# REABLEMENT IN GLASGOW

# Quantitative and Qualitative Research

A report by

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- Service users who participated in the qualitative face to face interviews
- Reablement staff who participated in the Force Field analysis session (Social Work, Cordia & North East Rehabilitation Team)
- Reablement/ mainstream staff who participated in the Survey Monkey questionnaire (Social Work, Cordia & North East Rehabilitation Team)
- Reablement Steering Group
- North East Operational Managers Group
- Reshaping Care – Care at Home group
- The Joint Improvement Team

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## EXECUTIVE SUMMARY

### Introduction

March 2012 quantitative and qualitative research began in Glasgow's North East Reablement pilot area.

- The aim of the quantitative research was to collate views and opinions of service users who had gone through the 6 week reablement programme. The information was gathered via telephone interviews using a template Survey Monkey questionnaire. **A total 73 interviews were conducted**.
- The aim of the qualitative research was to carry out a longitudinal study to examine the impact of reablement taking account of service user and stakeholders views in terms of satisfaction levels, reablement processes and any arising issues. The following methods were used to capture views and opinions :
  - Cross Agency Reablement/ mainstream staff:- force field analysis focus group (**11 staff**); Survey Monkey online questionnaire **(18)**; face to face interviews **(13)**
  - Service users:- Four face to face interviews per service user over a six month period (**13**)

The following additional information was used to support the research above:

- Performance Activity Data:- This included North East service users data where clients had been supported through reablement during periods 4, 5 and 6 (**181 service user cases)**
- Case Studies – **2** (one Social Work involvement and one NE Rehabilitation Service)
- Cordia Home Care, Care Inspectorate Inspection Report 2012
- Staff Action Plans
- Reablement DVD

### Performance Activity Data (181 service users)

- Total hours reduced from 1731 at point of hospital discharge to 839 at end of reablement. Equates 51.53% reduction. Total hours reduced to 770 following transfer to mainstream services. Equates 55.2% since point of hospital discharge. Number of days in reablement ranged from 2 to 82 days with average being 33 days
- A third 66 (36.46%) service users were on zero hours at the end of reablement period i.e. did not transfer to mainstream. Average reablement days for these clients was 27 days. Average hours at point of discharge was 8.04 per week. At period 6 only 5 service users recommenced home care where hours per week ranged from 1 to 6.25

- 115 (63%) service users continued with mainstream home care at end of reablement. Average days of reablement was 36. The average weekly hours at point of discharge was 10.44 hours per week.
  - 12 (10.43%) weekly plans were higher at end of reablement compared to hours of discharge
  - 28 (24.35%) weekly plans were the same at end of reablement compared to hours of discharge
  - 75 (65.22%) weekly plans were lower at end of reablement compared to hours of discharge.

**Service User Consultation**

Information below is based on qualitative and/ or quantitative data

- 10 (76.92%) service users said they were seen within 24 hours of being discharged from hospital; 1 (7.69%) was seen after 2 days and 1other (7.69%) after 3 days.
- 7 (53.85%) individuals fully understood what reablement was about after the initial discussion; 4 (30.77%) part understood it; 1 (7.69%) did not understand at all; and 1 (7.69%)was unsure
- 6 (46.15%) individuals had received some information about reablement compared to 4 (30.77%) who did not. Three (23.08%) were unsure.
- 8 (61.54%) service users said goals had been discussed with them compared to 3 (23.08%) who said they had not. One (7.69%) was not sure
- 11 (84.62%) said they were confident in achieving goals set. Of these 10 (90.91%) gave favourable comments on goal setting.
- In terms of frequency, the type of support service users required the most via reablement service included personal care needs, mobility within the home, and preparation of meals.
- Majority of service users said they were satisfied with the reablement service received.
- A significant number of service users said they were able to ‘resume their usual activities’ (82% quantitative) and ‘do more things for themselves’ (74% quantitative and 69% qualitative) after having gone through reablement.
- Over half 41 (56.16%) required less support at the end of reablement whilst 25 (34.25%) required the same.
- Staff were highly praised by a significant number of service users in both studies carried out.

- At the end of the reablement service the qualitative research showed that all service users were able to sustain the lower hours of homecare achieved or remain independent within the community
- Transition from reablement to mainstream homecare had been smooth for all but one service user.

**Staff Consultation**

**1. The initial consultation with staff included Force Field Analysis. (Social Work, Cordia & North East Rehabilitation Service NERS)**

- Forces working towards reablement included: - less stress for some staff, networking, communication, quality time with service users, dedicated time, saving money, increasing service user independence, quick reviews, speed of OT assessments, goal driven, person centred, and interagency work.
- Forces working against reablement included:- increased workload; difficulty fitting into other agency systems; communication; inappropriate referrals; duplication; paperwork; emergency cases & home care work time; changing guidelines; confusion over who provides OT service.

The above findings of staff consultation were presented to Reablement Steering Group for discussion. Themes emerging from the analysis were useful in compiling questionnaires for next phase of staff consultation.

**2. The second consultation with staff included Survey Monkey Questionnaire** – 31 staff completed the survey.

- What worked well for staff:
  - Staff's understanding of reablement and its principles
  - Joint goal setting with service users
  - Work satisfaction
  - Skills gained through Reablement were seen to be good for personal development
  - Positive feedback received from service users and families
  - Training. Meetings/ briefings, talking to colleagues, reablement information circulated were also helpful
- What needed to improve for staff:-
  - **Social work**: - clearer roles & responsibilities for OT's; assessment paperwork; structured policy & procedures; too much autonomy; dedicated time to do reablement admin work .

- **Cordia Reablement Staff**:- screening; slow Rehab OT input; medical information available at discharge; sensitivity towards service user at changeover to mainstream; reablement lower than anticipated numbers
- **Cordia Mainstream Staff**: - meet reablement homecare staff face to face at changeover; have access to reablement client diaries; be included in reablement discussions/ meetings/ training; medical information; time factor; staff resource depleted due to reablement.
- **NE Rehabilitation Service**:- A separate Reablement OT service should be set up instead of using half social work and half NE Rehabilitation Service; staff resource; roles & responsibilities; co-ordinating joint visits; access to admin; accessing copies of assessments; paperwork; communication

**Case Studies & DVD**

Two anonymised case studies were included in the research. One with social work Occupational Therapy involvement and the other NE Rehabilitation Service. Both studies show the client journey: - background information; hospital admission; OT assessment & goal setting; support provided; and outcomes.

In addition to this "Cordia have produced a short video that explains the Reablement service and shows the benefits of it with the use of two real-life case studies." The video is available on the Cordia website at:

*http://www.cordia.co.uk/Our-Services/Home-Care/Reablement.aspx*

**Overall Findings & Discussion (fuller discussion page 30)**

1. **Limitations of the qualitative research include:** - unforeseen circumstances resulted in the control group & unpaid carer group consultations not taking place; poor staff response from the staff consultation, particularly Social Work and NE Rehabilitation Service; limited research resource time.

2. **Reablement Outcomes:** - Methods used to capture data for this research provided sufficient evidence to support the effectiveness of reablement in terms of positive outcomes achieved. The following outcomes were significant in relation to levels of home care support required by service users at the end of reablement:

    a. A sizeable proportion of service users went on to be independent in the community and most were able to sustain this over a period of time

    b. Where home care recommenced for those independent in the community, number of hours of support provided was small

c. Service users who had moved onto mainstream home were mostly on reduced home care packages

The above outcomes were also certified by Cordia's inspection study which reported:-

> *"The reablement programme continued to expand across the city of Glasgow. We shadowed and talked with reablement staff and were particularly impressed by the focused goal planning that went in to responding to the clients changing care needs and central role that the home care worker had in this process. This was summed up by one client who told us, 'I used to be a nursing officer so I can say with confidence they do a good job.' Consequently, we found that many residents no longer needed the services of a home help service or only a reduced service as a result of the reablement teams work."*

Outcomes in relation to service user empowerment, confidence and ability to do things for themselves were also evidenced through the Survey Monkey telephone interviews and qualitative research interviews.

3. **Service User Satisfaction**: - Both quantitative and qualitative research reported that most service users were satisfied with the reablement service. This was equally evident through Cordia's inspection report, case studies and reablement DVD. Service users were given the opportunity to speak openly on all aspects of the reablement service from the initial social work visit at home, assessment, sharing of information, staff interaction, to the handover from reablement to mainstream where required. Service users said they felt empowered by the service received and in most cases showed that they felt confident and able enough to sustain the outcomes achieved at the end of reablement.
4. **Handover from reablement to mainstream**: - Most service users said the transition from reablement to mainstream homecare, where required, had gone smoothly. However, many Cordia mainstream staff felt the contrary and wanted issues resolved raised by them through the Survey Monkey questionnaire. Consequently, Cordia conducted a separate survey with its staff to discuss this and other issues raised.
5. **Staff have their say**: - Force field analysis and Survey Monkey consultation allowed staff to say what was working in terms of reablement and where challenges still existed. Discussions were taken to the Reablement Steering Group and each agency was held accountable for following up on the issues relevant to their agency. Action Plans were ultimately devised and followed through to tackle matters in hand.

6. **Staff satisfaction:** - Overall, staff across all three agencies were satisfied with the principles of reablement but were equally aware that existing challenges needed to be resolved for the service to function to its full potential. Many benefits of the service were listed of which improved communication, sharing of information and networking were the most common.

**Next Steps**

- Research study to be used to inform wider roll out programme of reablement across the City
- Undertake desk top research to scope paraprofessional roles and responsibilities within reablement
- Repeat cross agency staff consultation exercise to monitor views and opinions further down the line
- Pass research report to Joint Improvement Team as well as putting on to Connect and Internet

## 1. INTRODUCTION

In March 2012 two internal research projects were set up to collate quantitative and qualitative data in respect of the reablement pilot carried out in the North East area of Glasgow. The research work was overseen by a multi disciplinary Reablement Steering Group with representation from Social Work, Health, Cordia Homecare, Customer and Business Service, and the Joint Improvement Team. In the early stages of its work, a short term sub group with members from the Steering Group was set up to support the qualitative research. The findings of both research studies were ultimately to be used to inform the wider reablement roll out programme across the city as well as the North East area.

Within the body of this report essential reablement data has been incorporated from other areas of work endorsed by the Reablement Steering Group adding weight to the research strands as outlined above and in section 2 below. This includes: - performance activity, case studies, home care Care Inspectorate report, staff action plans and reference to a reablement DVD. This work has been included under quantitative/ qualitative headings – see Section 5 Methodology.

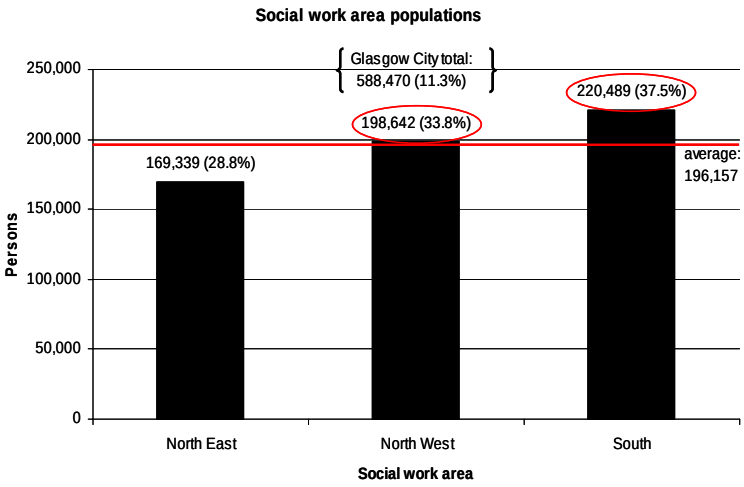
The Cordia Home Care, Care Inspectorate report (December 2012), as mentioned in the above, was opportune in its release in that Glasgow's reablement research was coming to an end and had something concrete and robust to compare its findings with which had used similar (also additional) methodologies in capturing its information. Findings of both pieces of work were similar in terms of the outcomes/ benefits of reablement which will be discussed later under Section 7.

