

## REGIONAL REABLEMENT SERVICE FOR NORTHERN IRELAND

### BRIEFING/POSITION PAPER:

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 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. This is 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”.**

## ***Scope***

The Reablement service is a community-based service which will be accessible and available across Northern Ireland, in the first instance within the Older People’s programme of care (65+) with an expectation that through time it would be phased into other adult services. It will be specifically targeted at those 65+ and who are:

- ✓ on the threshold of requiring a Domiciliary Care package or where an increase in an existing care package has been requested.
- ✓ experiencing a health or social care crisis, such as illness, deterioration in health or injury that affects their daily living activities.

## ***Service Delivery***

A Reablement service is a planned, intensive and time-limited service lasting 6 weeks or less designed to maximise the Service User’s independence. A Reablement Occupational Therapist carries out a functional assessment of the Service User’s daily living activities which will identify the areas for improvement . The Reablement Occupational Therapist and the Service User will jointly agree the goals required to move toward independence and these will be reflected in the Regional Maximising Independence Plan which will be used to chart the Service User’s progress.

---

The Reablement service will operate 7 days per week with the frequency and duration of visits determined at the initial assessment. However as the Service User progresses towards achieving their independence the length and the frequency of the visits will be reviewed and reduced by the Reablement Occupational Therapist in accordance with changing needs.

Reablement support will be delivered by specifically trained Reablement Support Workers who will enable the Service User to regain their independence in areas such as:

- personal care;
- transfers (eg in and out of bed, chair);
- medicine management;
- meal preparation;
- improving quality of life through social interaction.

At the end of the Reablement service, many Service Users will be able to live independently in their own homes. However, if at the end of Reablement the Service User has ongoing needs, these will be discussed with the Service User, and appropriate support to meet their assessed need will be provided.

### ***Partnership Working with the Community and Voluntary Sector***

Once a person is discharged from Reablement it is important to maintain their social, emotional, physical and psychological independence. In order to achieve this Health and Social Care organisations along with the Community and Voluntary sector and other statutory organisations will be required to work together to identify existing services within localities to promote healthy ageing and wellbeing. Where gaps exist further work will be required to meet the needs of Service Users.

### ***Performance Management and Benefits Realisation***

The principal benefit of Reablement is that, if successful, it can:

- reduce hospital admissions;
- support timely hospital discharge;
- increase the Service User's choice and autonomy;
- reduce reliance on family;

- 
- delay the need to commence domiciliary care;
  - delay the need for an increase to an existing domiciliary care package; and
  - reduce admission to residential and nursing homes.

To monitor the impact of Reablement the Health and Social Care Board and Trusts have developed a minimum dataset to monitor Reablement outcomes by taking into account a range of key areas including:

- ✓ 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;
- ✓ numbers of Service Users entering residential and nursing home care.