Reablement in Brighton & Hove

A Workbook for Practitioners
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By completing this reablement workbook you will be able to;

**Describe key definitions of reablement including:**
- What is reablement?
- The key principles of reablement
- The difference between reabling and non-reabling traditional care

**Describe the History of reablement including:**
- Origins of reablement nationally and in Brighton & Hove
- The future of reablement

**Explain how reablement services work in Brighton & Hove including:**
- The service user’s journey from assessment of potential need to receiving services
- Where reablement sits in the range of services a service user might use
- Reflect upon the role of your team in providing services to people

**Define the role of the professional including:**
- Explain what your role is in relation to delivering reablement
- Know how to deliver care in a reabling way
- Describe the role of other professionals who are involved in delivering reablement care.

**Understand common medical conditions:**
- Describe common medical conditions that may affect a service user
- Recognise how a medical condition can impact on reablement

**Understanding outcomes:**
- Describe what is an outcome
- Know how outcomes are set

**Recognise how to support and review a service user’s progress including:**
- Know how and where to record information about the service user
- Know when and who to refer concerns regarding the service user’s progress.
This workbook will take approximately 8 hours to complete. The workbook is designed so it can be completed in 80 minute sections.

It is recommended that the workbook is completed online as there are sections that will require you to watch an online film.

**Acquiring Knowledge:**
There are a number of ways you can develop your knowledge to complete the work book these include;
- Shadowing
- Asking questions
- Training
- Practicing
- Seeking advice/feedback

In order to complete your work book your manager will need to sign off in your supervision records that they are satisfied that you have met the learning objectives.
Section 2 Definitions

Learning Objectives:
After completing this section you will be able to describe:
• What reablement is
• The key principles of reablement
• The difference between reabling and non-reabling traditional care

What is reablement?

The Department of Health’s definition of reablement is:
‘the use of timely and focused intensive therapy and care in a person’s home to improve their choice and quality of life, so that people can maximise their long term independence by enabling them to remain or return to live in their own homes within the community. This approach focuses on reabling people within their homes … so they achieve their optimum stable level of independence with the lowest appropriate level of ongoing support care’.

In other words reablement supports people with poor physical or mental health to accommodate their illness by learning or relearning the skills necessary for daily living.

This means looking at:

• What abilities does a service user have?
• How can these be maximised so the service user can do more for them self?
• What can we do to help the service user to stay in their own home?

Think about a time when you have been ill or had an injury. What things did you find difficult?
Reablement is about supporting people to do things for themselves, and to adapt to their circumstances. Before starting a period of reablement the *outcomes* are discussed and agreed with the service user. The *outcomes* are the things the person would like to achieve through reablement.

List three outcomes a person may want from reablement

1.  
2.  
3.  

Outcomes that a service user may want as part of reablement could include

- personal care such as washing, dressing, continence promotion, getting in and out of bed
- cooking, preparing meals and helping to eat
- building confidence
- shopping, pension collection, laundry and other household tasks
- coping with impaired memory
- social and leisure activities
- indoor and outdoor mobility
What are the key principles of reablement?

The principles of reablement are:

- **Support people to do for themselves** rather than ‘doing to or for’ people
- **Work towards achieving outcomes**
- **Continually observe and assess**
- **Provide reablement sooner rather than later**: Early intervention will reduce the development of complex support needs in the future
- **Plan with the person** in order to maximise their choice and control

What do you think the differences are between reablement and traditional care?

Write a definition of care
There are a number of different definitions of ‘care’ in a social service context.

The dictionary definition of care includes:

- To look after or provide for
- To like or be fond of
- Careful or serious attention
- Attentive assistance or treatment to those in need

Care work means the work of looking after others. It includes unpaid and paid care. Caring work includes taking care of children, the elderly, the sick, and the disabled, as well as doing domestic work (such as cleaning and cooking.)

The traditional models of care have focused on doing ‘for’ rather than supporting people to do for themselves. This has been criticised as disabling and disempowering. However this is not to say that having a caring empathetic attitude is wrong. These are important attributes for any type of people work.

Compare the above definition of care with the definition of reablement on page five.

Now look at the comparison between reablement and traditional care on the next page.
Caring
Reablement

Doing for → Working with

Assisting ← Encourages and motivates

Person is dependant on carers ← Fosters independence

‘Doing for’ requires less time ← Supporting person to do for themselves takes longer

Ongoing ← Time limited

Limited opportunity for service user to do for themselves ← Increases opportunity for service user to do for themselves

Staff use more involved skills such as manual handling ← More soft skills such as communication and reflective practice
Watch this online video on reablement
https://www.scie.org.uk/socialcaretv/video-player.asp?guid=6886fa01-81da-4963-926c-e1b41c5170f0

What is the difference between a reablement and a traditional home care service?

What percentage of service users have a change in their care needs after a period of reablement?

What percentage of people don’t need any care services after reablement?

Case example: Brighton & Hove City Council:

Mrs B was referred to reablement after falling in her home and being admitted to hospital.

Mrs B went through the reabling service, initially starting with 4 calls a day.

Mrs B was very clear that she wanted to stay at home and regain the same level of independence she had prior to her fall.