## 2. AIMS

The purpose of the research studies was:-

| QUANTITATIVE RESEARCH | QUALITATIVE RESEARCH |
|---|---|
| • To collate views and opinions of service users within North East social work area having gone through the 6 week reablement programme. | • To carry out a longitudinal study to examine the impact of reablement on stakeholders in terms of satisfaction levels, reablement processes and any arising issues. |

## 3. North East Glasgow Demographics




With an estimated population of 588,470, Glasgow City contains the highest proportion, 11.3%, of Scotland's estimated population of 5.19 million (GROS '2009 Small Area Population Estimates'). Of the total population, 169,339 (28.8%) is in North East area of the City; 198,642 (33.8%) in North West area and 220,489 (37.5%) in South.

North East's population comprises of 33,417 (19.7%) children 0-17, 110,893 (65.5%) adults 18-64, and 25,029 (14.8%) older people 65 and over, with the highest rate of older people among the three areas (North East Social Work Area Fact Sheet 2011).

## 4. Research Context

In Scotland, "Developing Care at Home Services has been crucial to the Reshaping Care for Older People programme where the Joint Improvement Team (JIT) has supported a programme to assist local partnerships with service reviews and redesigns. The thrust of the programme has focused on care at home services by redesigning care at home, complemented by reablement and rehabilitation models to optimize the capabilities of older people." Glasgow has benefited greatly from this input and the support from JIT at its Reablement Steering Group meetings.

"In February 2009 JIT/ ADSW Home care group carried out a research to show progress of Councils providing reablement across Scotland" a useful tool for any Council about to embark on its reablement work. http://www.jitscotland.org.uk/action-areas/care-at-home/

In 2009 Edinburgh Council commissioned evaluation study provided additional food for thought for Glasgow and other Councils starting their own reablement journeys.

Generally, at a national level, most reablement evaluation studies undertaken tended to collate quantitative and/ or qualitative data and more often then not were longitudinal. Studies differed in that some local authorities opted to commission/ contract out their research to independent bodies (Leicestershire County Council 2000; Edinburgh 2009)) whilst others conducted their own (East Dorset 2010). A significant number of research studies were carried out by Joint Improvement

Teams/ Partnerships or Research Bodies focusing on numerous local authorities than just the one (Yorkshire & Humber 2010; Whole Systems Partnership CSED 2011; Social Policy Research Unit 2010).

The Care Services Efficiency Team (CSED) in England identified and developed more efficient ways of delivering adult social care. The programme closed on 31 March 2011 and developed a website with abundant information on reablement in terms of research, tool kits, good practice and case studies. CSED also produced a report on local authorities outsourcing their reablement service showing successes and tendering arrangements. (http://democracy.york.gov.uk/(S(vm2jryv2bb4a1b55jhhfq1qp))/documents/s48487/Annex%20B2%20Call-in%20Reablement%20Service.pdf)

There was some uniformity in the findings of the literature researched where the following was commonly reported on:

- Reablement as cost effective service where prevention and early intervention has paid off.
- Evidence of reduction in home care hours or service no longer required at the end of reablement period.
- Reablement promoting independence, empowering service users and improving quality of life
- Cross agency interaction and lessons learned – roles & responsibilities
- The importance of Homecare and OT service
- Staff support required
- Family members/ carers benefitting from reablement as well as service user
- Various models used and benefits or issues with each.
- Performance reporting – paperwork and toolkits used
- Cases studies

## 5. METHODOLOGY

### 5.1 Quantitative research

5.11 Performance Activity Data

Reablement activity data for periods 4, 5 and 6 was analysed where the service had been fully completed.

5.12 Survey Monkey Questionnaire

All service users at the end of the reablement period were contacted by telephone and offered the choice to participate in the research. Where service users agreed to take part, questions from an online Survey Monkey form were read out and completed over the phone by North East area administration staff. Please note that in a small number of cases a family member may have provided the information required to complete the questionnaire.

### 5.2 Qualitative research

The qualitative research methodology was more complex in its approach and the following factors had to be taken into consideration:

5.21 Stakeholders Involved

The number of individuals to be involved in the consultation was influenced by:

- Research staff resource and
- Survey timescales.
- Stakeholders willingness to participate

Stakeholders to be consulted included - **reablement and some mainstream staff** (Cordia; Social Work Services; and NE Rehabilitation Service); **reablement service users**; **control group service users**; and **unpaid carers**.

Where possible, all reablement staff would be included in the survey for consultation or a proportional representation taken where numbers were deemed to be too large i.e. all admin staff from each agency would be included but only a sample of reablement home care staff.

Health and Social Care Direct staff, although part of the reablement discussions, were not included in the consultation as it was felt their input to reablement was from the periphery. A total 106 stakeholders were targeted for consultation – see table below.

**Stakeholders Targeted for Consultation**

| Service Users | Unpaid Carers | Social Work Staff | Cordia Staff | NE Rehabilitation Service |
|---|---|---|---|---|
| 20 reablement service users (North East Area)<br>20 control group service users (North West Area) | 10 unpaid carers | 3 admin<br>5 OT's<br>5 Social Care Workers<br>2 Team Leaders | 1 reablement co-ordinator<br>11 reablement home carers<br>1 mainstream co-ordinator<br>10 mainstream home carers<br>1 admin | 2 admin<br>5 nurses<br>3 OT's<br>4 physio's<br>3 support workers |

5.22 Methods of Consultation

**(i) Reablement Service users**

Four face to face interviews with each service user were conducted over regular intervals using semi structured questionnaires. The first interview was staged at the start of reablement, the second at the end of reablement, the third 6 weeks from when reablement finished and the final interview 6 weeks after the third interview. This provided valuable service user outcome data over a period of time from the start of reablement to beyond over a 6 month period i.e. numbers admitted back into hospital, moving onto mainstream or becoming independent in the community. Areas of satisfaction and dissatisfaction experienced by service users were also captured.

**(ii) Control Group Service users**

Consultation with the service user control group within North West social work area failed to take place as there was no uptake for the research study.

**(iii) Unpaid carers**

Face to face interviews with unpaid carers also failed to materialise as carer uptake from North East area was reported to be poor.

**(iv) Staff**

Reablement and some mainstream staff involved with reablement service users were consulted for the study i.e. Cordia mainstream involvement at the end of reablement; NE Rehabilitation Service OT's, physiotherapists & nursing staff.

Methods employed for the consultation included:

- Focus group session using force field analysis
- Face to face interviews using Survey Monkey questionnaire template
- Online Survey Monkey.

5.23 Case Studies & Home Care DVD

Two anonymised case studies have been included in the report to show reablement at work within Glasgow where one study focuses on Social Work involvement and the other NE Rehabilitation Service involvement.

In addition to this, Cordia Home care produced a short video focussing on two real life case studies. The cases highlight the benefits of reablement which are fully endorsed by the findings of this research study.

## 6. ANALYSIS

### 6.1 Performance Activity Data

The following analysis is based on "Fully Completed" cases during Periods 4; 5; and 6 in Glasgow's North East area.

181 service users 'fully completed' reablement during this 12 week period of which a third 57 (31.5%) had NE Rehabilitation Service involvement and 122 (67.4%) Social Work.

6.11 Summary Analysis

| Hospital discharge and end of reablement period hours | <65 | >65 | Total |
|---|---|---|---|
| Total hours at point of hospital discharge | 120.5 | 1610.75 | 1731.25 |
| Total hours at end of reablement period | 36.5 | 802.75 | 839.25 |
| Total hours following transfer to | 35.5 | 734 | 769.5 |
| No. of service users | 12 | 169 | 181 |

The table on the left shows a summary analysis of the service reduction on hours at hospital discharge, end of reablement and transfer to mainstream.

The overall total number of hours reduced from 1731 at the point of hospital discharge to 839 **at the end of the reablement period**. This equates to a reduction of 51.53%, of which:

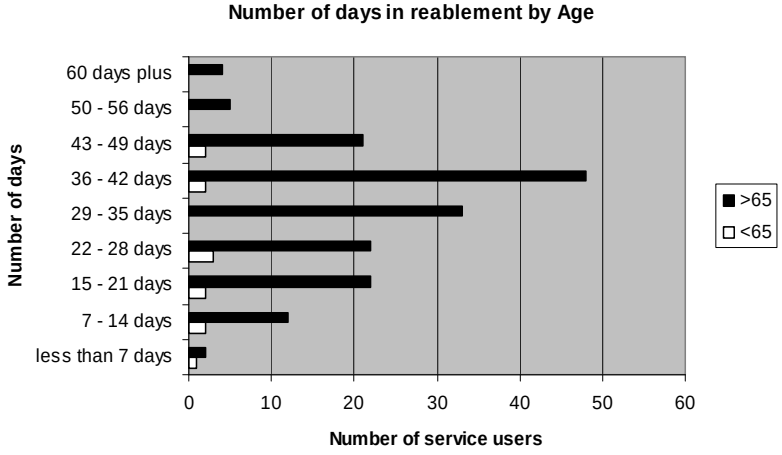
- Age 65+ (169 service users): 1611 hours reduced to 803 hours (50.16%)
- <65 (12 service users): 120 hours reduced to 36 hours (70%)

The overall total number of hours reduced to 770, **following transfer to the mainstream services**. This represents a reduction of 55.52% since the point of hospital discharge, of which:

- Age 65+ (169 service users): 1611 reduced to 734 hours (54.44%)
- <65 (12 service users): 120 reduced to 36 hours (70%)

6.12 Period of Reablement Service

The number of days in reablement ranged from 2 days to 82 days, with an average of 33 days. The graph on the left shows the statistics from the available data:



## 6.13 No Further Service Required

| Reablement Time period | <65 | >65 | Total | % |
|---|---|---|---|---|
| less than 7 days | 1 | 2 | 3 | 4.5% |
| 7 - 14 days | 2 | 7 | 9 | 13.6% |
| 15 - 21 days | 2 | 11 | 13 | 19.7% |
| 22 - 28 days | 2 | 13 | 15 | 22.7% |
| 29 - 35 days | | 9 | 9 | 13.6% |
| 36 - 42 days | | 11 | 11 | 16.7% |
| 43 - 49 days | | 4 | 4 | 6.1% |
| 50 - 56 days | | 1 | 1 | 1.5% |
| 60 days plus | | 1 | 1 | 1.5% |
| Total | 7 | 59 | 66 | 100.0% |

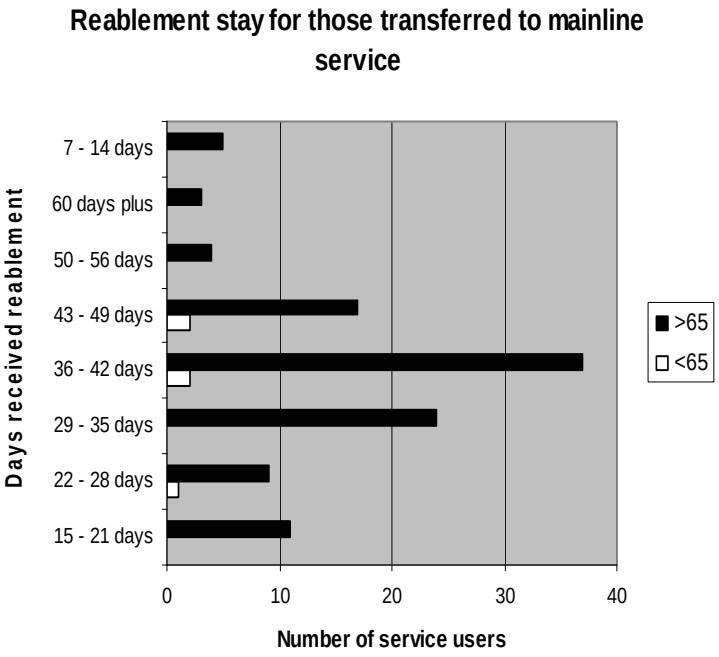
| Number of hours at point of discharge | <65 | >65 | Total |
|---|---|---|---|
| 1 | | 1 | 1 |
| 3.5 | 3.5 | 63 | 66.5 |
| 5 | | 5 | 5 |
| 7 | 7 | 77 | 84 |
| 7.5 | | 30 | 30 |
| 8 | 8 | 16 | 24 |
| 10.5 | | 115.5 | 115.5 |
| 11 | 11 | 22 | 33 |
| 14 | 14 | 98 | 112 |
| 14.5 | | 14.5 | 14.5 |
| 15 | 30 | 15 | 45 |
| Total | 73.5 | 457 | 530.5 |
| average | | | 8.04 |

The table above left shows that 66 service users were on zero hours at the end of the reablement period, i.e. did not transfer to mainstream (of which 7 were under 65 years). The average reablement period for these service users was 27 days.

