge planning which could include making arrangements:

- ✓ to gain access to the service user's home;
- ✓ for delivery of equipment and/or provision of minor adaptations; and
- ✓ to support the administration of medication, where appropriate.

NOTE:	Consent on the part of the service user is integral and must be obtained at the outset and reviewed throughout the process as per NISAT Consent Form.

→ Named Reablement Occupational Therapist will:

- ✓ outline to the service user, family member and/or carer the purpose of their visit;
- ✓ explain the Reablement service and how it operates; and
- ✓ provide and share a copy of the regional Reablement leaflet (which includes relevant contact details) with the service user, family member and/or carer.

→ Following joint agreement with the service user the Named Reablement Occupational Therapist will undertake a range of assessments as appropriate to the service user's need(s). These will include:

- ✓ Northern Ireland Single Assessment Tool (NISAT);
- ✓ Moving and Handling Assessment;
- ✓ Environmental Risk Assessment;
- ✓ Functional Independence Measure and Functional Assessment Measure (FIM FAM);
- ✓ Assistive Technology (eg Telecare) Assessment; and
- ✓ Other assessments as deemed appropriate.

→ On completion of the assessment process the service user will be informed of the assessment outcome(s).

→ In addition the needs of the carer should be considered and the family member and/or carer should be made aware of:

(a) what will be required of them as a carer;

(b) the services and support would be available to them as a carer and how to access these;

(c) their right to an individual Carer's Assessment (Carers and Direct Payments Act (Northern Ireland) 2002);

(d) where appropriate the Reablement Occupational Therapist will demonstrate specific techniques or use of equipment.

Family members and/or carers have a choice as to:

(i) whether or not to assume a caring role and provide care on discharge;

(ii) the amount of care they feel they can safely provide.

NOTE:	No assumption should be made about the families' and/or carers' ability or willingness to provide care or continue to provide care.

3.2.3 Service Delivery

→ On completion of the assessment(s) the service user and Reablement Occupational Therapist will jointly identify and agree realistic goals which the service user will work towards.

→ Goals should have measurable and/or determinable out comes which will demonstrate the service user's progress. As these goals are met the length and the frequency of the hours of service delivery will be reviewed and changed.

→ Identified goals and tasks must be recorded on the Regional Reablement Service User's Goal-Setting Plan. **(See Appendix 3)**

→ Following joint completion of the Service User's Goal-Setting Plan the Reablement Occupational Therapist, in collaboration with relevant colleagues, must complete complementary documentation including Service Plan Timetable and confirm the agreed times, frequency and duration of calls with the service user and Reablement Co-ordinator.

→ Promote and maximise the use of Assistive Technology within the Reablement Pathway (eg Telecare) to support independence and/or to manage risk.

→ Consider the need for daily living equipment and/or minor housing adaptations to support service user's independence, where deemed relevant and appropriately to the service user maximising their independence.

→ Service users must have their own individual file kept within their home which should include:

- ✓ Regional Reablement Leaflet;
- ✓ NISAT Consent Form;
- ✓ Moving and Handling Assessment;
- ✓ Service User's Goal-Setting Plan;
  (formerly Regional Maximizing Independence Plan);
- ✓ Communication Log;
- ✓ Service Plan Timetable;
- ✓ Reablement Staff Recording Sheets (e.g. Daily/Progress Logs);

Evaluation of the Service User's Experience of the Reablement Service.

→ Reablement Occupational Therapist(s) must liaise with the Reablement Support Worker(s) to inform and share essential information about the service user and the delegated tasks they must undertake in line with the Service User's Goal-Setting Plan.

→ All staff delivering the Reablement service must famaliarise themselves with the service user's individual file, information contained therein and record all visits and progress.

NOTE:	If a service user is admitted to hospital during their Reablement episode the Reablement service should cease as per Trust Protocol. This can range from 48-72 hour timeframe.
NOTE:	The service user will be re-referred to the Reablement service, if deemed appropriate, following their discharge from hospital.

