•IRISS•

reablement team. *Studying, research and developing*

•IRISS•

Reablement. *Stage one*

- Introduction to reablement.
- Who is involved in the reablement services.
- Main aims & goals.
- Workshop.
- The personas & SWOT analysis.
- Insights, opportunities & the next steps.

Introduction

What is it?

To give a person the support they need to live an independent life and compensate what disease has taken away from them.

How it differs.

The focus is enabling people to regain their skills and abilities. The method of reaching that goal is dependent on the skills and abilities we want to acheive.

What does it do?

It provides economical, physical, psycological and social support to satisfy basic needs and restore abilities, self confidence and independence of each individual with understanding of their uniqueness.

* Social work services-Reablement core brief.

People involved in the reablement services.

Who is needed?

Occupational therapists
Reablement coordinator
Reablement home carers
Team leader
Area operations manager

Main aims & goals.

To get people living with minimal support from other services.
To reable each individual in accordance with their needs and desires.
To change the mind set that there is no life/fun after 60.

* Social work services-Reablement core brief.

Opportunities.

Prioritising housing is often prioritising reablement.

Promoting effective methods for carers will increase successful reablement.

Care on the right time could limit the damages.

Success stories within reablement could motivate clients towards becoming more independent.

Workshop.

What did we do?

To gain a better understanding of what servises are like now, our initial research took us to the south of Glasgow whare we designed a workshop with a group of older people. In this workshop we wanted to find the strengths, weaknesses, threats and opportunities of all services people were involved with. Our workshop was well structured but ended up being one big discussion. In the end this worked out well as we gained many insights and lots of contacts.

First step - icebreaker

To get the participants to relax, we showed pictures of activities to inspire them to think about what they enjoy.

Second step - three questions

What matters most to you?
What gaps are in the services you receive?
What would you want to change?

Third step - ability mapping

Activities
Transport
Chores

Hospital
(Fast track)

24hrs

24hrs

4-6 weeks

Paitent is due to be discharged
from hospital
referred to Rehabilitation Team.

Assessment
while in hospital
discusses needs
and aims
(reason behind the
aims).

Discharged from
hospital, with
support package
in place 4-6
weeks depending
on needs.

Discharged

Care is offered for as long
as the client requires, and
changed accordingly.

Community
(Non fast track)

Refered from GP, Social Services
or Self Referal and assessed.