Despite some concerns from her family who wanted a traditional homecare service staff worked in a reabling way and at the end of the process Mrs B needed one call a week to assist with hoovering.
Having completed this section you should now be able to describe:

- What reablement is
- The principles of reablement
- The difference between reabling and non-reabling traditional care

Write down the three most important things you have learnt in completing this section.

Manager’s comments
Reablement is a model of care which began 10 years ago with a pilot scheme in Leicestershire County Council’s Homecare team.

Prior to reablement, the way care was provided in Leicestershire meant:

- People did not have the opportunity to do things for themselves.
- There was very little choice for the person in how their care was provided
- There was no focus on what the person wanted to achieve
- The person and their carers were not asked about what they wanted

This meant that older people were kept in hospital for longer than necessary and when they left hospital the care provided meant they were not helped to regain their independence.

The pilot scheme in Leicestershire found that after 6 weeks of reablement care people need less or no home care service.

Reablement has a long term effect. Two years after reablement, two out of five service users need only the same amount of home care or less.
Reablement in Brighton & Hove City Council

Brighton & Hove City Council introduced a reablement pilot scheme called ‘Independence at Home’ in October 2008.

The scheme aimed to ensure that people who used Brighton & Hove services maximised their independence, grew in confidence and lived fulfilling lives.

The pilot scheme ran for 6 months. Results included;

- Over one in three people who had reablement needed no further care
- One in four needed a reduced package of care

After April 2009, reablement is offered to all new service users. In the light of experience this has been refined with reablement being offered to all new service users identified as having reablement potential

The Future of Reablement in Brighton & Hove

Home care providers are helping to identify people who could benefit from reablement when, for example, people who have had a change of circumstances such as illness, hospitalisation or the loss of a partner.

In addition Brighton and Hove City Council are looking at how reablement can be introduced and considered in other areas such as day service provision.
Go to the online video on Reablement (9 minutes)

What are the benefits of providing reablement care to the:

- Individual
- Health services
- Adult social care

Having completed this section you should now be able to describe:

- The origins of reablement nationally and in Brighton & Hove
- The future of reablement

Manager’s Comments
Learning Objectives:
After completing this section you will be able to:
- Describe the person’s journey from assessment of potential need to receiving services
- Describe where reablement sits in the range of services a service user might receive
- Reflect upon the role of your team in providing services to people

Assessment Process for Reablement

There are several ways a person may be offered a reablement care service including:

1) A referral from a social worker
2) Referrals from the Care Matching Team
3) Home First (this is a discharge to assess model)

As reablement continues to expand this list will increase.

Access point

Access Point is the first point of referral for people requiring social care services.

When a person contacts Access Point, an assessment is made of the person’s requirements. If their needs are not complex Access Point may provide simple pieces of equipment and sign post the service user to complex pieces of equipment.

If the person’s needs cannot be met by Access Point, they will be referred to Adult Assessment Services who will carry out a more in-depth assessment of the care needed. This may include a period of intensive reabling home care support.
Discharge to Assess – Home First
Traditionally a person medically fit for discharge from hospital would have their support needs assessed at the point of discharge. This approach has the disadvantage that the assessment is conducted outside of the person’s day to day environment, during a period when they have been acutely unwell and that discharge is frequently delayed when there are difficulties meeting the person’s needs.

An alternative to this approach is to assess the person in their home following discharge. This is called discharge to assess, and is currently referred to as Home First.

In the discharge to assess model, once medically stable the person leaves hospital to return to their own home with interim care support as recommended by the ward staff. At the time of writing this is being provided by Coastal Care.

“The regulations require that intermediate care and reablement provided up to 6 weeks, and minor aids and adaptations up to the value of £1,000 must always be provided free of charge.” … Care Act Statutory Guidance

This is illustrated in the chart on page 15.
Home First Hospital Discharge Flowchart

Person in hospital

Person medically stable is discharged home

Initial Support (Coastal Homecare) in person’s home. Assessment for reablement potential, care and support needs, equipment

Only short term support required? No

Short term care and support (Coastal Homecare) No

Coastal Homecare as a trusted assessor can assess when short term support is no longer required No

Care Act Assessment by hospital social work team. Personal budget / long term care & support arrangement

Independence at Home provides reablement

Ongoing support needs? No

Close Yes

Yes

No
Timeline

This is a typical timeline for a person starting their reablement journey. This can be up to six weeks, or may be shorter if the person has reached their reablement potential.

**Day (-1)** Referral to Independence at Home.

**Day 1** Independence at Home team visit person and complete 'First Visit'.

**Day 2/3** Person Centred Plans (PCP) agreed and put in place, and reabling support starts.

**Day 3-14** Home Care Support Workers support service user, recording progress towards PCP goals and feeding back to the Care Support Managers.

**Week 2** Care Support Manager (CSM) visits to discuss progress with the service user and agrees adjustments to PCP and plan changes to visit durations.

**Week 2-3** Home Care Support Worker continues to support service user, recording progress and reporting back to the CSM who adjusts/reduces the support visits inline with the service user's progress.

**Week 4-5** CSM visits and completes a formal review of the care needs. Agrees future plans for support care, either:

(i) Plans to end care or
(ii) Identifies ongoing care needs, in which case a social worker will conduct a Care Act Assessment.

