8

REABLEMENT PROCESS

8.1 What is reablement?

Reablement is the process of helping a service user regain confidence and the ability to carry out activities of daily living and self-care for themselves, in order to restore or improve their level of independence and reduce the need for long-term support, following a crisis in their lives (e.g. being in hospital). Reablement is a time-limited intervention usually of up to six weeks, but can be longer in certain circumstances e.g. for 12 weeks following a stroke. Reablement is free to all those who are eligible for adult social care.

There is a range of services that can support the reablement process:

- the in-house Reablement Home Care team;
- the Community Rehabilitation Team (CRT) which is managed by Health and includes input from occupational therapists and physiotherapists;
- bedded rehabilitation services, which include Alexandra Unit, Ellesmere and Thamesbrook, accessed via the CRT;
- telecare.

8.2 When to use reablement

Reablement services can be accessed either from the community or from hospital.

Reablement should always be considered first before developing a longer-term support plan or care plan. Offer reablement services to service users if there is potential for the person to become more independent. Reablement is a new concept for many service users and needs to be explained carefully. Some service users may believe that care should always be provided. Be sensitive about their concerns but explain the benefits in terms of increased independence and less need for care and support longer-term. Explain...
that it is important for the service user to engage positively in the process (if their cognition or mental health allows them to do so) if they are to regain independence.

The period of reablement is up to six weeks; it can be for a shorter period where appropriate. Reablement is not ‘six weeks of free care’.

Service users unlikely to benefit from reablement include those who require palliative care or continuing health care.

If you are unsure about whether there is potential for a service user to become more independent through reablement, discuss the case with your team manager.

8.3 Other reablement routes

- Learning disability service users follow their own reablement programme within the Learning Disabilities service.
- Mental health and drug and alcohol service users follow recovery models within their own service.

8.4 Setting up reablement

Completing the assessment has automatically opened a care plan. Identify the outcomes to be aimed for during the period of reablement and develop a care plan to achieve them.

If the service user is being discharged from hospital and previously had a care plan, then where appropriate, un-suspend all homecare, meals or direct payments on all the relevant ASCC documents where appropriate

Record this care plan on ASCC.

Please Note: This care plan is a plan for the reablement period of up to six weeks. It may include actions that need to be started immediately to address longer-term needs. It will be reviewed after four weeks to see what longer-term plans are needed, including considering the option of a support plan and direct payments. See 8.

Manager

Check and sign off the care plan.

Once your manager has signed off the care plan, refer the case to the relevant reablement service. If this is the Reablement Home Care service, then use the Referral to Reablement Service form. For other services, use their referral forms. Go to Sn 8.

The Home Care reablement supervisor contacts the service user and arranges a home visit to develop a detailed service plan. The supervisor contacts the Emonitoring Team to create the order.

The reablement manager gives the referrer potential dates and times of service to start. Following the assessment the reablement manager confirms these with the referrer and Emonitoring team.
8.5 Reviewing reablement and determining the next steps

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