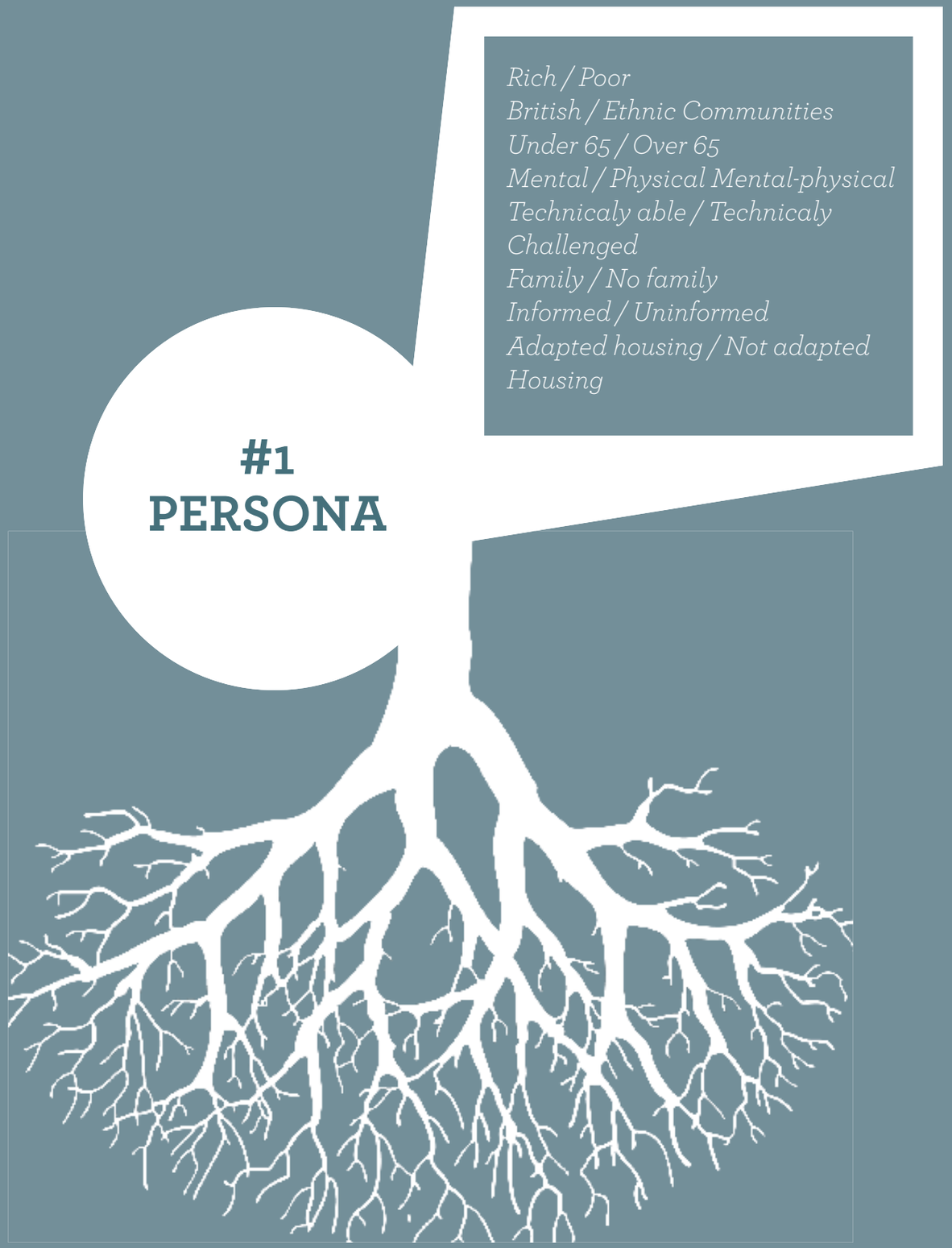
Care Package is set up based
on needs of client (often long
term condition).

After talking to both people who use services and professionals, we can now draw out a service map, which looks like this.
This helps us create a step by step journey through the services that any one of the people we've spoken to could have taken.

Personas - mapping.

Wealth Ethnicity.
Age.
Condition.
Technology.
Family.
knowledge.

From contacts gained at the initial workshop we were able to come up with personas to put through our service map, and to use in future to test out our concepts. We also came up with a persona mapping technique, from this we could make up all possible personas to test against the idea spectrum.



The personas characters.

Personas

"Henry"

Carer for his wife who is 67. She is wheelchair bound after suffering from a stroke. She could walk after leaving the hospital. She didn't receive any further treatment and her condition worsened.

"Doris"

Carer for her sister who became paralysed. Though her sister was mentally fit, she spent much of her time in her living room because of the vast expense of adapting her house. Doris became her full time carer.

"Anne"

Carer for her husband who has dementia, and also other family members. She would like her husband to be more independent but feels she lacks the means to make this happen. Anne finds tremendous support from her carer group.

"Aisha"

She speaks very little english, she has a large support system within her family, and there is an issue of pride in keeping it that way. She is still quite phisically able but she is not really motivated towards reablement as she is uninformed.

Workshop.

SWOT analysis

Strengths

Free up resources.

Short term intervention.

Benefits sustained for 12 months or longer.

Reduce use of home care.

Gives user feeling of independence & control.

Builds confidence.

Staff – satisfaction due to results.

Focus on positive results.

Helps user regain skills.

Enables people to stay at home.

Changes mindset & expectation.

Weaknesses

Age based instead of needs based.

Only free for 6 weeks.

Living aids hard to get.

Time gap between services.

No follow up.

Lack of recognition of differences between people.

Budget.

Opportunities

Technology.

Health promotion & motivation (success stories).

Educate & inform.

Make services personal.