**Week 6** End package of care, or long-term care and support arrangements (e.g. personal budget, independent homecare agency).
Explanation of terms

**Care Matching** – An assessment may identify the person’s needs as 4 calls a day 7 days a week. The Care Matching service will help identify who can provide the allotted care. It could be Brighton & Hove City Council’s Independence at Home, an independent provider or a combination of both. Care matching service is used for providing both reablement and traditional care.

**Telecare** – Equipment and services that support someone to remain safely in their home. Examples of Telecare include a call service for help if a person falls, a system to remind someone to take their medication at an allotted time and voice activated environmental controls.

**Equipment**- There is a range of equipment available to support people to become or to maintain their independence with their activities of daily living such as raised toilet seats, perching stools and grab rails.

**Adaptations**- Changes to the physical environment, for example hand rails or bath lifts.

**Review**- After the person has been through up to a maximum of 6 weeks reablement their care needs are reviewed. The review may find that there is a need for a personal budget or continuing traditional care or there are no further care needs. If the person does need a care and support plan this will be reviewed annually by the Adults Assessment Team.

**The Community Short Term Service**- promotes recovery from illness, prevention of unnecessary admission to hospital or a care home and supports timely discharge from a hospital setting. The Community Short Term Service is a multidisciplinary team consisting of health and social care staff including physiotherapists, nurses, social workers and care & support staff.

For instance after a stay in hospital a person may not be ready to go home but they do not require any further intensive hospital based medical treatment. However, the person may need a further period of rehabilitation support and
assessment to get their strength and confidence back and regain daily living skills.

**Residential/Nursing Care** – Assessment determines the level and/or type of care required means that the person cannot remain in their home and the person requires residential services or a nursing home.

**Independent Home Care Providers** – Private companies that tend to provide traditional home care although this is changing and there are a number independent care providers who provide both reablement and traditional home care.

**Personal Budget** – A personal budget is an umbrella term for a sum of money allocated to the person to cover their care and support needs. This is a key mechanism for enabling personalised support. Instead of a person with care and support needs being supported through a traditional provider service, a personal budget provides the opportunity to arrange more personalised types of care and support, such as a personal assistant. Personal budgets include direct payments, which are managed by the person themselves, and personal budgets that can be managed on behalf of an individual.

**Adult Assessment Services** - work with people who are in need of community care services and require complex case management and / or safeguarding interventions.

Think about your team. What services do they provide to service users?

Which other teams/professionals do you work closely with?
**Pop Quiz**

1. James has recently become unsteady on his feet. He needs some help.  
   a. Who could he contact?  
   b. What could he be offered?

2. What team can help Jeanette to access a day centre?

3. What practical equipment, adaptations and telecare could be used to support a person who is visually impaired to stay in their home?

4. Levi has been discharged from hospital after having been treated for pneumonia. Levi is very weak and needs to build up his strength. Which service would he access?

5. How often are reablement person centred plans reviewed?

6. How often are care and support plans reviewed?

7. If a person cannot remain in their own home, what other types of care might they have?

8. Dionne has recently been discharged from hospital after a fall. She needs to have 3 calls a day to assist with personal care and food preparation. Who might be involved in organising a homecare service for Dionne?

9. What percentage of people do not need home care after they have had reablement?
Having completed this section you should now be able to:

- Describe the service users journey from assessment of potential need to receiving services
- Describe where reablement sits in the range of services a service user might receive
- Reflect upon the role of your team in providing services to people

Manager’s Comments
Learning Objectives:
After completing this section you will be able to:
- Explain your role in relation to delivering reablement
- Know how to deliver care in a reabling way
- The roles of other professionals involved in delivering reablement

All professional carers whether providing traditional or reablement care need to have the following key skills:

Communication skills
This includes:
- Tailoring the communication to meet the individual – posture, choice of language, tone of voice etc
- An awareness of what the other person is ‘saying’ both verbally and non-verbally
- Choosing the right time to communicate – when the person is most alert, attending and not diverted

Self-awareness skills
At its simplest level, self-awareness involves having an understanding of how other people perceive us and how we come across to them. Often the same behaviour can be viewed differently.

It is important we adapt our behaviour to fit with the person we are working with to ensure there is a person to person fit. For example some people like people to be calm and softly spoken; others prefer lively and assertive people. As a skilled care worker we need to read people and adapt our behaviour accordingly.

Complete this e-learning training programme on Communication and Recording. This will also support you if you are working towards standard 6 of the Care Certificate.

https://learning.brighton-hove.gov.uk/elearning/Course/Detail?CourseId=181
As well as communication and self awareness, there are other skills that are vital for providing a high standard of care in both traditional care and reablement. Some of these skills can be acquired through training and shadowing but many are gained through experience and reflective practice. Below is a cycle of reflective practice in providing social care based on Gibbs Reflective Cycle.
Reflective Practice – based on Gibbs Reflective Cycle

Description (What happened?)
Social care workers need to be keen observers and be sensitive to the nuances of the situations they are working in. This is particularly important in knowing when to report issues to management.