3.2.4 Review of the Service User's Progress:

→ Service User's Goal-Setting Plan and the Service Plan Timetable must be reviewed and updated to reflect progress and changing needs of the service user.

→ Review and monitoring of the services user's progress must be continuous throughout the Reablement episode, therefore, established mechanisms must be in place to facilitate:

- ✓ effective lines of communication between the service user, family and/or carers, Reablement Occupational Therapist and Reablement Support Workers regarding all aspects of the service user's care and service delivery.

→ There must be arrangements in place, outside the Reablement service operational hours, for the service user and/or family/carer to be able to urgently contact/report a change in the service user's circumstance (ie Out-of-Hours service).

→ There should be established links with and referrals made to other disciplines, (ie other statutory, non-statutory and community and voluntary organisations/groups).

3.2.5 Discharge of Service User from the Reablement Service:

(i) Discharge from the Reablement Service where the Service User requires No Ongoing Statutory Service:

→ Reablement Occupational Therapist carries out final review of the Service User's Goal-Setting Plan.

→ Reablement Occupational Therapist links with, and refers where appropriate, to other disciplines (ie statutory, non-statutory and Community and Voluntary organisations/ groups).

→ Reablement Occupational Therapist completes discharge process capturing service user's outcomes. Where complex needs have been identified a Discharge Summary should be completed, where appropriate, and forwarded to the service user's General Practitioner (GP).

→ Reablement Support Worker should direct the service user to complete Evaluation of the Service User's Experience of the Reablement Service.

→ At the end of the Reablement episode the service user's file(s) must be retrieved from the service user's home and closed and/or archivesd as appropriate, in accordance with Trust protocol.

(ii) Discharge from the Reablement Service where the Service User Requires a Domiciliary Care Package (ie New, Decreased, Increased or Same Package) the following is required:

→ Care and Support Plan, Risk Assessment and Service Plan Timetable must be updated for commissioning of Domiciliary Care Package.

- → Where the service user has been in receipt of a Domiciliary Care Package prior to Reablement and are discharged from the Reablement service requiring the same level of care the same Domiciliary Care Package could be Restarted in accordance with Trust's protocols.

- → Where the service user requires a **New, Decreased, Increased** or **Same** Domicliary Care Package, **Brokerage** should be utilised as part of the Discharge process to source Domiciliary Care provider(s).

SECTION 4: CONCLUSION

The Regional Reablement Pathway will underpin the key aspects of the Regional Reablement Model Northern Ireland (2015). The benefits of Reablement will be monitored and measured against the:

(i) Regional Minimum Dataset which includes:

- ✓ the numbers of Service Users entering Reablement;
- ✓ length of stay;
- ✓ Service User outcomes ie those requiring **no ongoing** care package, **reduced**, **same** or **increase** in existing package;
- ✓ number of Service Users entering residential and nursing home care.

(ii) Evaluation of the Service User's Experience of the Reablement Services. (**see Appendix 4**)

(iii) Functional Independence Measure and Functional Assessment Measure (FIM FAM).

APPENDIX 1

Health and Social Care Board

Transforming Your Care

REGIONAL REABLEMENT MODEL FOR NORTHERN IRELAND (2015)

STRATEGIC CONTEXT

'Transforming Your Care' – A Review of Health and Social Care in Northern Ireland (2011) recommended that the Health and Social Care Board introduce a Reablement Model of Care across Northern Ireland from 2012. The approach is to provide older people with intensive and time limited support with daily living tasks with the aim of enabling the individual to do the task as independently as possible at the end of the process. In other words the **Reablement ethos** is considered to be a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible.

The Reablement Model in the first instance was to be implemented within the Older People's programme of care (65+) with an expectation that through time it would be phased into other adult services. From 2012 each Health and Social Care Trust has taken steps to adopt the Model and establish, implement and roll-out the Reablement service.