The table above right shows the average weekly hours at the point of discharge as 8.04 hours per week.

As at Period 6, only five of the above service users recommenced a home care service (all age 65+) where hours per week received ranged from 1 to 6.25.

## 6.14 Continuing Home Care Service




| Hours at discharge | <65 | >65 | Total |
|---|---|---|---|
| Total hours at hospital discharge | 47 | 1153.75 | 1200.75 |
| Total service users | 5 | 110 | 115 |
| average weekly hours | | | 10.44 |

The above table shows that following on from their reablement service, 115 service users continued with a mainstream home care service (of which 5 were under 65 years). The average reablement period for these service users was 36 days – see graph on the left. The average weekly hours at the point of discharge was 10.44 hours per week – above table.

## (i) Amendment to plan during the reablement period:

| Service users with packages increased | <65 | >65 | average hours per week >65 | Total |
|---|---|---|---|---|
| Total hours at hospital discharge | 3.5 | 87 | 7.91 | **90.5** |
| Total hours at end of reablement | 6 | 136 | 12.36 | **142** |
| Total number of service users | 1 | 11 | | **12** |
| **Total average hours increase** | | | | **4.29** |

Table above: 12 service users where the weekly plan was higher at the end of the reablement period compared to the hours at the point of hospital discharge. The average increase was 4.29 hours per week:

- Age 65+ (11 service users): average 7.91 hours per week increased to 12.36
- <65 (1 service user): 3.5 hours per week increased to 6 hours.

| Service users with packages stayed the same | <65 | >65 | Total |
|---|---|---|---|
| Total hours at hospital discharge | 7.5 | 237.5 | **245** |
| Total number of service users | 1 | 27 | **28** |
| **Total average plan** | **7.5** | **8.80** | **8.75** |

Table above: 28 service users where the weekly plan was at the same level as the hours at the point of hospital discharge. The average plan was 8.75 hours per week:

- Age 65+ (27 service users): average 8.80 hours per week

| Service users where package has decreased | <65 | average hours <65 | >65 | average hours >65 | Total |
|---|---|---|---|---|---|
| Total hours at hospital discharge | 36 | 12 | 829.25 | 11.52 | **865.25** |
| Total hours at end of reablement | 23 | 7.67 | 429.25 | 5.96 | **452.25** |
| **Total number of service users** | **3** | | **72** | | **75** |
| ***Average decrease*** | | | | | **5.51** |

- <65 (1 service user): 7.5 hours per week

Table above: 75 service users where the weekly plan was lower at the end of the reablement period compared to the hours at the point of hospital discharge. The average decrease was 5.51 hours per week:

- Age 65+ (72 service users): average 11.52 hours per week reduced to 5.96
- <65 (3 service users): average 12 hours per week reduced to 7.67

**(ii) Amendment to plan – from HD through to Mainstream:**

- 14 service users where the weekly plan was higher in continuing mainstream compared to the hours at the point of discharge. The average increase was 4.04 hours per week:
- Age 65+ (13 service users): average 7.5 hours per week increased to 11.65
- <65 ( 1 service user): 3.5 hours per week increased to 6.0
- 21 service users where the weekly plan was at the same level in continuing mainstream as the hours at the point of hospital discharge. The average plan was 9.43 hours per week:
- Age 65+ (20 service users): average 9.5 hours per week
- <65 (1 service user): 7.5 hours per week
- 80 service users where the weekly plan was lower in continuing mainstream compared to the hours at the point of discharge. The average decrease was 6.33 hours per week:
- Age 65+ (77 service users): average 11.24 hours per week reduced to 4.85
- <65 (3 service users): average 12 hours per week reduced to 7.33

## 6.2 Service User Consultation

The following analysis is based on data taken from the quantitative Survey Monkey telephone interviews (as at 2/10/12) & qualitative service user interviews.

### 6.21 Service User Profile

Profile of service users participating in the two research studies was as follows:

| QUANTITATIVE | QUALITATIVE |
|---|---|
| • 73 (50%) of the 145 service users contacted to participate in the telephone interview agreed to do so. Of these:<br>• 52 (71%) were female and 21 (29%) male<br>• the majority at 64 (88%) were aged over 66<br>• almost three quarters at 53 (73%) were of white Scottish ethnic origin whilst 19 (26%) were not known and 1 (1%) was classed as white other British<br>• 51 (70%) cases were within North East Area; 18 (25%) within South; 1 (1%) within North West and 3 (4%) were unknown. | • 13 (65%) service users out of the 20 required to participate in the research agreed to do so. Of these:<br>• 8 were female and 5 male<br>• Their ages ranged from 52 to 88 and over three quarters (10) were aged 70 plus<br>• All were of white Scottish ethnic origin |

### 6.22 Reablement Process

***When Did someone come to speak to you about the Reablement Servce in your home?***

***(Qualitative Research)***

| | |
|---|---|
| **LESS THAN 24 HOURS AFTER DISCHARGE FROM HOSPITAL** | **7** |
| **24 HOURS AFTER DISCHARGE FROM HOSPITAL** | **3** |
| **2 DAYS AFTER DISCHARGE FROM HOSPITAL** | **1** |
| **3 DAYS AFTER DISCHARGE FROM HOSPITAL** | |
| **MORE THAN 3 DAYS AFTER DISCHARGE FROM HOSPITAL** | **1** |
| **DON'T KNOW/ NOT SURE** | **1** |
| **TOTAL** | **13** |

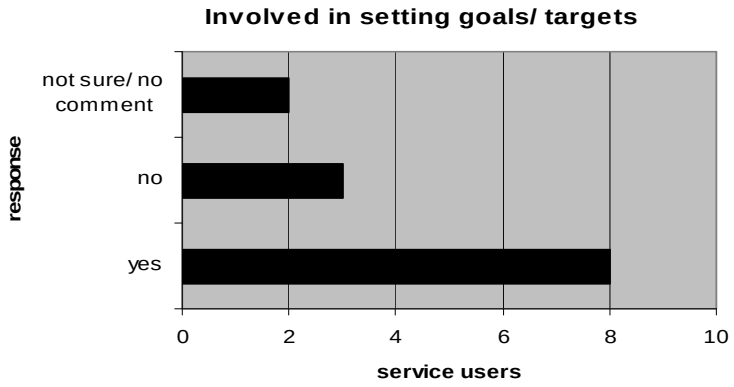
***Within 24 hours of hospital discharge, service users should receive a visit from a social work occupational therapist or a care manager to assess their support needs to see whether reablement is appropriate.***

The qualitative research found that most service users 10 (76%) were seen by the reablement service within 24 hours of being discharged from hospital. However, one person was seen after 2 days of discharge and another after 3 days.

When asked whether service users understood what reablement was about after the initial discussion at home with reablement staff, 7 out of the 13 individuals answering said they fully understood; 4 said they only part understood; 1 did not understand at all; and 1 person was not sure.

***Written as well as verbal information on reablement should be shared with service users.***
Six individuals said they had received information leaflets from the reablement team whilst 4 said they had not. A further 3 people were not sure. Of the 6 people having received leaflets, 5 said they found them helpful.

***Person centred goal setting are central to the Reablement ethos….The reablement team should discuss with the service user what goals they would like to achieve before realistic goals are set.***




Eight (61%) service users said reablement goals had been discussed with them; 3 said they had not; and 1 person was not sure if they had – see graph on left. When asked how confident individuals were in achieving the goals set, 11 (84%) said they were confident; 1 was not confident at all; and 1 was not sure.

In terms of what individuals thought about the goal setting, 10 favourable comments were received and 1 not so favourable. The latter service user unhappy with the reablement service was reassessed shortly after the research and with his consent moved onto mainstream homecare as reablement was deemed to be unsuitable. The following comments are an example of the positive comments received:

*"fantastic"*

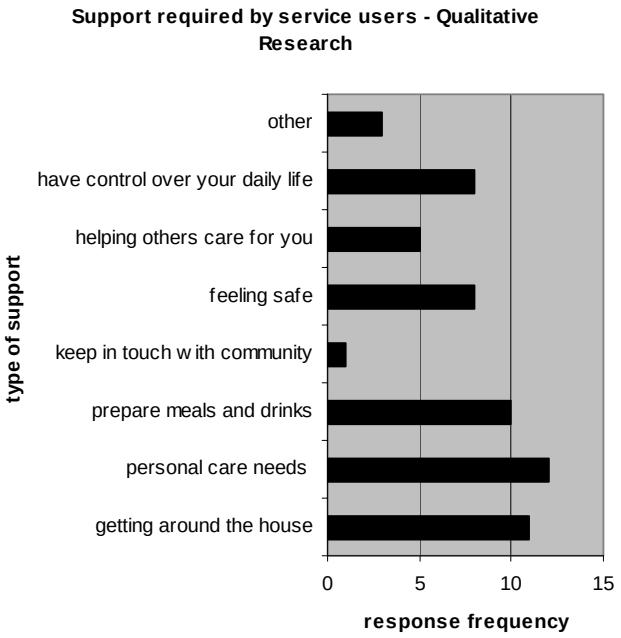
*"better because it makes you use yourself"*

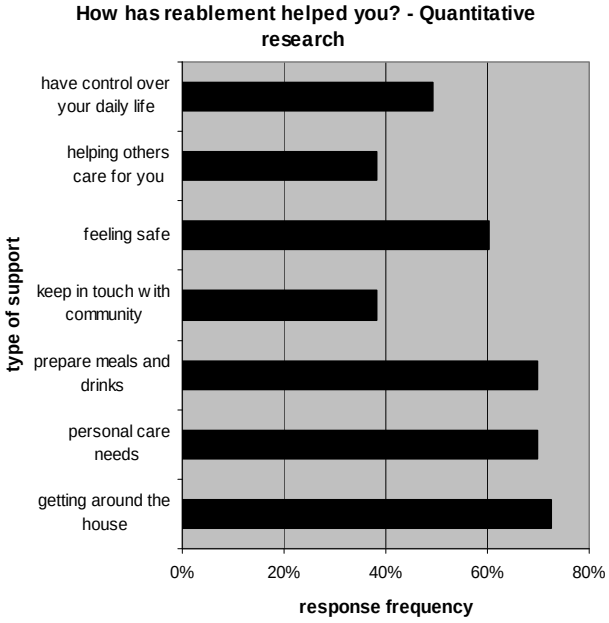
*"great for self encouragement and stops deterioration"*