Action Plan
By observing, recognising feelings, evaluating the situation, identifying key issues and thinking how can things be done differently, social care workers can learn from situations, gain skills and provide better care.

Feelings (How did it make me feel?)
Social care work has a significant emotional component. There are two sides to handling feelings. Social care workers need to understand how clients, carers and others involved experience their feelings. Social Care workers also need to be sensitive to the ways in which social care work emotionally affects them. Empathy is similar to sympathy but subtly and importantly different. Empathy involves understanding or appreciating the feelings of others, but without necessarily experiencing them.

Conclusion (What did I learn? What would I do next time?)
Social care workers need to evaluate situations to avoid uncritical, routine practice by remaining open to new ideas, new perspectives and new approaches. It is also important to get feedback from others and through supervision. This allows the identification of what can be done differently.

Evaluation (What was good/bad about the situation?)
Situations can arise where it is necessary to ‘think on your feet’, to be able to react quickly but without panicking. When a highly pressurised situation develops, there may be little or no time to plan a measured response, but Social care workers none the less have to respond. It is important to evaluate what has been good about the experience and what was bad to learn from the experience.

Analysis (What sense can I make of the situation?)
Social care workers must be able to identify key issues in a particular situation. This means sorting out the important ‘bits’ from a mass of information.
Think about an incident involving another person where there was a conflict.

1. Describe the situation

2. How did you feel? How did the other person feel?

3. What was good about the experience? What was bad?

4. What did you learn?

5. If the incident happened again, what would you do differently?
Skills for Reablement

A reabling attitude requires you to:

- Have unconditional positive regard for the person and be non-judgemental. Often when the person starts reablement they have had a period of illness or injury and their physical ability may appear limited, frail and unable to meet their desired outcome.

- Not intervene unless the person is putting themselves at risk of injury. It is difficult to watch someone having difficulty and part of our role as social care workers is to help. But to enable the person social care workers must step back and focus on helping the person to reach their chosen outcomes.

- Encourage but not patronise. There will be times when the person will find a task difficult and their ability will fluctuate. Your role is to support the person through the use of encouraging language and negotiation.

- Empathise rather than sympathise.

- Be approachable but still professional.

Technical Knowledge

You need to have knowledge of a range of conditions and how they may affect the person whilst providing reablement care (See Common Medical Conditions). It is also necessary to have a knowledge of the different pieces of equipment that can safely promote independence and reduce risk to the person (see Supporting the Service User).

Multi-Disciplinary team practice

A multi-disciplinary approach values the differing perspectives of different professionals. You will need to work well with others. In practice this will look like appropriate listening, questioning and sharing information.
Professionals involved in Reablement Care

Care Support Manager (CSM)
CSMs are responsible for managing the delivery of the reablement care to service users. They visit the person at the start of their package of care to discuss and agree with them the goals they most want to achieve by the end of the reablement period. They then put in place the detailed Person Centred Plan, which the support workers use to help the service user to progressively build-up to those goals. CSMs visit the service users regularly during the reablement period to monitor and adapt the care, but they also receive regular feedback from the care team on progress and speak to service users and their carers on the telephone.

Towards the end of the reablement period – at about 4 weeks – the CSM will carry out a review of the person’s care needs. In some cases the person will have improved to the point where professional care is no longer needed. For other people, they will still have ongoing needs with which they need help, in which case the person will have a full Care act Assessment.

Social Workers are professionally qualified members of staff. When a person appears to have social care needs the local authority must assess their needs under the Care Act. The social worker is the person responsible for carrying out the Care Act Assessment. This is a holistic assessment, looking at the person’s strengths and wellbeing, identifying what needs the person has and what outcomes are important to the person.

Occupational Therapists are professionally qualified staff skilled in helping people maximise their independence. Occupational therapists are able to identify techniques, equipment and adaptations to the living environment that can contribute to and maintain a person’s daily living skills.

Physiotherapists are medical professionals with the skills to assess the person’s physical functioning. They are able to suggest therapeutic interventions (for instance exercises) and other adjustments (such as zimmer frames) that can help people improve and/or adapt to their level of physical functioning.

Home Care Support Workers support service user, recording progress towards PCP goals and feeding back to the Care Support Managers.
Having completed this section you should be able to explain:

- Your role in relation to delivering reablement
- How to deliver care in a reabling way
- The roles of other professionals involved in delivering reablement
Learning Objectives:
After completing this section you will be able to:
- Describe common medical conditions that may affect a service user
- Recognise how a medical condition can impact on reablement

Understanding the Medical conditions impact on functional ability:
There are a number of common medical conditions that you may encounter in providing reablement care. These conditions may affect the reablement process.