RATONALE FOR UPDATING THE REGIONAL REABLEMENT MODEL

The Regional Reablement Model was originally issued in 2012-13 as a guide for Trusts in their work to establish the Reablement Service Model, with the intention to review in the light of Trusts' experiences of embedding the key components of the Model. The areas of revision were initially identified by the then Operation and Practice Workstream through a series of themed workshops which were held during 2013-14.

These sessions also highlighted a variation in Trusts' measures on access, targeting and availability, etc.

To determine the progress and effectiveness of the Reablement service across the Health and Social Care Trusts, the Reablement Project Board approved a Regional Audit in 2014 which was conducted by the Health and Social Care Board (HSCB) with input from KPMG which brought an independent perspective and an opportunity to help quantify the potential for benefits realisation based on experience elsewhere throughout the United Kingdom. This Review demonstrated that there was a divergence in how the Trusts interpreted the Model and its roll-out. However, it also clearly highlighted the essential components which should be considered for adoption within a Northern Ireland Model. Therefore, to ensure a convergence across the region the HSCB in this Commissioning Statement has revised the Model to reflect key essential elements which will underpin a consistent and effective Model based on this learning.

It is the expectation that by developing an agreed revised regional Model a more consistent approach will be achieved in order to measure outcomes, plan investment and set out a "road map" for further improvement.

REGIONAL DEFINITION FOR REABLEMENT

The following definition of Reablement has been endorsed by the Reablement Project Board for adoption and use regionally.

Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability, and necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, deterioration in health or injury.

The aim of Reablement is to help people perform their necessary daily living skills such as personal care, walking, and preparing meals, so that they can remain independent within their own home.

"Reablement will help you to do things for yourself rather than having to rely on others".

OBJECTIVES OF REABLEMENT

- To ensure that people are supported to live independently and remain in their own home as long as possible.
- To promote and maximise independence and help to facilitate early hospital discharge, mitigate the need for hospital admissions and delay the need for ongoing Domiciliary Care.
- To embed a culture of Reablement within the workforce so that this approach is promoted across staff teams, and subsequently with prospective Service Users and their Families/Carers.
- To promote a person-centred approach to all aspects of the Reablement episode (ie supporting the Service User to prioritise those functional and social independence tasks which are deemed important to the Service User).
- To ensure the Reablement service interfaces effectively, for example: with Hospital Discharge, Intermediate Care, Domiciliary Care, Self-Directed Support and Day Care.
- To promote the person's access and integration to services in local communities by ensuring that staff have a knowledge base of services available within their localities/communities.
- To define and maximise the use of community and voluntary based alternatives which through the provision of low-level services could reverse or delay deterioration in a person's level of independence and social functioning.

SCOPE

The Reablement service will be inclusive, acting as an "in-take" pathway and should be accessible and available across Northern Ireland for Older People (65+) who are on the threshold of requiring a Domiciliary Care package. The expectation is that through time Reablement will be phased into other adult services/programmes of care.

ESSENTIAL COMPONENTS OF THE REABLEMENT SERVICE

Establishment of the Reablement Service
➢ Ensure there are clearly identified leadership structures to drive forward Reablement and other Community Care Reform initiatives.
➢ Ensure staff have a clear understanding of and commitment to the Reablement philosophy and practice and ensure this is communicated to Service Users, their Families/Carers.
➢ The Reablement service should be viewed as a distinct service with its own branding and should not be a hybrid of Domiciliary Care.
➢ The Reablement service should be an Occupational Therapy-led Model.
➢ Ensure 100% geographical coverage in all Trusts' localities.
Prevention and Early Intervention
➢ In order to maximise the use of community and voluntary alternatives it will be necessary to scope and map existing services, their role and function in order to identify gaps in support services within communities.
➢ Further develop partnership working with community and voluntary based alternatives, independent providers and/or other Government agencies to extend the continuum of available services.
➢ Consolidate and enhance partnerships with the community and voluntary sector through Service Level Agreements to support a Reablement Model.
➢ Develop and adopt a reigonal Model for Community Navigation.
➢ Develop and maintain an electronic/web-based Directory of information on the range of statutory, commuity and voluntary based alternative services available within each of the Health and Social Care Trusts' localities.
➢ Ensure dissemination of the Directory to all relevant Trust staff with a responsibility for navigating to and promoting community and voluntary alternatives to better manage demand on statutory services.
➢ Develop a mechanism to monitor diversion and signposting activity to other agencies.