*"I was terribly bad at first but things have started to come together again"*

## 6.23 Reablement Support

***Reablement contributes to the key policy objective of supporting people to live healthy and independent lives at home for as long as possible.***



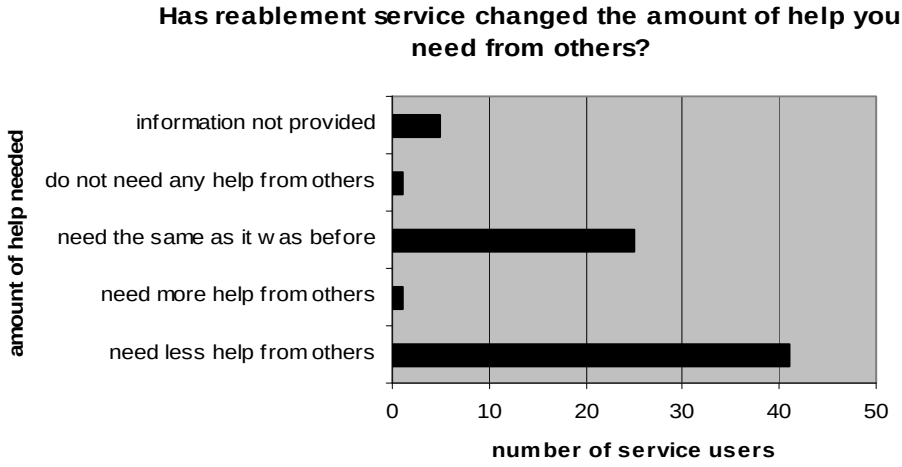




Both research studies showed that personal care needs; mobility within the home; and preparation of meals were areas of support service users required assistance with the most frequently. However the degree of support required amongst individuals varied from some requiring support only in one area and others requiring several areas of support. On average, most service users required support with four or more areas. (See graphs above).

Both studies evidenced that a significant number of service users at the end of reablement were able to:

- ‘resume their usual activities’ (82% quantitative ) and
- ‘do more things for themselves’ (74% quantitative; 69% qualitative).

In terms of ‘ability to do more for themselves’, the quantitative research also showed over half at 41 (56%) service users required less support at the end of reablement whilst a third at 25 (34%) required the same as before. Only one person felt they needed more help than before and another said they did not need any help. Five people did not answer the question. (See graph below).




Of the service users not coping so well, the qualitative research saw two cases (15%) where service users, due to a deterioration in their health, were hospitalised shortly after their reablement period and required an increased home care package on discharge.

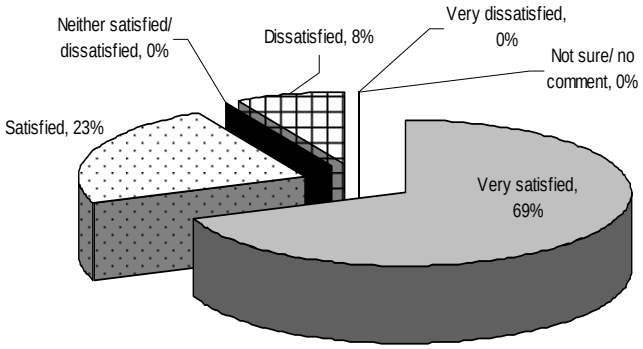
Overall, service users participating in the qualitative research spoke favourably of reablement staff supporting them. Nine individuals (69%), one specific to Cordia homecare, said they were very helpful and supportive; 1 said they were quite supportive but more could have been done; and 1 person made a statement saying it was the 'same staff as before.'

Case studies on page 34 show the range of duties covered by reablement staff across agencies in supporting service users at home during their reablement journey.

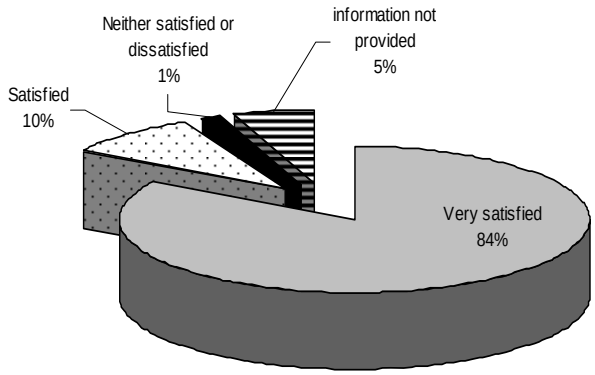
6.24 Reablement Satisfaction

Both quantitative and qualitative research studies rated service user satisfaction as high. This outcome was measured during the reablement period for the qualitative research whilst for the quantitative it was measured at the end of reablement. Only one person showed any dissatisfaction out of the two studies (qualitative) and as already stated earlier in the report the individual was found not to be suited to reablement and consequently moved onto mainstream home care. The charts below show the results of the two studies in terms of satisfaction levels.

**How satisfied are you with reablement - Qualitative research**




**How satisfied are you with reablement? - Quantitative research**




As well as the hard data recorded as in the above, service users were able to provide softer data on the reablement service. The following statements are an example of what was said:-

| QUANTITATIVE | QUALITATIVE |
|---|---|
| *"I feel more confident and the carers were fantastic!"*<br><br>*"Delighted with service, all workers were great, carers & OT's"*<br><br>*"The OT's visiting could not have been nicer. Has also improved my independence"*<br><br>*"Very positive experience, thanks to everyone for their help"*<br><br>*"If all the workers are like the reablement carers then we have nothing to worry about, very satisfied with service. I feel more confident with doing a lot more myself"*<br><br>*"All great although there were a lot of different girls in house. Nothing seems to be consistent"*<br><br>*"One of the carers was exceptional and referred me on for other services. But found other carers to be quite unhelpful"*<br><br>*"Relatively happy but did state that was not happy with the last carer who attended as she only stayed half the time that she should have"* | *"staff setting the goals to work towards is good"*<br><br>*"everyone very helpful and friendly"*<br><br>*"can't fault it"*<br><br>*"would rather have dinner earlier"*<br><br>*"so far but would like consistency as to when the carer comes in the morning*<br><br>The latter two statements were made by individuals who were satisfied with the reablement service but nevertheless wanted specifics highlighted. Consequently, the comments were passed onto the social work reablement staff by the researcher and the service users were appropriately supported. |

6.25 Service User Outcomes

At the end of the 6 week reablement period and thereafter, outcomes for individual service users varied depending on their health and ability to care for themselves. At the third interview stage within the qualitative research, service users were asked to comment on their health:

- 6 service users said their health had deteriorated but they were coping ok at home
- 4 said their health had remained the same
- 2 said their health had improved and that they were coping well
- 1 person had dropped out of the research study and moved onto mainstream homecare.

The table below shows outcomes of the twelve individuals who participated in the qualitative research from start to finish. The outcomes are reflected at stages of interviews taking place i.e. after 6 weeks of reablement; 6 weeks after the end of reablement; and 6 weeks thereafter.

**OUTCOMES**

| | **END OF REABLEMENT PROGRAMME** | **6 WEEKS AFTER END OF REABLEMENT** | **6 WEEKS THEREAFTER** |
|---|---|---|---|
| **INDEPENDENT IN THE COMMUNITY** | **5** | **5** | **5** |
| **MAINSTREAM HOME CARE** | **5** | **5** | **7** |
| **REABLEMENT PROGRAMME** | **1** | | |
| **HOSPITAL ADMISSION** | **1** | **2** | |

At the end of reablement, 5 service users went onto mainstream homecare whilst another 5 went on to live independently in the community. All 10 (83%) managed to sustain their outcomes over the next six months since completing reablement. However, of the 12 individuals participating in the research, one person was hospitalised during reablement, recomenced onto reablement at discharge, returned to hospital and ultimately moved on to mainstream homecare. Another person remained in hospital for several weeks at the end of reablement and then also moved on to mainstream home care.

6.26 Transition from Reablement to Mainstream Home Care/ Independence

Service users who had moved onto ‘mainstream homecare’ (7) or ‘independent in the community’ (5) were asked of their experiences within the quantitative research. Of those moving onto ‘mainstream home care’ service user responses varied from 4 saying the process was smooth and easy; 1 saying it was partially smooth with difficulties; and 2 that it was difficult. Comments provided from those who had experienced some difficulty were:

*“I was wary at the start”*

*“there were mixed messages about the meals”*

One unpaid carer from the quantitative research had also left a comment in connection to the handover which was written up by interviewer as:

> *“Could have been better communication re. transfer to mainstream homecare. Daughter was unaware her mother had reached Reablement potential and was transferring. They were initially told they would be on Reablement for 6 weeks, but it only lasted 4 which caused the daughter problems”*

## 6.3 Staff Consultation

6.31 Force Field Analysis

Focus group discussions were held with 11 staff nominated by the multidisciplinary reablement group. Discussions focussed around ‘forces working towards reablement’ and ‘forces working against reablement.’ A weighting score between 1 and 5 was assigned against each discussion topic where 5 was the most important and 1 the least. At the end of the discussion scores were totalled to see which ‘force’ was greater – see table below.

Staff were then requested to focus on 'forces working against reablement' and see how they could be made into 'forces working for reablement' taking away any obstacles. See table below.

| Force Field Analysis: Session with Reablement Staff 07/03/2012 | |
|---|---|
| **Forces working against Reablement** | **Solutions** |
| Increased workload for Rehab team - no resources. Since reablement 30% increase. Cordia Home Care also feel the same | Use Change Fund money |
| There is a challenge to fit into other systems | Use Joint systems or even partial joint |
| Communication | Want to know more about processes across agencies - whose responsible for what. Training/ shadowing/ pdp |
| Cordia - more stress → keeping reablement clients who need palliative care or are terminally ill. Sometimes up to 5 days. | Social Work Services should screen out appropriate reablement cases. Should also flag up on Social Care Direct system that case is not appropriate for reablement. Cordia co-ordiantor should be able to phone Reablement team to say that a specific case is mainstream and not reablement |
| Perception across care providers is different if client appropriate for Reablement | Need to talk to each other more |
| Electronic trigger which is faceless/ nameless does screening | Can't do anything about this |
| Duplication of work | Need to talk to each other more |
| Tip of the ice berg - currently only a few people benefiting from reablement | Resource implications |
| Beau racy/ paperwork. Certain processes cannot be dealt with until gone through appropriate people and channels | Streamline the whole thing. Should be able to phone each other |
| Cordia - work time very unrealistic. Especially Fridays - when emergency cases sometimes double and have normal reablement cases coming through as well. The system bottlenecks and staff are working flat out. | Resource implications. Resolve issues at hospital end i.e. why does system bottleneck on a Friday? |
| Guidelines change constantly →can cause confusion/ frustration. Aware that reablement is new and this bound to happen. | Each agency is involved in Operational Meeting where changes should be discussed and passed on to others. Steering Group also a channel for discussion and circulation of information |
| Varying systems across agencies | Joint systems or partial join |
| Too many procedures/ criteria's | Speak to each other |
| dual client - who provides OT? | Discuss at Operational Meeting to resolve |
| Cordia - internal problems whether a case is mainstream or reablement | Area Service Manager to deal with individual situations. Reablement staff should be able to talk to each other and resolve whether a case lies with mainstream or reablement home care. |

Results from the force field analysis were taken to the Reablement Steering Group for action and also used to compile questionnaires for the next phase of the staff consultation.

Main areas highlighted as challenging included: Increased workload; varying cross agency systems; screening problems; work duplication; bureaucratic paperwork; systems bottlenecking; clarity of roles & responsibilities; set guidance and structured policy procedures.