Osteoarthritis

Cause: Breakdown and eventual loss of cartilage in joints
Symptoms: Affects movement in hands, feet, spine and weight bearing joints such as hips and knees. The condition will worsen
Physical Effect: The condition causes pain and there is a reduced range of movement in the affected joints
Implications for Reablement: People with Osteoarthritis often have a better range of movement in the morning which will deteriorate throughout the day

Rheumatoid Arthritis

Cause: Auto immune disease that causes swelling around the joints and body organs
Symptoms: The illness can last for a number of years and patients can have long periods without symptoms
Physical Effect: The illness can worsen and lead to joints being destroyed and physical disability
Implications for Reablement: People with Rheumatoid Arthritis often have a better range of movement throughout the day
Osteoporosis

**Cause:** Density of bone is lost making them fragile

**Symptoms:** Early diagnosis is difficult as symptoms only show when the bone fractures or crumbles

**Physical Effect:** In the spine, Osteoporosis can cause chronic lower back pain, loss of height and cause people to stoop (Kyphosis)

**Implications for Reablement:** Osteoporosis cannot be improved but can be stabilised

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Stroke

**Cause:** Sudden death of brain cells due to a problem with the blood supply from either a blockage or rupture of an artery

**Symptoms:** Numbness, weakness or inability to move face, arm or leg on one side of body, difficulty speaking, sudden loss of sight in one eye or blurred vision, confusion or difficulty understanding, loss of balance or coordination, severe headache, seizures, loss of consciousness

**Physical Effect:** Abnormal muscle tone either spasms or limp; memory and abstract thinking can be affected; confusion, anxiety and depression; sensations of pain and pressure; visual disturbances; speech and language can be affected e.g. slurred speech.

Often the symptoms will affect the opposite side of the body to the affected side of the brain i.e. if the left brain is affected the symptoms will appear on the right side of the body.

**Implications for Reablement:** As well as the physical effects of the stroke, a person may have emotional disturbances such as denial that a stroke has occurred or learned responses are forgotten leading to inappropriate responses. The physical effects can include unilateral neglect where one side of the brain does not acknowledge the damaged side for example if asked to draw a house the person will only draw one side
**Angina**

**Cause:** Decreased supply of blood oxygen to the heart due to a narrowing of the coronary arteries. Will normally occur during exertion, severe emotional stress or after a heavy meal

**Symptoms:** chest feels pressured, heavy, tight or being squeezed or an ache

**Physical Effect:** Pain often radiates to the neck, jaw, arms, back or even the teeth

**Implications for Reablement:** Stable Angina is the most common type, is predictable and can be relieved by medication. Unstable Angina is more serious, attacks last longer and are often the precursor to a heart attack

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**Chronic Obstruction Pulmonary Disease (COPD)**

(a) **Chronic Bronchitis**

(b) **Emphysema**

**Cause:** Permanent obstruction of flow of air through the airways in and out of the lungs. The obstruction is most commonly caused by smoking but can be a result of air pollution, repeated damage to the lungs from infections or inherited disease

**Symptoms:** Shortness of breath and increased carbon dioxide in the blood can lead to headaches

**Physical Effect:** People with COPD may be more prone to respiratory infections, produce lots of mucus or have a chronic cough

**Implications for Reablement:** People with COPD will have a changing tolerance to physical activity and may need to rest frequently
Hypotension (Low Blood Pressure)

**Cause:** Flow of blood is too low to deliver enough oxygen to vital organs such as the brain, heart and kidneys. The organs do not function normally and may be permanently damaged.

**Symptoms:** Blood pressure is below the normal range of 90/60 to 120/80

**Physical Effect:** Dizziness, falls, fainting

**Implications for Reablement:** Symptoms of Hypotension occur when a person stands up too quickly from a sitting or laying down position

Hypertension (High Blood Pressure)

**Cause:** Blood is pumped around too quickly placing pressure on the arteries which increases the risk of developing heart and/or kidney disease, hardening of the arteries, eye damage and strokes

**Symptoms:** Blood pressure is above the normal range of 90/60 to 120/80. Blood pressure between 120/80 and 139/89 is called pre-hypertension. Blood pressure of 140/90 and above is Hypertension

**Physical Effect:** People with high blood pressure often do not feel sick. In fact, hypertension is often called "the silent killer" because it may cause no symptoms at all for a long time

**Implications for Reablement:** Symptoms of Hypertension include dizziness, headache, shortness of breath and blurred vision

Think about what equipment could be used to assist someone with any of the above medical conditions.
There are no right or wrong answers to this, but did you think of any of these words?

- Angry
- Sad
- Frustrated
- Irritable
- Exhausted
- Overwhelmed

What we are thinking about here is how people feel having lost some functional ability. The greater the loss, the stronger their feelings are likely to be. One way of thinking about this is in terms of the person going through bereavement. The person has experienced a loss, and the experience of this is the bereavement. This will not usually be on the scale of losing a loved one, but may have some similarities.

The Kubler-Ross cycle of grief is one way to think about how people experience loss. There are five stages to this model:

1. **Denial.** Not taking on board what has happened. “There’s nothing wrong with me”. “I'll cope”.
2. **Anger.**
3. **Bargaining.** Taking on board the new situation but wishing it wasn’t so, trying to negotiate a different situation. “Isn’t there some ….?”, “Why me?”
4. **Depression.** The person is at their lowest point now that the reality of the situation has sunk in.
5. **Acceptance.** The person comes to accept their new situation and is ready to move on again.

According to the model a person may move between one state and another; the stages suggested by Kübler-Ross are one description of how most people experience bereavement.
What this means for your work

You can use the Kubler Ross model to help you think about why the person is behaving as they are and how they are experiencing grief. For instance, if a person is in a state of denial they will not acknowledge the loss of their functional ability. Before they are ready to engage in a reabling approach they will need to move to accepting their situation. Your role may involve supporting the individual to accept their situation. You could do this by asking the person to 'show you how.....', 'Tell me what will happen when....' etc.