Pathway into the Reablement Service
➢ Streamline and reduce the access points to core services and ensure that the maximum numbers of Service Users who meet the threshold for a Domiciliary Care package are considered against the criteria for Reablement; and where this is met, benefit from an opportunity of the Reablement service.
➢ Ensure application of the Regional Reablement Eligibility Criteria to maximise appropriate targeting.
➢ Adopt and use the Northern Ireland Single Assessment Tool (NISAT), as appropriate, for all Service Users.
➢ Adopt and use the Regional Maximisinig Independence Plan.
➢ Promote the use of Assistive Technology within the Reablement episode (eg Telecare) to support independence and/or to manage risk.
➢ Service User progress should be reviewed throughout the Reablement episode and goals and tasks modified to meet the Service Users' needs.
➢ Discharge pathways to be agreed with the Service User: (i) Those not requiring Ongoing Statutory/Domiciliary Care Support but may require signposting to Community/Voluntary based alternatives. (ii) Those requiring Ongoing Domiciliary Care Support (ie New, Reduced,Same, or Increased package, Residential or Nursing Home).
➢ Complete Regional Service User Exit Interview and/or Service Satisfaction Tool at the end of each Reablement episode.
➢ Brokerage should be utilised as part of the Discharge process to support Service Users who require ongoing care after a Reablement episode to access a package of care in a timely manner and at optimum cost.
Service Delivery
➢ A Reablement episode is a planned and time-limited service, lasting 6 weeks or less, designed to maximise the Service User's independence.
➢ The operational hours for the service should span from 7.00 am to 11.00 pm, and be delivered 7 days per week. In delivering the Reablement service, cognisance should be taken of the times that the Service User normally peforms their regular activities of daily living.

➢ The role of the Reablement Support Workers includes assisting the Service User in daily living activities (eg: personal care needs, mobility, medication, meals management).
➢ Where a Service User is in receipt of a pre-existing Domicliary Care package and/or Self-Directed Support (eg Direct Payment) this should be suspended when Reablement is commenced. Howevever, taking cognisance of the need for flexibiity for cases to be considered on a case-by-case basis (80:20 rule) taking into account the principles of safety and risk.
➢ The Reablement service should be focused on the achievement of the Service User's goals for independence; as these goals are met hours of delivery will change.
➢ There will be a requirement to have an Out-of-Hours arrangement for the Service User and/or family/carer where there is a need to urgently contact/report a change in the Service User's circumstance to the Reablement service or where support and/or advice is needed. This arrangement could be integrated into pre-existing Trusts' Out-of-Hours services.
Governance
➢ Implement regionally agreed competency framework for Reablement Support Workers and Occupational Therapists working within the Reablement service.
➢ Apply a regionally agreed Learning and Development programme for Reablement Support Workers and Occupational Therapists working within the Reablement service.
➢ Apply regionally agreed supervision standards for Reablement Support Workers.
Performance Management
➢ Application of agreed regional minimum data-set for performance management and information.
➢ Monitor performance of each locality Team to facilitate benchmarking with a view to enhancing efficiency/effectiveness.
➢ Adhere to regional targets as identified by the Health and Social Care Board and outlined in the Commissioning Plan Directions.
Benefits Realisation
➢ Agree with Trusts Key Performance Indicators (KPIs) which will quanitfy the longetivity and benefits of the Reablement service.