Continuity of services.

More flexibility with housing especially GHA.

Improving living aids.

Threats

Capacity.

Housing.

Access.

Budget.

Current mind set.

Poor training.

After gathering all our initial information we now had a good idea of what reablement was and how its being run at the moment. We could not draw out a SWOT analysis to map out the strengths and weaknesses of the service.

Insights.

Findings.

Poor ***housing*** is a big obstacle to reablement.

There is a lack of ***carer awareness***

Lack of ***motivation*** from both service providers and users.
Time gap between services can create major damage within reablement.

From this analysis we could then extract the main insights, weaknesses and opportunities.

Opportunities.

Prioritising housing is often prioritising reablement.

Promoting effective methods for carers will increase successful reablement.

Care on the right time could limit the damages.

Success stories within reablement could motivate clients towards becoming more independent.

•IRISS•

Reablement. *Second step.*

- Summary of initial research
- Second stage research & meetings
- Personas
- Maslow pyramid - swapping & sharing
- Concepts
- Work method - next steps

Second stage research & meetings

Meetings

Cornerstone Care
Sheltered housing
Nan McKay Hall

Our next step was to visit professionals in their work place. In one week we visited Cornerstone Care, sheltered housing and the Nan Mckay Hall. This again gave us a greater understanding of how these places were run, highlighting further strengths and weaknesses.

Shared housing

Visiting the shared sheltered house.

There were 10 adults living in the house - 6 women and 4 men.

The lower level contained 2 flats of 3 women each.

The upper level contained 4 men, 2 in each flat.

The standard of living conditions were, very high- each adult had their own bedroom furnished to their taste.

In each flat there was at least 1 member of staff looking after the residens of the property.

The reason the system works so well is due to the reduction of travel times of the staff between properties. During the night 1 member of staff remains in the property (75% less staff then if each person lived on their own) there is a peak of staff on during the day till about 2pm, then its reduced accordingly.

Nan McKay hall

-The hall has been running for 30 years

-Its used by most people in the community but mainly by older people

-It is used for a variety of activities: bingo, lunch club, dancing, zumba, beading, crafs, computer classes, photography, exercise, holidays

-They also go on different nights out - they feel safe all together

-Some were reluctant to take on new things but others said they love trying new things, “its much better than staying in on my own”

-There were a few people that came that were not from the area, they travel to the hall because there is nothing like this where they live

-Some of the things they make at the hall they sell to raise money

-One woman made cards to sell to raise money for a cancer hospice

-How is this place funded? Lottery funding, fund-raising days, selling things they make, selling cards, bric-a-brac

-They have lunch days at the hall, lunch is provided from school kitchens, they pay £2 and get a 3 course meal

-What would you do if the hall wasn’t here? “I’d be stuck in the house” “I’d be stuck between my four walls

-Where would you go to meet friends if the hall want there? “Maybe their house of a cafe”

-Where would you go to meet new people? “ I wouldn’t”

-Hall was made of recycled buildings, and old school that had an upgrade donated them