When working with any person in a reabling way, even when they appear to have accepted their situation, you should be mindful that the sometimes challenging approach of re-ablement will confront the person with their situation. Given this, you can expect the person to become frustrated and angry!

Your role is to support the individual, acknowledging how they feel, i.e. an empathic approach. Your role is not to take on the feelings of the person (which is to sympathise), or to collude. This can be hard, emotional labour and you should receive guidance and support from your supervisor.
What might the symptoms indicate? Draw a line to each condition.

- Mr K has difficulty getting out of bed in the morning
- Mrs M has lower back pain, recently she hit her arm on a table resulting in a fracture
- Mrs W has not been reading or watching TV recently, she says they give her a headache
- Sometimes Mrs E can walk up the stairs to bed unaided, other times it can take 15 minutes as she needs to frequently rest
- Mr T only eats the food on the left side of the plate
- Mrs J finds it difficult to walk to her bathroom in the evening
- Recently Mr L has been fainting when getting out of bed
- After lunch Mr A frequently complains about the food. He says it gives him indigestion he says the top of his stomach feels tight and chewing makes his jaw sore.

Conditions:
- Osteoarthritis
- Rheumatoid Arthritis
- Osteoporosis
- Stroke
- Angina
- Chronic Obstructive Pulmonary Disease
- Hypotension
- Hyper tension
What medical condition might the service user have?

- Mr K has difficulty getting out of bed in the morning
- Mrs M has lower back pain, recently she hit her arm on a table resulting in a fracture
- Mrs W has not been reading or watching TV recently, she says they give her a headache
- Mrs E can walk up the stairs to bed unaided, other times it can take 15 minutes as she needs to frequently rest
- Mr T only eats the food on the left side of the plate
- Mrs W has not been reading or watching TV recently, she says they give her a headache
- Mrs J finds it difficult to walk to her bathroom in the evening
- Recently Mr L has been fainting when getting out of bed
- After lunch Mr A frequently complains about the food he says it gives him indigestion he says the top of his stomach feels tight and chewing makes his jaw sore.

NB You are not a doctor and we are not encouraging you to diagnose but you should be aware that some conditions will affect reablement.
Having completed this section you should now be able to:

- Describe common medical conditions that may affect a service user
- Recognise how a medical condition can impact on reablement
Section 7 Working in an outcome focused way

Learning Objectives:
After completing this section you will be able to:

- Explain what an outcome is
- Know how outcomes are set

What are outcomes?

As already mentioned outcomes or goals the service user wants to achieve through reablement are set by the service user possibly with the involvement of family and carers.

The outcomes need to be SMART goals in that they must be:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time bound**

For reablement purposes the outcomes need to be well defined so as to;

- Be clear to anyone with a basic knowledge of the care plan
- Know if the goal is obtainable and how far away the completion of the goal is
- Know when it has been achieved
- Be within the availability of resources, knowledge and time
- Meaningful to the service user
- There must be enough time to achieve the goal
- Not require too much time to complete as this can be counterproductive. If it is taking too long to reach a goal the service user may lose motivation.
How outcomes are set
When the Care Support Manager visits the person for the first time they will explore what outcomes are important to the person. These will be described in the Person Centred Plan with a description of the reablement support required to help the person meet their outcomes.

At a first visit a number of processes are gone through and recorded. These include:

- Creating the support plan and person centred plan;
- Agreeing times for calls;
- Checking whether the person has or needs a key safe;
- Completing risk assessments and informing the person about the protocols and procedures of the Independence at Home Team.

The support plan captures key information such as the person’s name, date of birth, G.P., key contacts, medical information, whether risk assessments and restrictive practices are in place and details of planned visit times, duration and a description of what each visit is intended to support the person’s independence with. See the Link File for the current version of a support plan.
The **person centred plan** includes:

- The person’s biography
- A description of what is important **to** the person – describing the person’s preferences (food, person care, social etc.), routines, interests and what is important to the person’s wellbeing and quality of life.
- A description of what is important **for** the person – which looks at areas of health and daily living (e.g. diet, medications, finance, continence, safeguarding).
- The person’s reablement plan outcomes.

The person centred plan (PCP) is created through a conversation with the individual that maximises the opportunities for the person to lead the process and leads to a discussion of what outcomes are important to the person, so that the Independence at Home Team understands how it can support the person to achieve their outcomes.

Having completed this section you should now be able to explain:

- What an outcome is
- How outcomes are set

Manager’s Comments
Section 8 Supporting, Reviewing & Recording

Supporting the Person

Once the person centred plan has been completed each reablement outcome is written on a separate sheet and then placed in the person’s link file. The sheet includes space to record the staff member’s and the person’s comments on their progress towards their objectives.

For example an outcome might be “to be able to wash and dress myself and to able to have a shower/bath without any help”

Your role would be to help support the service user to acheive the goals, record the person’s progress on the Reablemmt Outcomes sheet, and report any issues or concerns to the CSM.