COMPONENTS FOR FURTHER DEVELOPMENT

➢ Those of 65+ years who meet the eligibility criteria must have access to Reablement services across all Health and Social Care Trusts.
➢ Consideration to be given to the expectation of the Regional Reablement Model being phased into other Adult Programmes of Care.
➢ HSC On-line should contain relevant Reablement content, to include directory of services to support signposting and diversion and encourage a proactive approach to prevention, by seeking to identify potential Service Users who could be offered preventive care to keep them healthier and reduce their risk of requiring intensive health and social care in the future.
➢ A single point of access for all Social Care referrals, which should include screening, diverting people to other agencies, signposting to local community and voluntary based alternatives and providing Reablement as a gateway to core services where appropriate.
➢ Outcome measure(s) to be further developed to capture the financial and non-financial benfits of the Reablement service and subsequently implemented.
➢ Further develop performance management systems to capture additional data on effectiveness and efficiency of the service model.
➢ Regional standardisation and application of specialist assessment tools eg cognitive assessments, outcome measure tools.
➢ Flexibility of service coverage by Occupational Therapists over a 7 day week.
➢ Operate within regional guidelines in relation to the range and maximum number of cases allocated/carried by Occupational Therapy staff.
➢ Operate within regional guidelines in relation to the range and maximum number of cases allocated/carried by Reablement Support Workers/Assistants.

REGIONAL REABLEMENT ELIGIBILITY CRITERIA

The criteria below, must be applied to all those referred to the Reablement service:

- ✓ The Reablement service will be accessible and available across Northern Ireland to all Older People (65+) who are on the threshold of requiring a Domiciliary Care package.

- ✓ Where the assessed needs are identified as Critical and/or Substantial then the "Fair Access to Care Services" criteria must be applied. **(see Appendix 1).**

  AND

- ✓ Requiring assistance of a single member of staff.

  *In exceptional circumstances a Service User may require the assistance of two members of staff as the Reablement episode commences. However, this must only be required in the initial phase of the Reablement episode.

- ✓ The referral to the Reablement service is from either the hospital or community pathways.

- ✓ Has a social care need that affects their daily living activities rather than a therapeutic need.

- ✓ Is medically stable (ie there is no immediate change or deterioration expected in the Service User's health/condition).

- ✓ Lacks confidence and/or requires support after a health or social care crisis, such as illness, deterioration in health or injury.

- ✓ Has difficulty in performing their essential daily living activities (eg personal care needs, mobility, medication management, meals management).

- ✓ Is motivated to actively engage with the Reablement service.

- ✓ The Services Users have the cognitive ability to relearn daily living activities.

EXCLUSIONS FROM THE CRITERIA

Service Users who would not be considered eligible for a Reablement service:

- ⌦ Service User with complex needs requiring assistance of two members of staff.
  (unless in exceptional circumstances see above*).

- ⌦ Palliative End of Life Care.

- ⌦ Advanced/late stages of Dementia.

- ⌦ Service User whose condition is liable to immediate deterioration or where the risk factor is such that it would hinder participation in the Reablement service.

- ⌦ Service User is not motivated and not prepared to actively engage in the Reablement process.

- ⌦ Service User who is at the early stage of a fracture or illness and is not symptom free.

- ⌦ Service User who has recently completed a period of Community Rehabilitation and has reached their maximum potential.

Note: ***The Regional Reablement Model for Northern Ireland (2015) will be further enhanced through the development of the Regional Reablement Pathway.***

Appendix 1

ACCESS CRITERIA FOR DOMICILIARY CARE FOR ALL ADULT CLIENT GROUPS

Introduction

1. The purpose of this circular is to provide a framework for a more consistent approach to eligibility and fairer access to domiciliary care services for both care managed and non-care managed clients (This applies to all adult client groups). The key principle behind these eligibility criteria is that people should be helped wherever possible to live independent lives with safety and dignity in their own home. In this respect Trusts should be aware of their statutory duty to offer a Direct Payment in place of traditional services

2. Trusts have a responsibility to use their resources fairly and wisely. These eligibility criteria are designed to determine how vulnerable a person is, what risk they face now and in the future and to ensure that those at greatest risk are given the highest priority.