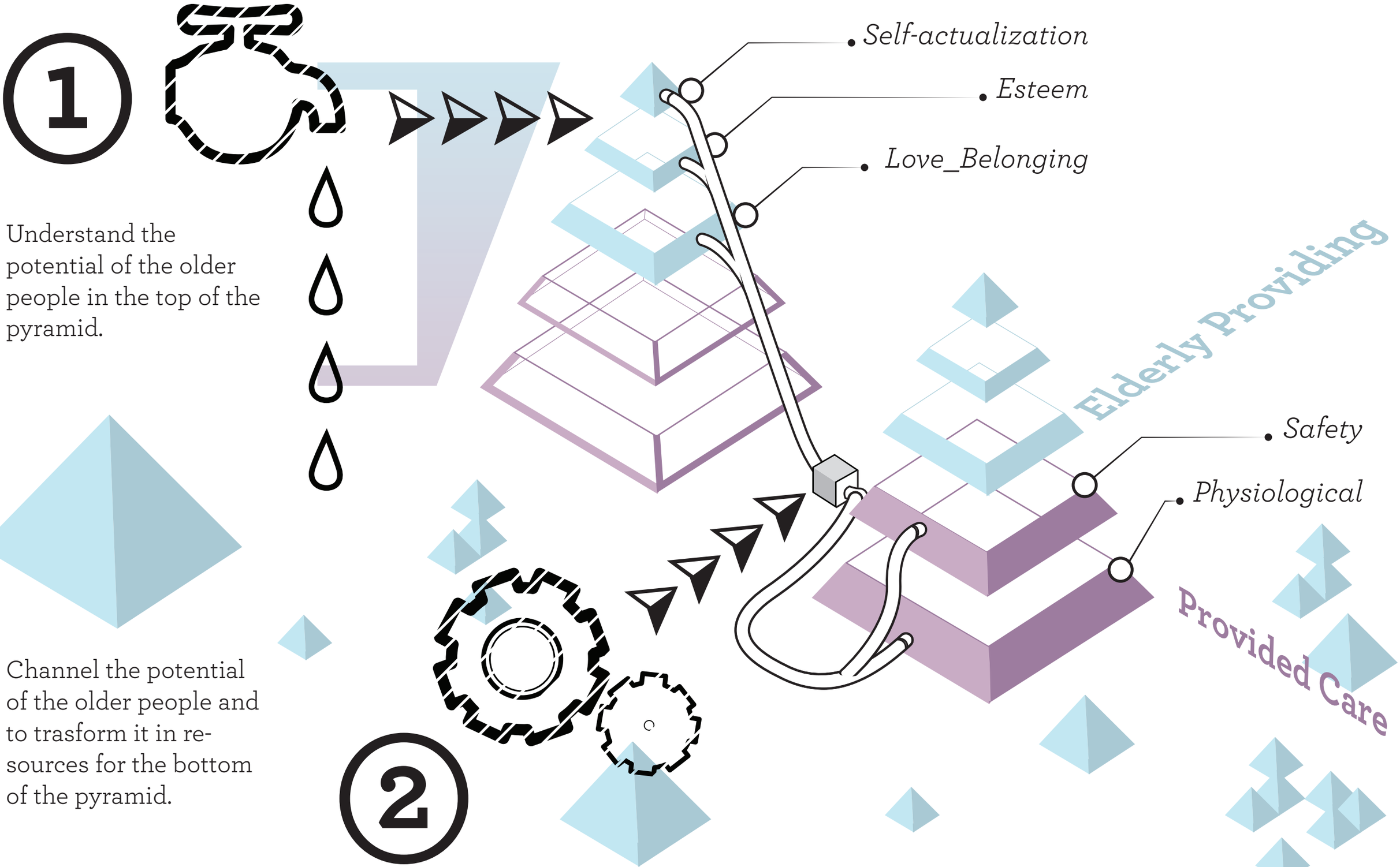
-Do you use the internet? “No not at all, I don’t see the point in it” “yea, I use ebay to buy and sell”

Floating care

Provides support to over 16's to enable them to stay in their own home.
The care is not tied to a particle properly.
The service is provided on the understanding the care will last no longer than two years.
The care is flexible to the persons needs.
Available to the following client groups:
Older People
those with Mental illness
learning/ physical disabilities
sufferers of Domestic Violence
Drugs/alc problems
Homeless

Refugees
Teen parents
Young people at risk of leaving care
HIV/Aids sufferers
The service is free to those who
receive housing benefit.
all others must go through a ‘Fairer
charging assessment
the service is not designed to replace
personal care/health care.
suitable :
Helps set up/maintain a house or
tenancy.
Maintain finances/benefit claims.
developing independent living skills.
gaining access to services
ensuring the home access is safe and
secure.
services normally follow a discharge
from Hospital.