Progress towards reaching outcomes will vary from person to person and it is vital that we support the person when they may be tired, frustrated or struggling with a task. We can use a number of different tools to assist service users including:

Acknowledgement

Acknowledge that you have understood the person’s experience of pain/anger/anxiety/frustration by what you say or do. For example if they are finding a task difficult, acknowledge this but emphasise and focus on what they are achieving despite how they feel.

Giving Feedback

Giving feedback is important to establish rapport and trust. Discuss and remind the person of your purpose and the positives of reablement. Ask them how they think they are getting on in terms of achieving their objective and tell them how you feel they are doing, be open and honest but always follow up by positive suggestions.
**Negotiation**
It is vital to negotiate on a daily basis with the person you are working with on the enabling aims and compromise where necessary. People may achieve different things every day due to health issues or how they are feeling. People will have different expectations of what you are there to do and expect you to complete tasks they are able to achieve, negotiation may be necessary to resolve this and ensure the person is progressing.

**Structuring**
The person’s reablement outcomes are co-produced by the person and the CSM. These are recorded on a template kept in the person’s link file. The template includes space to record the outcome, and any further steps /prompts needed to help the person achieve their outcomes. The rest of the template is for support staff and the person to record progress towards outcomes.

Each task you support the person to achieve must be structured in order to set boundaries and consistency; this gives a sense of control and safety to both the carer and the service user. Please try to encourage the service user to complete the task in accordance with the plan as they may put themselves at risk.

If you or the person feel the task can be achieved differently feedback to the office before trying to attempt it with them.

**Demonstrating**
The person may find it helpful if the support worker demonstrates the activity they are required to do, this can be done by:

- Guiding
- Verbally prompting
- Physically prompting

This allows the person to develop skills and enhance performance and helps to maintain their attention to the task at hand.

**Encouraging**
Positive reinforcement is key to the whole reabling process. This is the use of positive words and reassurance (even in difficult situations) to encourage the person to achieve their aim. In this way they can build on skills and increase confidence through trial and error and work towards task completion.
Problem Solving
Step back! Allow the person to make mistakes. Remember this is a learning or re-learning process for them. Give them time to explore and solve some of the problems they are having and find their own solutions. Use open questions.

- How does that feel?
- What works best for you?
- How did you manage to do this before?
- Where do you normally keep that?

Equipment
There is a variety of different pieces of equipment that can safely promote independence and reduce risk to the person. Telecare should always be considered when putting in place a reablement plan. An occupational therapist or member of staff competent in enhanced assessment can recommend equipment. This can be purchased on the high street, online or loaned to the person. Some examples of equipment are:

**Dressing equipment**
- Long handled shoe horn
- Sock aid
- Dressing stick
- Button hook

**Mobility**
- Helping hand
- Bed blocks
- Chair raisers
- Leg lifter
- Cantilever table

**Telecare**
- Temperature extremes sensor
- Medication Reminder
- Personal pendant
- Bogus caller alarm
- Empty bed sensor and many more

**Kitchen Equipment**
- Plate surround
- Foam handled – knife/fork/spoon
- Rocker knife
- Dycem
- Belliclamp
- Small travel kettle

**Personal Care**
- Long Handled Sponge
- Bath board
- Wall fixed rails
Reablement Service Link Files

If the person agrees a copy of the paperwork will be kept in their home in a blue folder called a Reablement Service Link File.

The link File is given to everyone who receives support from the Promoting Independence / Reablement Service. It contains important information about the person and the Independence at Home service including

- The Support Plan.
- Contact names and numbers
- Important details about the person, for example, the name of next of kin and Doctor.
- Two Assessments of Risks (Environmental & Personal) – these identify anything that needs to be considered to ensure the safest method of providing support for both the person and the support workers
- Diary sheets (Cfrec 1s) / continuation recording sheets for Support Workers to record their visits and the tasks they have completed and information on your general wellbeing.
- Medication Record.
- A section for the person to add their views and comments.

As a support worker you must check the link file each time you visit the person. This will help you understand what is going on with the person, see their progress towards their reablement outcomes and see relevant notes from the person and other support staff. You should also use the file to record after each visit.

At the start and end of each visit you scan the disc on the front of the link file with your mobile phone. This will keep an electronic record of the start and end of your visit times.

Please speak to your supervisor for further details about the content of the link file and your expectations in using the file.

Reporting concerns

Concerns about the general progress of the person toward their reablement outcomes should be reported to the managing CSM at the earliest practical opportunity. This might be within the call itself, or at the next convenient gap in your work plan. Early reporting allows the CSM the best opportunity to intervene effectively, and turn the situation around.

If the managing CSM is not available, you can report the situation to Duty who will pass on the information to one of the CSM’s “buddy” colleagues. (CSMs work in groups to cover each other when off-shift or otherwise unavailable).