3. Wherever possible domiciliary care services should be 'rehabilitative' in nature, enabling people to help themselves, maintaining existing skills and developing appropriate new ones, rather than 'doing' to or for them. The primary responsibility is to those at greatest risk, either to themselves, their carers or others. However, it is recognised that preventative, 'low level' support can avoid deterioration in an individual's situation that then becomes a greater risk to independence. Trusts should therefore develop methods of risk assessment to help them identify those individuals where risks to independence appear relatively low but are likely to become more serious over time. The benefit of preventative action to support carers, and the key role the voluntary and community sectors can play in the delivery of services should be recognised.

Definition

4. Domiciliary Care is the provision of *personal care* and associated domestic services that are necessary to maintain an individual person in a mutually agreed measure of health, hygiene, dignity, safety and ease in their home.

5. *Personal care* is defined as undertaking any activity which requires a degree of close personal and physical contact with individuals who regardless of age, for reasons associated with disability, frailty, illness, mental health or personal physical capacity are unable to provide for themselves without assistance.

Assessment

6. Assessments should be carried out in such a way, and be sufficiently transparent, for individuals to:

    - Gain a better understanding of their *presenting* and *eligible* needs
    - Identify the options that are available for managing their own lives
    - Identify the outcomes required from any help that is provided
    - Understand the basis on which decisions are reached

7. "*Presenting needs*" are the issues and problems identified when an individual is referred to the Trust for social care support. "*Eligible needs*" are those 'presenting needs' for which the Trust will provide help because they fall within the eligibility criteria.

8. Eligibility for an individual is determined following a person centred assessment. The kind of assessment carried out will depend on the complexity of the person's presenting needs – a core assessment may, for example, indicate that a service user has some complex needs which require a specialist assessment. Everyone with a presenting problem that might feasibly be met by a community care service is entitled to an assessment to an appropriate degree, and Trusts have a duty to ensure that people who need help are assessed.

9. The assessment process should include an evaluation against the risks to the client's independence that result from needs both in the immediate and long term. This evaluation should take account of how needs and risk might change over time and the likely outcome if they were not provided. This risk assessment will take account of the client's autonomy, health and safety, ability to manage daily routines and involvement in family life.

10. While the assessment should determine overall risk, different needs can pose varying risks and should, therefore, be banded accordingly. It is therefore essential that 'the individual' is NOT banded. Identified risks to independence, or personal safety, should then be compared to the eligibility criteria (and banded as critical, substantial, moderate or low), thus enabling eligible needs to be identified.

11. The determination of eligibility in individual cases should take account of the support from carers, who have a statutory entitlement to have an assessment in their own right. Carers may include family members, friends and neighbours who can help them individuals meet their presenting needs. If, for example, an individual cannot perform several care tasks, but assistance can be accessed from another source, then this would not be classed as an eligible need.

The Criteria

12. The criteria for domiciliary care cover the following services:

    - Personal care
    - Practical care
    - Non-residential respite care
    - Day care/Resource Centre
    - Transport as required (where this falls within the domiciliary care budget)

13. Appropriate domiciliary care services will be provided if the individual risk assessment identifies a critical or substantial risk to independence and help cannot be sourced from elsewhere. Commissioners will determine with Trusts which services can be provided to those individuals who following a risk assessment are determined to fall within the categories of moderate or low priority. This determination will be reached on the basis of resources available.

Critical – when

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.
- Hospital discharge is delayed (risk to the individual of infection or less of independence from remaining in a hospital bed)

Substantial - when

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or

- the majority of family and other social roles and responsibilities cannot or will not be undertaken.
- Significant possibility of inappropriate admission to hospital or residential care

Moderate - when

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will not be undertaken.

Low – when

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

Low priority ('low risk') – where a service cannot be provided, individuals should be given advice and information about assistance available from other organisations.