6.32 Survey Monkey Questionnaire

**(i) Background**

This staff consultation was carried out July 2012. Total 31 (55%) staff completed the Survey Monkey questionnaire out of the 56 targeted where 13 (42%) were represented by Cordia

reablement homecare staff, 9 (29%) Social Work Services; and 9 (29%) from NE Rehabilitation Service. Cordia reablement staff completed the Survey Monkey questionnaire through face to face interviews (due to problems with internet access) whilst Social Work and NE Rehabilitation Service staff completed it online.

In addition to this, 11 (19%) face to face interviews were conducted with Cordia mainstream staff involved in the handover of reablement at the end of the 6 week period. Questions focussed specifically around the handover process.

**(ii) Overall, what's working well?**

Staff at all levels had a clear understanding of reablement aims and objectives as evidenced by the comments below:

> *"Helping people and getting them back on their feet & getting their independence. Helping with confidence & self esteem. Striving for total independence but in reality some wont get this." (Cordia)*
>
> *"To establish an appropriate level of homecare service following a period of reablement. That level of service may be maintained or decreased depending on patients needs. To promote independence." (NERS)*
>
> *"To work with service users to improve their mobility/confidence to carry out tasks on their own. There would then not be a need for the home care service to assist with these tasks, therefore reducing the budget." (SWS)*

Goal setting was principally seen as a positive step forward:-

> *"I am able to know that the homecarers are facilitating reablement process and progressing patient goals on a regular basis. The patient is then receiving regular and consistent input to progress." (OT- NERS))*

Over half the staff at 54% rated working with the Reablement Service as excellent or good where 92% were Cordia staff compared to 33% Social Work and 22% NE Rehabilitation Service staff. However, when asked what was working well in terms of reablement, 100% Cordia reablment staff provided positive statements compared to 77% Social Work Services and 44% NE Rehabilitation Service. The positive statements focussed around; service user empowerment to gaining independence; cross agency intensive support benefitting clients; and quality input. The following statements sum up positive feedback from staff across all three agencies:

> *"Job satisfaction is great. I enjoyed the job previously but much more satisfying with reablement. You get to see the final outcome with the service user. I feel part of the process in helping someone.*

*Your opinion counts. I feel part of a bigger team, working with other agencies - I didn't have this before." (Cordia)*

*"Reablement OTs have a good relationship with Cordia I feel that I have had good outcomes with service users" (OT -SWS)*

*"I am able to know that the homecarers are facilitating reablement process and progressing patient goals on a regular basis. The patient is then receiving regular and consistent input to progress." (OT- NERS))*

Some staff felt that reablement was beneficial for their personal development in terms of new skills being offered. In addition to this staff commented on the 'good relationships' with other agency staff.

Staff reported that feedback from service users and families had generally been favourable with 52% saying it was mostly favourable to 26% saying it was partially favourable. Where it was partial, staff felt vulnerability and complexity of individual cases played a major role. Favourable feedback in the main was associated with service users and families showing their gratitude and appreciation of the service:

*"Thanks & gratitude received from clients and family. They show their appreciation when service has worked & they don't need any further help. Clients are well satisfied by this achievement."*

*"Family quite happy with service, so mostly favourable. They don't want person sit about all day - happy they can do things for themselves."*

Reablement training by staff had been well received and staff said it had been useful in practice. However, there was also a strong consensus that it needed to be ongoing to keep up with any changes or updates within the service. Cordia and Social Work staff were more specific in the type of training received than NE Rehabilitation Service staff. Cordia staff spoke of the 4 day training which included: moving & handling, OT equipment; stepping back, videos and role playing. All Cordia staff spoke positively in terms of their training:

*"….Without training it would have been impossible to take a step back. You get put into the position service users are in & then it makes you think different on how your approach to them would be. - I use it in my home life as well now."*

*"Wearing body suits gives concept service user might be feeling or going through. How would you approach this situation? And then deal with it appropriately"*

Type of training delivered to Social Work staff varied on job designations. Occupational therapy staff, spoke of a 2 day training programme covering introduction to the service and role of

individuals in the team. The admin worker spoke of the Carefirst Non Residential Service Package Training delivered in respect of processes / procedures for service packages whilst the social care workers spoke of seeing some presentations.

One person (physiotherapist) from NE Rehabilitation Service said half day training on reablement had been delivered whilst six staff (2 OT's; 2 nurses; 1 physio; 1 NERS support worker) said no training had been offered.

In addition to the formal training delivered, staff rated other ways reablement information was shared with them which was seen to be as equally important. As shown by the table on the right, the following were rated quite highly: - work colleagues; briefings/ meetings and circulated written information. Other in the table included sharing of information verbally, via phone and/ or through care diaries.

| | excellent | good | average | fair | poor | not sure/ not known | not applicable |
|---|---|---|---|---|---|---|---|
| written information circulated | 10 | 6 | 4 | 1 | 3 | 4 | 1 |
| briefings/ meetings | 11 | 5 | 5 | 4 | 1 | 2 | 2 |
| supervision sessions | 7 | 4 | 3 | 1 | 1 | 2 | 11 |
| personal development plan | 3 | 3 | 3 | 1 | 2 | 2 | 16 |
| work colleagues | 14 | 12 | 4 | | 1 | | |
| conferences/ seminars | 1 | 2 | 3 | 1 | 1 | 2 | 19 |
| other | 5 | 4 | 1 | | 1 | 2 | 16 |

**(iii) What needs to improve?**

There was general consensus across all agencies of some duplication of work. This was seen across agency as well as internally – the following examples put this into context: - Cordia admin spoke of identical referrals being forwarded by different workers; other agency staff spoke of duplicate information logged on a number of systems; there was also duplication in assessments between reablement & stroke service teams; client's were getting visit's at tea time by Cordia reablement and mainstream home carer at same time.

Some issues captured by the research were more specific to individual agencies and have therefore have been written up under the heading of each agency as follows:-

***SOCIAL WORK***

- Social Work OT's and SCW's said that clearer roles & responsibilities were required
- SCW's said that assessment paperwork & communication needed to improve
- OT's felt more structured policy & procedures were required
- OT's felt there was more autonomy in reablement work than in their previous OT role which needed to change.

- Reablement admin staff often pulled away from reablement work to cover phones/ reception for wider OPPD Team.

***CORDIA REABLEMENT HOME CARERS***

- Screening was still a problem. Inappropriate referrals not fitting the reablement criteria were filtering through i.e. service users with dementia; terminal illness; pelvic fractures…
- Home carers felt that NE Rehabilitation Service OT input was too slow and OT's did not always update notes in diaries
- Medical information needed improving i.e. home carers were having to access chemist's to get emergency set up for medical provision; dossit boxes on hospital discharge did not always display relevant information; and pharmacy names were often missing from paperwork
- Degree of sensitivity required with service users at the start of reablement or at changeover
- Reablement numbers very low at the point of the consultation and Cordia staff felt they were being pulled into mainstream home care work
- More mainstream clients therefore home carers sometimes spending less time with reablement clients
- Inform service users of imminent charges beforehand
- Improve ways to encourage clients to take their own tablets rather than using prompts

***CORDIA MAINSTREAM HOME CARERS***

- Allow home carers to meet face to face at the end of reablement changeover to exchange information
- Reablement diaries should be passed onto mainstream home carers containing more detailed information i.e. aids & adaptations being used…
- Mainstream co-ordinators showed frustration at not being allowed to attend reablement meetings.
- Mainstream home carers felt some medical information was missing at changeover
- Mainstream home carers said time was a big factor in the way they worked and could therefore not provide the same level of support as reablement home care staff
- Mainstream home care staff felt reablement training should be offered to them too.
- There was a degree of cynicism with some mainstream staff – no guarantee that 6 week reablement period is going to work
- Work load issues blamed on staff lost to reablement not being replaced

***NE REHABILITATION SERVICE***

- A separate Reablement OT service should be set up instead of using half social work and half NE Rehabilitation Service
- Lack of NE Rehabilitation Service staff resources impacts on caseload and staff unable to attend weekly reablement meetings. This also impacts on first visits.
- Clarification required on home carer roles and degree of training received
- Difficulty in contacting reablement admin staff to discuss assessments or goals
- Difficulty in arranging joint visits with reablement home care co-ordinators as they finish early
- Difficulty with getting copy of assessments i.e. bringing initial copy to office to copy and then driving back to deliver to clients house – carbon copy would save time (physio)
- Paperwork time consuming
- Communication between NE Rehabilitation Service and other reablement staff needs to improve.

### 6.4. Case Studies & DVD

Please note identity of service users in both case studies has been protected and an alias name used instead.

6.41 North East Social Work

**Background**

Mr Smith is a 78 year old gentleman who lives with his grandson in a housing association ground floor flat in the East End of Glasgow. He has a supportive ex-wife and daughter who assist with shopping and pre-preparing meals, whilst his grandson assists with housework. Mr Smith's daughter and wife visit daily, however his daughter reports that her mother has her own health problems and would be unable to sustain daily calls in the future.

Mr Smith was admitted to hospital following a heart attack and subsequent collapse. He also has a history of several falls over the last year caused by him losing his balance. His previous medical history consists of brain injury, stroke and angina. After two weeks Mr Smith was assessed in hospital as being medically fit for discharge, however he required assistance at home with washing/dressing in the morning, meal preparation at breakfast and lunchtime and medication prompt at breakfast and teatime. Reablement was considered an appropriate service to implement on discharge as Mr Smith had had no home care support in place before his admission to hospital, and he was keen to regain as much independence as possible, and rely less on his family for assistance.

**Occupational Therapy (OT) assessment**

24 hours after discharge from hospital Mr Smith was visited by the Reablement Occupational Therapist, when a full initial Occupational Therapy assessment was completed and reablement goals were discussed and set around Mr Smith's own identified needs and wishes. The goals reflected both short term and longer term outcomes, with the aim of Mr Smith requiring no assistance with washing/dressing, meal preparation and administering of medication at the end of the Reablement period. The goals were recorded in the client held Reablement care diary, allowing the Reablement carers to follow a consistent approach and assist Mr Smith to achieve his goals, as directed by the Occupational Therapist. The Occupational Therapist met weekly with the Reablement carers to discuss Mr Smith's progress and achievement of goals, and the Occupational Therapist was able to progress goals and alter Mr Smith's care package as he continued to improve and regain his independence. The Occupational Therapist also re-assessed Mr Smith mid-way through the Reablement input and again on discharge from the service.

The Occupational Therapist also provided aids to daily living to compliment the care plan and reduce the risk of Mr Smith falling again. Mr Smith was provided with a walking frame to improve his unsteady gait; a perching stool to allow him to wash himself safely at the bathroom sink; a kitchen trolley to facilitate safe transportation of meals and drinks to and from his kitchen; a urine bottle to reduce the need to mobilise to the toilet at night; and a shower stool and grab rail to facilitate safe and independent showering. He was also referred for a community alarm.

**Outcomes**

By providing a client centred reablement approach, as well as an Occupational Therapy assessment and interventions, and by consulting and engaging Mr Smith and his family in the reablement plan, the reablement Service was able to assist Mr Smith to regain his previous level of independence and allowed his ex-wife to feel confident in reducing her daily calls to twice weekly for assistance with shopping. Mr Smith reported that he had felt supported and encouraged by the Reablement team, and that his confidence to remain safely at home was greatly improved.

6.42 NE Rehabilitation Service

**Background**

Mrs Thompson is an 83 year old lady who lives alone in a sheltered housing complex in the East End of Glasgow. She was admitted to hospital following a series of falls and seizures, and remained in hospital for a number of weeks while she received inpatient rehabilitation. Mrs Thompson has no close family, and prior to her hospital admission she received Cordia home care four times daily to assist with personal care, meal preparation, medication prompt, housework and shopping. Mrs Thompson was discharged from hospital with an increase to her existing care package to include assisting with toileting at each of the four calls.