Situations to report are:

- Person is unwell or tired, and temporarily unable to maintain progress
Having completed this section you should now be able to explain:

- how and where to record information about the person
- when and who to refer concerns regarding the person’s progress

Concerns about a sudden change in the person’s health or a situation which places them at risk of harm should be reported to the IAH Duty office by telephone immediately. Depending on the situation, they will advise about your immediate actions and will take forward any actions at the office end.
Appendix A

JARGON BUSTER
Some of the key terms you need to know

These are taken from Think Local, Act Personal Care and Support Jargon Buster (last accessed December 2017). They are written to be relevant to all people, not just professionals. For more details see:
https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/

Activities of Daily Living
Things you do every day to look after yourself, such as eating, washing, dressing and using the toilet. An assessment of your needs will look at how well you can manage your activities of daily living, and what help and support you need.

Acute Care
Health care that you receive in hospital following an injury, operation or illness. It is different to any care you may receive for an ongoing health condition from your GP, community nurse or other professionals in the community where you live.

Aids and Adaptations
Help to make things easier for you around the home. If you are struggling or disabled, you may need special equipment to enable you to live more comfortably and independently. You may also need changes to your home to make it easier and safer to get around. Aids and adaptations include things like grab rails, ramps, walk-in showers and stair-lifts.

Assessment
The process of working out what your needs are. A Care Act assessment looks at how you are managing everyday activities such as looking after yourself, household tasks and getting out and about. You are entitled to an assessment if you appear to have social care needs, and your views are central to this process.

Asset Based Approach
A way of helping people by looking at what they have, rather than what they lack. This approach helps people make use of their existing skills, knowledge and relationships. It is also called a 'strengths-based approach', and can be used as a way of improving local areas, by promoting what is good about an area rather than focusing on problems. See also co-production.

Care Act 2014
A law passed in England in 2014 that sets out what care and support you are entitled to and what local councils have to do. According to the law, councils have to consider your wellbeing, assess your needs and help you get independent financial advice on paying for care and support.

Co-production
When you as an individual are involved as an equal partner in designing the support and services you receive. Co-production recognises that people who use social care services (and their families)
have knowledge and experience that can be used to help make services better, not only for themselves but for other people who need social care.

**Direct Payments**
Money that is paid to you (or someone acting on your behalf) on a regular basis by your local council so you can arrange your own support, instead of receiving social care services arranged by the council. Direct payments are available to people who have been assessed as being eligible for council-funded social care. They are not yet available for residential care. This is one type of personal budget.

**Integrated Care**
Joined up, coordinated health and social care that is planned and organised around the needs and preferences of the individual, their carer and family. This may also involve integration with other services for example housing.

**Personal Assistant**
Someone you choose and employ to provide the support you need, in the way that suits you best. This may include cooking, cleaning, help with personal care such as washing and dressing, and other things such as getting out and about in your community. Your personal assistant can be paid through direct payments or a personal budget.

**Personal Budget**
Money that is allocated to you by your local council to pay for care or support to meet your assessed needs. The money comes solely from adult social care. You can take your personal budget as a direct payment, or choose to leave the council to arrange services (sometimes known as a managed budget) - or a combination of the two.

**Person Centred Care**
An approach that puts the person receiving care and support at the centre of the way care is planned and delivered. It is based around you and your own needs, preferences and priorities. It treats you as an equal partner, and puts into practice the principle of 'no decision about me without me'.

**Prevention**
Any action that prevents or delays the need for you to receive care and support, by keeping you well and enabling you to remain independent.

**Resource Allocation System**
The system some councils use to decide how much money people get for their support. There are clear rules, so everyone can see that money is given out fairly. Once your needs have been assessed, you will be allocated an indicative budget - so that you know how much money you have to spend on care and support. The purpose of an indicative budget is to help you plan the care and support that will help you meet your assessed needs - it might not be the final amount that you get, as you may find that it is not enough (or is more than enough) to meet those needs.

**Safeguarding**
The process of ensuring that adults at risk are not being abused, neglected or exploited, and ensuring that people who are deemed 'unsuitable' do not work with them. If you believe that you or someone you know is being abused, you should let the adult social care department at your local council know. They should carry out an investigation and put a protection plan in place if abuse is happening. Councils have a duty to work with other organisations to protect adults from abuse and neglect. They do this through local safeguarding boards.

**Secondary care**
Care that you receive in hospital, either as an inpatient or an outpatient. This may be planned or emergency care. It is more specialist than primary care.
Self-care
Things you do for yourself to keep yourself as healthy and well as possible. It is everything from eating healthy food, to looking after minor illnesses, to managing a long-term condition such as diabetes. It does not mean managing completely on your own without a doctor, nurse or other professional.

Social Model of Disability
A way of looking at disability that looks at the person not their physical disability, and says that the person is disabled by the barriers in the world.

Telecare
Technology that enables you to remain independent and safe in your own home, by linking your home with a monitoring centre that can respond to problems. Examples are pendant alarms that you wear round your neck, automatic pill dispensers, and sensors placed in your home to detect if you have fallen or to recognise risks such as smoke, floods or gas-leaks. The monitoring centre is staffed by trained operators who can arrange for someone to come to your home or contact your family, doctor or emergency services.

Wellbeing
Being in a position where you have good physical and mental health, control over your day-to-day life, good relationships, enough money, and the opportunity to take part in the activities that interest you.

Appendix B – Credits
Written by Bola Ajani, June 2011
With thanks to: Tim Wilson, Debbie Greening, Helena Grace and Julian Seaborne
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