14. Where an individual is assessed as being eligible for a service, Trusts should be aware of their statutory duty to offer a Direct Payment in place of traditional services. Alternatives to the need for domiciliary care assistance **must** always be explored during the assessment to include the availability of contributions from own resources/family/wider community/voluntary sector/other agencies. People who fall below the threshold should **not** be placed on the waiting list for domiciliary services, however other services may be provided by the Trust. Where services cannot be provided a register of 'unmet need' should be collated by the Trust for use in future planning and service enhancement and development.

Review

15. Review is an essential element in ensuring that appropriate domiciliary care is available to those most in need of it. All individuals should be advised at their assessment that this will be reviewed on a regular basis, and that any services provided may be changed (including reduction or withdrawal) if their needs and risks have changed.

Appendix 2

NISAT	Consent	Oct 2015

General Information

Assessed Person's Details	
Name	
DOB	
H&C No	
Address	
Post Code	
Contact Tel No	

Consent

Consent

- ☐ I agree that the information provided in my assessment may be shared with health and social care professionals and service providers who can contribute to my care
- ☐ I agree that information in relation to my health and social care needs may be shared with my carer(s)
- ☐ I agree that information in relation to my health and social care needs may be obtained from others involved in my care
- ☐ I understand that I may withdraw my consent to share information or have further assessment at any time, but that this may affect ability to provide full services for me
- ☐ I understand that I have the right to restrict what information may be shared and with whom, but that this may affect ability to provide full services for me

Restrictions				
Please specify which information you do not wish to share				
Please specify with whom you do not wish to share information				
Consent type Verbal Written None (please give reason)	Please select an item below Choose an item.			
Assessed person's signature			Date	
Print Assessor Name		Designation	Contact Tel No	
Assessor's signature			Date	

Appendix 3

Health and Social Care in Northern Ireland

REABLEMENT SERVICE

SERVICE USER'S GOAL-SETTING PLAN

Name of Service User: _____ **Health and Social Care Number:** _____

DATE	WHAT DO I NEED TO BE ABLE TO DO TO LIVE INDEPENDENLTY IN MY OWN HOME		PERSON(S) RESPONSIBLE (eg Service User, Family, Carers, Staff & Volunteers)	REVIEW PERIOD (Number of days/weeks)	PROGRESS UPDATE To include: Signature of Reviewer and Date
	GOALS: this is what is important to me to live at home	TASKS: the activities to help me regain my independence			

NOTE: This form must be completed in black ink
(May 2016)

DATE	WHAT DO I NEED TO BE ABLE TO DO TO LIVE INDEPENDENLTY IN MY OWN HOME		PERSON(S) RESPONSIBLE (eg Service User, Family, Carers, Staff & Volunteers)	REVIEW PERIOD (Number of days/weeks)	PROGRESS UPDATE To include: Signature of Reviewer and Date
	GOALS: this is what is important to me to live at home	TASKS: the activities to help me regain my independence			

Date of Discharge: _____

AGREEMENT

I _____
(Service User's Signature)

(i) understand the Reablement service and what it will do for me.

(ii) agree to engage with the Reablement Team and agree to work towards achieving the agreed Goals as outlined within this Goal-Setting Plan .

(iii) expect the Reablement Team to support me in achieving these goals and help me stay as independent as possible.

Reablement Occupational Therapist: _____ **Signature:** _____ **Date:** _____20__
(PRINT NAME)

NOTE: This form must be completed in black ink
(May 2016)

Health and Social Care in Northern Ireland

EVALUATION OF THE SERVICE USER'S EXPERIENCE OF THE REABLEMENT SERVICE

We would appreciate if you would take some time to complete this form. Your feedback is important to us to ensure we provide a quality service to you. The feedback which you provide will help in identifying what is done well and what could be improved upon or done differently.

DEFINITION: Reablement is a person-centred approach which is about promoting and maximising independence to allow people to remain in their own home as long as possible. It is designed to enable people to gain or regain their confidence, ability, and necessary skills to live independently, especially after having experienced a health or social care crisis, such as illness, deterioration in health or injury.