Before Mrs Thompson was discharged from hospital she was referred by ward staff to the North East Rehabilitation Services (NERS), a multi-disciplinary rehabilitation team, to facilitate a safe discharge and continue rehabilitation in Mrs Thompson's own home. Following assessment (which was interdisciplinary in format) on the ward by the NE Rehabilitation Service team, Mrs Thompson was considered suitable for rehabilitation. Mrs Thompson also met the criteria for a reablement service. The arrangement in Glasgow is that where a patient if referred for both rehabilitation and reablement on hospital discharge, the rehabilitation team also lead on the reablement service, providing Occupational Therapy input and setting and progressing reablement goals.

On Mrs Thompson's discharge from hospital she was visited by the nurse from NE Rehabilitation Service. The assessment by the NE Rehabilitation Service team was comprehensive and involved a review of Mrs Thompson's mobility, balance, activities of daily living, medications and compliance as well as ensuring further medication supplies were arranged. The assessment also involved checking continence, skin integrity, blood pressure and pulse. Any issues raised in relation nursing, pharmacy, physiotherapy would have ensured a further detailed assessment by the specific profession and appropriate follow-up / treatment planning. The nurse set initial reablement goals, and also amended Mrs Thompson's care package as she did not require assistance with medication, toileting, and washing herself.

**Occupational Therapy (OT) assessment**

This assessment involved the use of the OT's core skills including activity analysis as well as interdisciplinary assessment skills. From the OT assessment the aims of rehabilitation were for Mrs Thompson to achieve independence in dressing the top half of her body, and in making a hot drink and snack/meal. The OT amended the Reablement goals to reflect these rehabilitation goals and assist in promoting independence and supporting the ongoing rehabilitation. By the end of the 6 week reablement period Mrs Thompson had achieved all her reablement and rehabilitation goals. She was discharged from the service with a care package comprising twice daily visits for assistance with dressing the lower half of her body and getting into bed at night time, twice weekly showering, and her longstanding assistance with shopping and housework.

**The benefits of Reablement within rehabilitation**

Mrs Thompson was used to home care four times daily prior to admission, and at the time this would have been appropriate due to her frequent falls, poor balance, variable mobility and living alone. A combination of moving into sheltered housing as well as rehabilitation at home to improve mobility and balance meant that the package was potentially more than she needed. However, Mrs Thompson drew a lot of confidence and reassurance from the high level of home care. Through reablement's weekly goal setting, encouragement by carers to achieve goals, and the weekly OT visits trying techniques and equipment, Mrs Thompson gradually made a transition from dependency on the carers to feeling empowered and able and willing to do much more for herself. Equally important were the regular reviews of mobility, medication compliance/issues and any nursing issues. For example, a main reason given by Mrs Thompson for not discontinuing the tuck in visit was the need for help positioning foot in a repose cushion. Assessment of skin integrity of her heel by OT and then the specialist assessment by the nurse showed there was no need for the cushion and its continue use was Mrs Thompson's own preference. The reablement

focused Mrs Thompson's mind on putting into perspective what her needs versus wants were in relation to help with activities of daily living. This is difficult to achieve where patients do not receive a reablement service as there is not the same mechanism to encourage patients to take responsibility for their progress. The reablement concept allows the OT to be a more effective catalyst in helping the patient improve their quality of life by improving their functional independence.

Within rehabilitation the focus was on teaching Mrs Thompson the correct techniques for performing activities of daily living but this would not be followed through by the home carers and patient where a traditional care package is in place. Rehabilitation works well within reablement as it allows the complex needs of the patient i.e. nursing, pharmacy, physiotherapy to be met effectively through the interdisciplinary team as well as ensuring the follow on of rehabilitation goals by the carers under the supervision of the OT.

6.43 Reablement DVD

Cordia home care produced a short video that explains the reablement service and shows the benefits of it with the use of two real-life case studies. The video is available on the Cordia website at:

*http://www.cordia.co.uk/Our-Services/Home-Care/Reablement.aspx*"

## 7. Overall Findings & Discussion

### 7.1 Limitations of the qualitative research

Limitations included:

- Control group ‘mainstream home care service’ failing to happen
- Unpaid carer group failing to happen
- Poor staff consultation response from Social Work and NE Rehabilitation Service
- Limited research resource time

Unforeseen circumstances forced the control and unpaid carer group consultation not to take place. The control group consultation in particular would have been useful in adding further value to the research by being able to prove or disprove the benefits of reablement when researched alongside each other. In absence of this, the study generalised on some aspects of its findings.

The low number of service users participating in the qualitative research was also disappointing. However, the findings from it when explored jointly with the quantitative research, performance activity data, Cordia Care Inspectorate report and case studies provide sufficient data to support the work.

### 7.2 Reablement Outcomes

Methods used to capture data for this research provided sufficient evidence to support the effectiveness of reablement in terms of positive outcomes achieved. The following outcomes were significant in relation to levels of home care support required by service users at the end of reablement:

- A sizeable proportion of service users went on to be independent in the community and most were able to sustain this over a period of time.
- Where home care recommenced for those independent in the community, number of hours of support provided was small.
- Service users who had moved onto mainstream home were mostly on reduced home care packages

. The above outcomes were also certified by Cordia’s inspection study which reported:-

> *“The reablement programme continued to expand across the city of Glasgow. We shadowed and talked with reablement staff and were particularly impressed by the focused goal planning that went in to responding to the clients changing care needs and central role that the home care worker had in this process. This was summed up by one client who told us, ‘I used to be a nursing officer so I can say with confidence they do a good job.’ Consequently, we found that many residents no longer*

*needed the services of a home help service or only a reduced service as a result of the reablement teams work."*

Outcomes in relation to service user empowerment, confidence and ability to do things for themselves were also evidenced through the Survey Monkey telephone interviews and qualitative research interviews.

### 7.3 Service user satisfaction

Service users were offered the opportunity to speak openly on all aspects of the reablement service from the initial social work visit at home, assessment, sharing of information, staff interaction, to the handover form reablement to mainstream where required. Overall, the majority of service users were satisfied with the reablement service and the staff supporting it. This was equally evident through Cordia's inspection report, case studies and reablement DVD.

Where signs of dissatisfaction were shown, cases were referred by the researcher to the social work reablement team for attention. Consequently, all cases were systematically resolved to the satisfaction of the service user and reablement staff.

It must be pointed out that in a small number of cases, individuals could not recall whether a specific part of the process had taken place i.e. were you provided with leaflets on reablement? or were you involved in the goal setting?... This can partially be explained by service users frailty/ old age or not understanding the jargon used in posing questions such as 'goal setting.'

### 7.4 Handover from reablement to mainstream home care service.

The handover from reablement to mainstream home care for service users in general had been a smooth and problem free experience. Only two incidents of dissatisfaction were noted and the information was swiftly passed on to the social work reablement team to be appropriately dealt with. However, the staff consultation with mainstream home care workers in specific raised a number of issues at the handover stage which staff felt needed addressing - see page 32. Consequently these issues and others raised through a separate consultation by Cordia with its staff were acted upon and implemented into practice.

### 7.5 Staff have their say

The qualitative staff consultation provided an opportunity for all cross agency staff to have their say about areas within reablement which worked well for them and those where issues existed.

The force field analysis conducted in the early stages of the staff consultation proved to be a valuable exercise encouraging staff to openly discuss forces working towards and against reablement. Issues highlighted by staff under 'forces working against' were taken to the

Reablement Steering Group meeting for further discussion and action. The consultation was also a means to collating clear themes for the next stage of the staff consultation for questionnaire design which was to be implemented via Survey Monkey (online) and face to face interviews.

The questionnaire consultation, four months after the force field analysis, seemed to echo several of the same issues - see pages 27 and 28. These and other issues were taken back to the Steering Group meetings and it was agreed at this stage that each agency would be accountable for addressing its own discussions by drawing up an action plan.

Copies of actions plans from Social Work and Cordia were received and included in this study. See pages 53 – 57.

Cordia had consulted 18 home carers and 3 co-ordinators to inform its action plan. Discussions focussed on training; meetings; blackberry's; care diary; pattern of visits; handover to mainstream; communication; roles and responsibilities; and operational problems.

Social work similarly involved its OT's, social care workers and team leader in discussions to inform action plans. Key issues examined included: policy & procedures; guidance; roles and responsibilities; joint visits; working with community stroke team; financial assessment forms; referrals and medication.

In terms of the Rehabilitation Service it was reported that staffing resource for reablement was an on-going issue. NE Rehabilitation Service had contributed to the development plans and roll out of reablement in North East and South, however it quickly became apparent that this was not sustainable within the current resource. The service is aware that this requires further consideration in moving forward.

**7.6 Staff satisfaction**

Overall, staff across all three agencies were satisfied with the principles of the reablement service but were aware issues, as highlighted within the consultation, needed to be addressed for the service to function to its full potential.

Staff saw a number of benefits working in partnership with other agency staff such as improved communication, sharing of information and networking. However, common issues across agencies included better screening, work duplication, clarity of roles and responsibilities (particularly between social work OT's and NE Rehabilitation Service OT's).

Although staff had said screening had been a problem with inappropriate referrals filtering through – numbers coming through had been reported as being very small.

Cordia and Social work staff had spoken very positively in terms of reablement training received but felt that it needed to be continuous. Only one person from the NE Rehabilitation Service had said that reablement training had been provided. In addition to training received, all staff said reablement information had been received via a number of channels where work colleagues was the most frequent followed by papers circulated and then meetings/ briefings.

On the whole staff moral for Cordia homecare was high where staff had enjoyed the training and were keen to start the reablement work. The disappointment had been the low uptake of reablement by service users in North East which staff hoped would change.

Service users and Cordia staff also spoke positively at the speed OT equipment was accessed through reablement.

## 8. Next Step

- Research study to be used to inform wider roll out programme of reablement across the City
- Undertake desk top research to scope paraprofessional roles and responsibilities within reablement
- Repeat cross agency staff consultation exercise to monitor views and opinions further down the line
- Pass research report to Joint Improvement Team and put on to Connect/ Internet

## 9. REFERENCES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# 10. APPENDICES

## Appendix 1: Survey Monkey – Quantitative Service User Questionnaire

(Questions 1- 9 to be pre-populated before making the call)

1. Name
2. Carefirst Number
3. Gender
4. Age band
5. Ethnicity
6. Geographical area
7. Date Reablement Service completed
8. Date questionnaire undertaken
9. Service user telephone number

**The following is a sample text that will form the basis of the introduction to the client, what the phone call is about and why it is taking place.**

PLEASE NOTE: You should advise that you can call back if the time of the call is inconvenient. This is a call from the Reablement (Home Care) Service which you recently received. Would it be possible to speak to XXXXXX to answer a few questions about the service? We are calling to find out how the service is being delivered and we would like to hear your views. Everything you say will be taken in strict confidence under the Data Protection Act and will be anonymised in any report. I am going to ask you a set of seven questions with options. Please select which one is the most suitable for you, this should only take around 10 minutes.

The survey questions should be asked and the call ended by thanking the client for their participation. Thank you for you time. Your views will be used to enhance the future delivery of the service.

*10. Call should be ended if the client does not want to participate. Did this occur?
Yes…….. No…….

11. Overall, how satisfied were you with the Reablement service?

12. Did the Reablement service help you resume your usual activities?

13. Did the Reablement service help you do more for yourself?

14. If YES to Q12 or Q13 what has it helped you to do? (Please tick as many boxes as apply)

15. If NO to Q12 AND Q13, what could have been done differently to help you resume your usual activities or do more for yourself?

16. Has this Reablement service changed the amount of help you need from others such as family and friends?

17. Please add any other comments you have on the Reablement service

## APPENDIX 2: QUALITATIVE RESEARCH – SERVICE USER QUESTIONNAIRE 1

**REABLEMENT: SERVICE USER SEMI STRUCTURED QUESTIONNAIRE – initial interview**

D.O.B _____ Gender _____ Carefirst Number _____

**1. When did someone come to speak to you about the Reablement Service in your home?**
- less than 24 hours after discharge from hospital ☐
- 24 hours after discharge from hospital ☐
- 2 days after discharge from hospital ☐
- 3 days after discharge from hospital ☐
- More than 3 days after discharge from hospital ☐
- Don't know/ not sure ☐

**2. Did you understand what the Reablement Service was about?**
- fully understood ☐
- only part understood ☐
- did not understand at all ☐
- not sure/ no comment ☐

**3a. When visited at home by the Reablement staff, were you handed any leaflets about the Service?**
Yes ☐ No ☐ Not sure ☐

**3b. If yes, did you find these helpful?**
Yes ☐ No ☐ Not sure ☐

**3c If no, what were they missing?**

**4. Were you involved in setting goals/ targets with Reablement staff to help you do certain tasks by yourself which you couldn't manage after being discharged from the hospital?**
Yes ☐ No ☐ Not sure ☐

**5. How confident are you that you will be able to achieve these goals or targets?**
- completely ☐
- mostly ☐
- partially ☐
- not at all ☐
- not sure/ no comment ☐

**6. What do you think about the idea of setting goals/ targets and then achieving them?**

**7. How have you found the staff supporting you through the Reablement Process?**

**8a. Have you at any point had questions about the Reablement Service which you have not been able to ask?**
Yes ☐ No ☐ Not sure ☐

**8b. If yes, why did you not ask them?**

**8c. What were they?**

**9. Overall, how satisfied are you with the Reablement Service?**
- Very satisfied ☐
- Satisfied ☐
- Neither satisfied or dissatisfied ☐
- Dissatisfied ☐
- Very dissatisfied ☐
- Not sure/ no comment ☐

**10. Please use this space to explain your answer at Q10**

**11. How do you think the Reablement Service will be able to help you?**
- Getting around within your home ☐
- Looking after your personal care needs eg washing and dressing ☐
- Helping you prepare meals and drinks ☐
- Helping you communicate and keep in touch with other people/ community ☐
- Helping you keep safe ☐
- Helping others care for you ☐
- Helping you have more control over your daily life ☐
- Other ☐

Please specify other _____

**12. Additional information about the Reablement Service**

**Thank you for taking part in this survey**

## APPENDIX 3: QUALITATIVE RESEARCH – SERVICE USER QUESTIONNAIRE 2

**REABLEMENT: SERVICE USER SEMI STRUCTURED QUESTIONNAIRE – 2nd interview after 6 week Reablement Programme**

**i) D.O.B** _____ **ii) Gender** _____ **iii) Carefirst Number** _____

**iv) Stage service user at:**
Hospital admission ☐
Residential care admission ☐
Mainstream homecare ☐
Independent in community ☐
Died ☐
Reablement Programme ☐
Other ☐ Please specify _____

**v) Unable to interview service user** ☐
**vi) Reason** _____

1. **Overall, how satisfied are you with the Reablement Service at this stage?**
   Very satisfied ☐
   Satisfied ☐
   Neither satisfied or dissatisfied ☐
   Dissatisfied ☐
   Very dissatisfied ☐
   Not sure/ no comment ☐

2. **Can you please provide a brief comment to support your answer at Q1?**

3. **Did you feel the Reablement Service for you was:**
   Long enough ☐
   Just right ☐
   Too short ☐
   No comment/ not sure ☐

4. **Can you please provide a brief comment to support your answer at Q3?**

5. **How has the Reablement Service helped you?**
   Getting around within your home ☐
   Looking after your personal care needs eg washing and dressing ☐
   Helping you prepare meals and drinks ☐
   Helping you communicate and keep in touch with other people/ community ☐
   Helping you keep safe ☐
   Helping others care for you ☐
   Helping you have more control over your daily life ☐
   Other ☐
   Please specify other _____

6. **How do you think the service can be further improved?**

7. **Do you have any additional comments to make about the Service you received?**

**IF MOVED ONTO MAINSTREAM HOMECARE FROM REABLEMENT**

**8. How did you find the handover process?**

Easy and smooth ☐
Partially smooth with difficulties ☐
Difficult ☐
Not sure/ No comment ☐

**9. Can you please provide a brief comment to support your answer at Q7?**

**IF INDEPENDENT IN COMMUNITY**

**10. How have you coped on your own since Reablement Service stopped?**

Easy no problems ☐
Coping but some difficulty, which can be overcome ☐
Coping but some difficulty, not easy to overcome ☐
With difficulty ☐
Not sure/ No comment ☐

**11. Can you please provide a brief comment to support your answer at Q9?**

**12. Additional comments about the Reablement Service**

## Thank you for taking part in this survey

## APPENDIX 4: QUALITATIVE RESEARCH – SERVICE USER QUESTIONNAIRE 3 & 4

**REABLEMENT: SERVICE USER SEMI STRUCTURED QUESTIONNAIRE – 3rd & 4th interview 6 week intervals**

i) D.O.B _____ ii) Gender _____ iii) Carefirst Number _____

**iv) Stage service user at:**

| | |
|---|---|
| Hospital admission | ☐ |
| Residential care admission | ☐ |
| Mainstream homecare | ☐ |
| Independent in community | ☐ |
| Died | ☐ |
| Reablement Programme | ☐ |
| Other | ☐ |

**v) Unable to interview service user** ☐

**vi) Reason for not interviewing** _____

Please specify _____

1. **How would you currently describe your health?**

| | |
|---|---|
| health has improved and I am doing well | ☐ |
| health has stayed the same | ☐ |
| health has deteriorated but I am coping ok in the home | ☐ |
| health has deteriorated and I am not coping in the home | ☐ |
| other | ☐ |

Please specify _____

2. **Are you still able to support yourself in the following areas which the Reablement Service had helped you with?**

| | Yes | No |
|---|---|---|
| Getting around within your home | ☐ | ☐ |
| Looking after your personal care needs eg washing and dressing | ☐ | ☐ |
| Helping you prepare meals and drinks | ☐ | ☐ |
| Helping you communicate and keep in touch with other people/ community | ☐ | ☐ |
| Helping you keep safe | ☐ | ☐ |
| Helping others care for you | ☐ | ☐ |
| Helping you have more control over your daily life | ☐ | ☐ |
| Other | ☐ | ☐ |

Please specify other _____

3. **Is there any additional information you would like to share with us about how you are coping?**

**Thank you for taking part in this survey**

**APPENDIX 5: QUALITATIVE RESEARCH – SERVICE USER CONSENT FORM**

# Home Care Research - Service User/ Carer Consent Form

**NAME OF RESEARCH PARTICIPANT**:

**TITLE OF THE RESEARCH STUDY**:

*Home Care Qualitative Research* to capture views and opinion of service users/ carers of the Service provided

**CONSENT TO TAKE PART IN THE STUDY**:

I …….. (Put your name here)

agree to take part in the research study being carried out by Glasgow City Social Work Services. I have read the information and have had a chance to discuss it.

I understand that:

- I do not have to take part in the research if I don't want to
- If I change my mind and decide to withdraw from the research at any stage after signing this form, I can. I do not have to give a reason or sign anything to do so
- If I decide to withdraw from the research study, this will not influence any help or support I receive in any way
- The information kept on me will be treated as strictly confidential and will be stored securely
- Information I give will not be shared with anyone else unless I specifically state I want something raised and I will not be identifiable in the final written Report
- Any information I give will be used for research only and may be used for publication. It will not be used for any other purpose

SIGNATURE…… DATE: ……

WITNESSED…… DATE: ……..

# APPENDIX 6: QUALITATIVE RESEARCH – REABLEMENT STAFF QUESTIONNAIRE

**REABLEMENT: STAFF SEMI STRUCTURED QUESTIONNAIRE**

**Questionnaire Target Audience**

Social Work - Admin, OT's, Social Care Workers,
Social Care Direct - Admin
Rehab - Admin, Nurses, OT's, Physio's, support workers, Business Operations OP's team, Operational Managers
Cordia - business support admin
Cordia - Homecare co-ordinator, Home carers,

1. **Organisation Working for** ☐

2. **Job Title** ☐

3. **Work Pattern** Full Time ☐ Part Time ☐ Job Share ☐

4. **Are you working**
   a) Solely with reablement service users ☐
   b) Reablement and other service users ☐
   b) Other service users include _____
   c) Not working with any service users ☐

5. **Were you offered a choice to work with reablement?**
   yes ☐ no ☐ not sure/ don't know

6. **Briefly describe what impact reablement has had on your work remit?**

7. **a) Overall, how would you rate working within reablement (tick only one option)**
   Excellent ☐
   Very Good ☐
   Good ☐
   Adequate ☐
   Weak ☐
   Unsatisfactory ☐
   Not sure/ no comment ☐

   **b) Please provide some additional information to support your answer at Q7a)**

8. **a) How different is your role within reablement compared to what you did previously? (tick only one option)**
   It has changed drastically ☐
   It has changed only a little ☐
   It has not changed at all ☐
   Not sure/ no comment ☐
   Not applicable ☐

   **b) Please use the space below to support your answer more fully at Q8.a)**

9. **a) How would you rate each of the areas below in terms of level of support received to work in reablement (tick only one option per row)**

| | Excellent | Very Good | Good | Adequate | Weak | Unsatisfactory | Not applicable |
|---|---|---|---|---|---|---|---|
| written information provided/ shared | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| briefings/ meetings held & info shared | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| electronic information provided/ shared | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| questions answered when needed | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| terms & conditions offered | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

   **b) Please provide additional information to back any of the responses in the question above**

**10. In your opinion what are the main aims of the reablement service? (tick all options that apply)**

To reduce dependence on home care
To 'do with' service users instead of traditional 'do for' or 'do to'
Promoting independence for the service user
To promote interagency working
To save money
To improve quality of life
Other
Not sure/ no comment
Not applicable

**Please use this space to highlight other aims**

**11. Have you been offered any training to do your current job in reablement (tick only one option)**

yes
no
Not sure
Not applicable

**12. a) If training has been offered, how would you rate it? (tick only one option)**

Excellent
Very Good
Good
Adequate
Weak
Unsatisfactory
don't know/ no comment
Not applicable

**b) Please use the space below to give additional information on the training to support your answer at Q12**

**13. Briefly say in terms of reablement what is working?**

a) for you the worker?

b) the service user?

**13. Briefly say in terms of reablement what needs to be improved**

a) for you the worker

b) for the service user?

**14. a) If working directly with service users, what kind of feedback have you had from them regarding reablement service?**

Very favourable
Favourable
Not so favourable
Not favourable at all
Not sure/ no comment
Not applicable

**b) Please provide additional information to support your answer at Q14**

**15. Please provide any additional information**

**Thank you for taking part in this survey**

## APPENDIX 7: QUALITATIVE RESEARCH – MAINSTREAM HOME CARE STAFF QUESTIONNAIRE

### HOMECARE MAINSTREAM: STAFF SEMI STRUCTURED QUESTIONNAIRE

**1. Job Title** _____

**2. Work Pattern**

| Full Time | Part Time | Job Share |
|---|---|---|
| | | |

**3. Overall, how would you rate the handing over of service users from reablement to mainstream home care ?(tick only one option)**

| | |
|---|---|
| Excellent | |
| Good | |
| Average | |
| Fair | |
| Poor | |
| Not sure/ no comment | |

**4 What worked well with the transfer process?**

**5 What could have been done better?**

**6 Did you receive adequate information to allow you to support the service user?**

**Yes** ☐ **No** ☐ **Not sure/ don't know** ☐

**7 If yes, what information did you receive?**

**8 How was this information passed over to you?**

**9 What is your understanding of the reablement service?**

**10 How were you informed about the reablement service?**

| | yes | no |
|---|---|---|
| **Homecare co-ordinator** | | |
| **Team meetings** | | |
| **Work collegues** | | |
| **Training** | | |
| **Other** | | |

**Please specify** _____

**11. If yes answered to any of the options at Q9,**
**a) what information were you provided with?**

**b) was the information sufficient?**

**12 Since supporting services users from the reablement service**
a) In what ways would you say your work practice has changed?

b) Have you been able to continue to support to service users to maintain their level of independence (functional ability)?