The aim of Reablement is to help people perform their necessary daily living skills such as personal care, walking, and preparing meals, so that they can remain independent within their own home.

"Reablement will help you to do things for yourself rather than having to rely on others".

I am a:	**Service User:**	☐
	Carer completing this on behalf of the Service User:	☐
	Family Member completing this on behalf of the Service User:	☐

Name: (this is optional):	**Local area:**

BEFORE YOUR REABLEMENT SERVICE STARTED

1	**Before you started the Reablement service did you understand how the service was going to support you?**	**Yes:** ☐	**No:** ☐	
2	**Did you receive any information/literature about the Reablement service?**	**Yes:** ☐	**No:** ☐	
	If so, did you think the information/ literature was: (tick as appropriate)	**Very Helpful:** ☐	**Helpful:** ☐	**Unhelpful:** ☐
3	**Did you know how to contact the Reablement staff?**	**Yes:** ☐	**No:** ☐	
4	**Did you feel you were able to choose the goals you wanted to achieve to help you become more independent?**	**Yes:** ☐	**No:** ☐	
5	**Were your goals recorded by the Reablement Occupational Therapist?**	**Yes:** ☐	**No:** ☐	

DURING YOUR TIME ON REABLEMENT			
6	Did Reablement Staff introduce themselves to you?	Yes: ☐	No: ☐
7	Where you treated with dignity and respect?	Yes: ☐	No: ☐
8	Did you feel the Reablement Staff were approachable?	Yes: ☐	No: ☐
9	Did you have confidence and trust in the way the Reablement staff were supporting you to become more independent?	Yes: ☐	No: ☐
10	Did you feel the Reablement staff were appropriately skilled and trained in helping you to meet your needs and goals?	Yes: ☐	No: ☐
11	Did the Reablement Staff visit at a time that suited your daily routine?	Yes: ☐	No: ☐
12	Were the Reablement staff punctual?	Yes: ☐	No: ☐
13	Did you feel you had enough time, during your visits, when working with Reablement staff to achieve your independence?	Yes: ☐	No: ☐
14	Were you kept informed about any changes that were being made during your time on the Reablement service?	Yes: ☐	No: ☐
15	Was there a file kept in your home that the Reablement staff recorded their visits and followed your Plan?	Yes: ☐	No: ☐
16	If yes, did the Reablement staff make use of the file on each visit?	Yes: ☐	No: ☐
17	Did you feel that information about you was dealt with appropriately and confidentially?	Yes: ☐	No: ☐
18	Did you feel your views were taken into account throughout the Reablement episode?	Yes: ☐	No: ☐
19	Did you receive equipment?	Yes: ☐	No: ☐
	If so, did it enable you to become more independent?	Yes: ☐	No: ☐

	AFTER YOUR TIME ON REABLEMENT		
20	**Did you find the Reablement service reliable?**	**Yes:** ☐	**No:** ☐
	If No, what did you find to be unreliable?		
21	**Do you feel the service has enabled you to regain your independence and has supported you to stay at home?**	**Yes:** ☐	**No:** ☐
	If No, please specify:		
22	**At the end of Reablement, did you need any other support?**	**Yes:** ☐	**No:** ☐
	If Yes, was it explained to you how you would get this support?	**Yes:** ☐	**No:** ☐
23	**Has the Reablement service helped you improve your quality of life?**	**Yes:** ☐	**No:** ☐
	If No, please specify: _____		
24	**Did you know how to make a complaint if you were unsatisfied with the Reablement service and/or Reablement Staff?**	**Yes:** ☐	**No:** ☐
25	**Have you had any reason to make a complaint?**	**Yes:** ☐	**No:** ☐
	If Yes, were you happy with the way your complaint was resolved?	**Yes:** ☐	**No:** ☐
26	**What other comments or suggestions would you wish to make about the Reablement service?**		
Please ensure this Evaluation Form is returned at your earliest convenience to:			

Thank you for your co-operation and for taking the time to complete this.