**13 In your experience do service users transferred from the reablement service generally**

| | |
|---|---|
| require a higher level of support from mainstream home care | |
| require the same level of support from mainstream home care | |
| require a reduced level of support from mainstream home care | |
| support needs varied for all service users so cannot comment | |
| not sure/ don't know | |
| other | |

Please specify other _____

**14 Please feel free to add anything else regarding the transfer of service users from the reablement team to mainstream home care?**

## Thank you for taking part in this survey

## APPENDIX 8: QUALITATIVE RESEARCH – CORDIA DISCUSSION AND ACTION PLAN

The session was lead by Ann Watson with some help facilitating from Jill Scoular. 18 carers and 3 coordinators from reablement teams across the North East sector were invited to take part. Jill wrote comments up on a flip chart and these are in this document as part of an action plan.

The agenda for the day can be seen below:

- Training:
    - Is it fit for purpose?
    - Should there be more topics covered?
        - i.e. Stoma care, PEG feeding, managed medication?
    - Did they feel equipped to provide reablement homecare following the training?
    - Did you feel it was different from mainstream training?

- Blackberry
    - Are you using the device?
    - Are you comfortable using the device?

- Care Diary
    - Does it work?
    - Are you comfortable with the progress note writing? Did you receive enough training at the training sessions and through the weekly meetings?
    - Do you read the summary of the assessment?
    - Do you find the communication section useful?
    - Any improvements you would like to suggest?
    - In you opinion is it better than/worse than/same as mainstream diary?

- Your Role
    - Do you feel you are performing a different role in reablement than mainstream?

- Interface with Rehab and SWS
    - Do you have any comments on the information sharing with colleagues in SWS or the rehab team?
    - Do you feel the benefit of case discussion at the weekly meetings?
    - Do you feel confident enough to contribute to the weekly meetings?

- Pattern of visits
    - Do you feel there is still a substantial amount of work in the evening?
    - Do you feel tea and tuck calls are appointed appropriately?

- Outcomes
    - Handover to Mainstream
    - PSP

- Weekend Discharges

**CORDIA ACTION PLAN**

| Topic | Discussion Point | Comments | Actions | Responsibility |
|---|---|---|---|---|
| Training | Fit for purpose? | Too long and repetitive | None – comments from early session delivered by JIT | |
| | Medication | Include Managed medication training | | |
| | | Carers identify medication issues, coordinator highlighting MM scheme to OTs | OTs to receive training/ awareness session of MM | SWS |
| | Small Equipment | OTs often provide small equipment i.e. sock aid, include training on how to use equipment | Speak to Louise Wilson to include in OT section of training | JS, JMcG & LW |
| | Bath Boards | Other equipment used by OTs that we are not familiar with | Speak to Louise Wilson to include in OT section of training | |
| | Other client groups? | Require other training to be included i.e. mental health training | Discuss with Training | JS & JMcG |
| Weekly Meetings | | All reported feeling confident at the meetings | NFA | |
| | | All felt comfortable providing own views | NFA | |
| | | All felt they had a good relationship with the OTs | NFA | |
| | | All felt it would be an advantage to have rehab present at the meetings | Strategic work ongoing | NHS/SWS/Cordia |
| Blackberry | | Not enough training for those not 'tech' minded | Training arranged for some and can be arranged for others | JS & AOMs Denise Hay |
| | | Request for top up / further training i.e. short cuts etc | JS to speak to Denise Hay | |
| | | All using them and feel they are a requirement | NFA | |
| Care Diary | Daily Progress Sheets | Not enough space to write | monitor | JS/ AOMs |
| | | Older style of reporting? Family in? tea? etc | Continue to monitor | |
| | | Are we writing too much? | Continue to monitor | |
| | | Giving too much info when describing transfers? | JS to speak with LW re OTs advising in weekly meetings | JS |
| | Personal Information | Not filled in, whose responsibility? Where does the info come from? | Procedure agreed and communicated – continue to monitor | JS / RSMs |
| | Summary Assessment | All said that it was read and of value | NFA | |
| | Communication log | All said that it was read and of value | NFA | |
| | | Well used by OTs /DNs and families | NFA | |
| | Care Plan | Keep emailed copy as a ref for shopping housework etc | Procedure agreed and communicated – continue to monitor | JS / RSMs |
| | | Not all team get an email forwarded with the referral | | |
| | Communication | Communication from office not always good esp OOH | Monitor with new OOH service | JS |
| | Handover between shifts | Some email their back to backs | Procedure agreed and communicated – continue to monitor | JS / RSMs |
| | | Some have handover diary | | |
| | | Some have handover meetings | | |
| | | Work schedules need to be updated with w/e changes | | Coordinators |
| | PSP | Not done for 'not suitable' | Procedure agreed and communicated – continue to monitor | JS / RSMs |
| | | Updating existing PSP | | |
| | | Not everyone in the room was familiar with PSPs | | |
| | | Coordinators should speak to team re info in PSP | | |
| | | ~~Smooth handover – reablement coordinators should make mainstream~~ | | |

| | | | | |
|---|---|---|---|---|
| | | aware of PSP | | |
| Pattern Of Visits | | Generally the carers feel they are seeing the same pattern of visits. | Continue to monitor | |
| | | Occasionally a tuck will be removed | | |
| | | Carers see some flexibility for later/earlier visits | | |
| | | Sometime a combined tea/tuck or 'brunch' | | |
| | | All visits are being discussed at weekly meetings | | |
| | | 35H worker OOH workload can vary week to week | Capacity issue highlight to SWS | JS / SWS |
| | | Not enough reablement clients | | |
| Handover to Mainstream | | Carers reported little or no handover meetings | Procedure agreed and communicated – continue to monitor | JS / RSMs |
| | | Carers told to remove reablement diary and put in mainstream with no information handed over | | |
| | | Some examples of info sharing reported | | |
| | | Some examples of face to face handover reported | | |
| | | Variation across all areas reported | | |
| | | Reported that care packages agreed at transfer often change when transfer occurs esp when rehab or dual clients involved | Discuss at NE operational meeting Try to get examples | JS & AW |
| Communication | Weekend / OOH | Better communication required | New OOH structure – continue to monitor | JS / RSMs |
| | | Need team emails work records shared etc | | |
| | | Transfer paperwork OOH is vulnerable sometimes reablement still attending after transfer | | |
| Operation Problems | Medication | Carers unsure what to do with medication when patients discharged with a bag of medication from hospital | Assessment issue? – highlight to SWS | JS / SWS |
| | | Pharmacy can offer help but carers do not know persons capacity/ how much they should be doing. | | |
| | Personalisation Agenda | Client needing only house work and shopping after reablement. Coordinators have leaflets but OTs cannot/will not recommend us but other providers instead. | Highlight to SWS | Frances McMeeking |
| | Equipment | Sometimes waiting for initial assessment over a few days carers unsure of suitability or equipment required. | ? rehab delay | JS / G Bryan |
| | Notice | Reported that sometimes given very little notice if any on a transfer to mainstream | Continue to monitor | JS |
| Their Role | is reablement different? | Unanimously felt that the reablement role was different for the Homecarers | NFA – continue to monitor | JS / RSMs |
| | Beneficial? | All carers felt it was beneficial to clients | | |
| | | All carers felt it was a moral boost being included in the weekly meetings to discuss progress. | | |
| | | All carers felt it was moral boosts watching the service users make progress. | | |

## APPENDIX 9: QUALITATIVE RESEARCH – SOCIAL WORK DISCUSSION AND OT ACTION PLAN

| Key issue | Action | Responsible | Target date |
|---|---|---|---|
| Lack of clarity and procedures around non-Reablement specific roles such as major adaptations.<br>Lack of clear guidelines as to working with community OTs when a reablement case is also on OT waiting list or has been allocated to OT | Further discussion around Reablement OT role and capacity in dealing with major adaptations, and development of clear guidelines regarding same. Fiona to draft protocol and circulate for discussion with Team Leaders at OT Management meeting | Fiona Brown, Louise Wilson, SW OT Team Leader | OT management meeting taking place on 26/11/12 |
| Lack of clear boundaries for roles in situations such as ASP issues. | Mental Health Legislation training<br><br>Further team training around ASP issues and relevant Community Care acts<br><br>OTs to complete Gold module on SSA | Louise Wilson<br><br>Cath Bagley | AWI and MHA training arranged for 28/11/12 and 04/12/11<br><br>Cath Bagley to present to team on ASP issues 14/01/13 at team meeting<br><br>January 2013 |
| | Development of guidelines surrounding role of reablement OT in ASP issues | Louise Wilson/ Cath Bagley | January 2013 |
| Lack of clarity around OT role within new community home care referrals | Further training regarding dealing with new home care referrals, particularly guidance on recommending assistance with non-personal care tasks. | Home Care Team Leader | January 2013 |
| Need for good joint working between OTs and Home Care SCWs, and awareness of roles, to continue and improve | Regular joint home care and Reablement team meetings<br><br>Training needs of staff re. home care and Reablement to be highlighted in supervision | Louise Wilson/ Home Care Team Leaders<br>Louise Wilson/ Home Care Team Leader | Ongoing from November 2012<br>Ongoing |
| Joint discharge visits between OTs and SCWs proving difficult to arrange and would be better targeted for discharges where there are contentious or complicating circumstances | Action now implemented from October 2012 | N/A | |
| Ambiguity and 'grey areas' to Reablement team roles in relation to working with Community Stroke Team (CST) | Process now being implemented whereby clients with CST involvement on hospital discharge are screened out of reablement by SCD and referred back in by the CST at an appropriate stage. This requires ongoing collaboration and monitoring to ensure appropriate referrals are received | Louise Wilson/ CST Team Leader (Claire Stewart) | ongoing |
| Ambiguity and 'grey areas' to Reablement team roles in relation to working with rehabilitation team | Work to improve communication and joint working ongoing. Reablement OTs now phoning rehabilitation teams daily to cross check referrals, and, in the North East, are attending weekly rehabilitation meetings to discuss joint reablement and rehabilitation clients. Plans are in place for this to be replicated in the South and North West.<br><br>Guidelines regarding criteria for reablement and rehabilitation OT involvement have been written and agreed by reablement and rehabilitation.<br><br>Above ongoing work requires monitoring. | Louise Wilson/Rehabilitation managers | ongoing |

| | | | |
|---|---|---|---|
| Lack of confidence/knowledge around completing financial assessment forms | Further training/guidance on completing financial assessment forms | Louise Wilson | January 2013 |
| Insufficient/incorrect referral information being provided on hospital discharge creating difficulty accurately desktop screening | Log of examples and further discussion with acute representatives | Louise Wilson/Fiona Brown/ Steering Group | ongoing |
| Lower than anticipated referral numbers | Ongoing work to target community referrals under way | N/A | |
| Further clarity on medication issues, particularly regarding Cordia roles and responsibilities required | Medication training session by community pharmacist for all Reablement staff<br>OTs to receive information on medication training provided to Cordia staff | Louise Wilson<br>Louise Wilson | February 2013<br>February 2013 |