Hierarchy pyramid



Work method

Our goals

Service

Reablement today

Evalutation & Feedback

Bring older people together

Older people to give back/provide

Raise self esteem

Reduce need for home care

Create a sustainable service

Require little funding input

Perception of being useful/pride

Better quality of life

Ideas

Achievieng

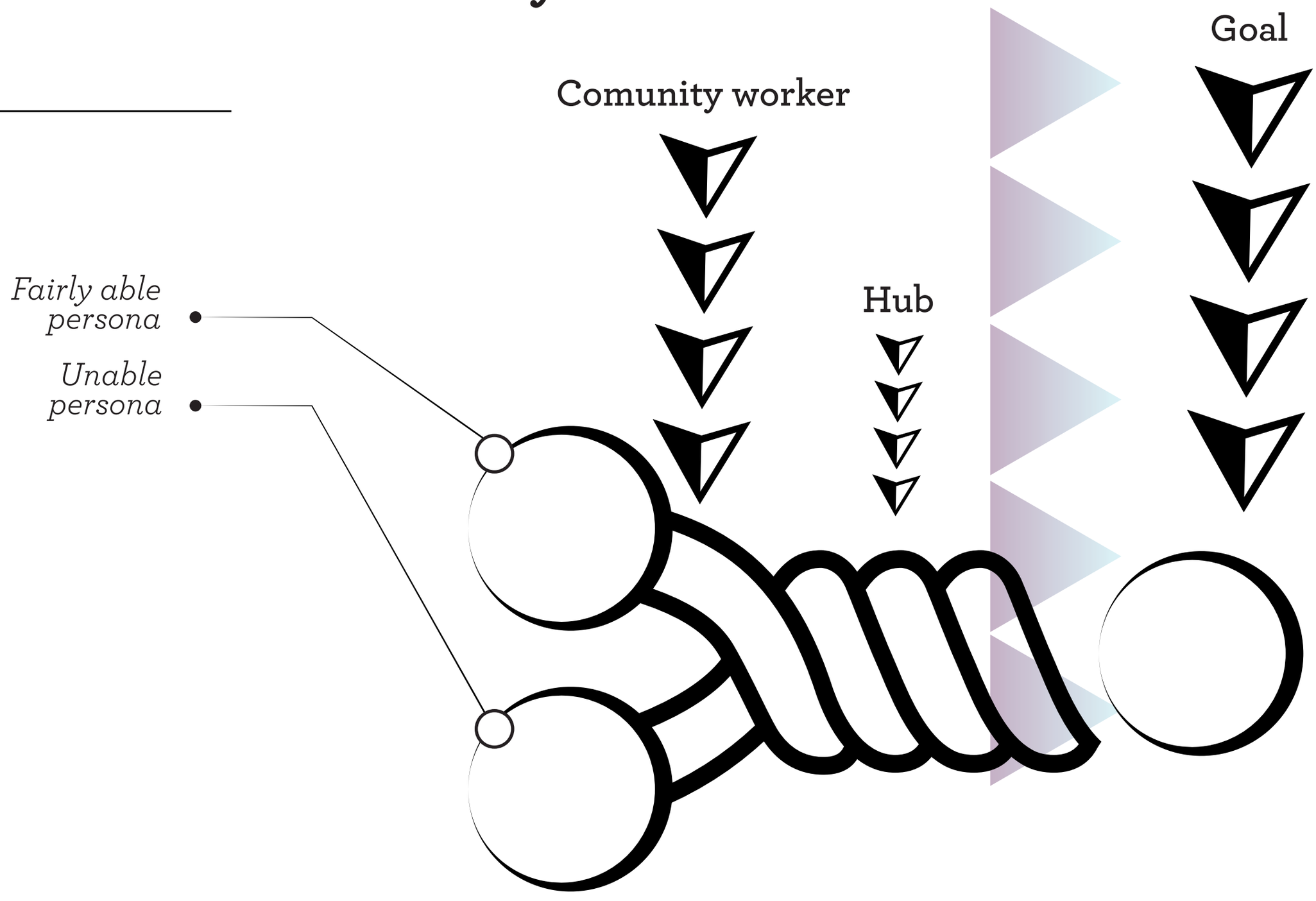
•IRISS•

Reablement. *Third step.*

- Concept
- Further research
- Concepts to take forward
- Development of these concepts
- Next steps

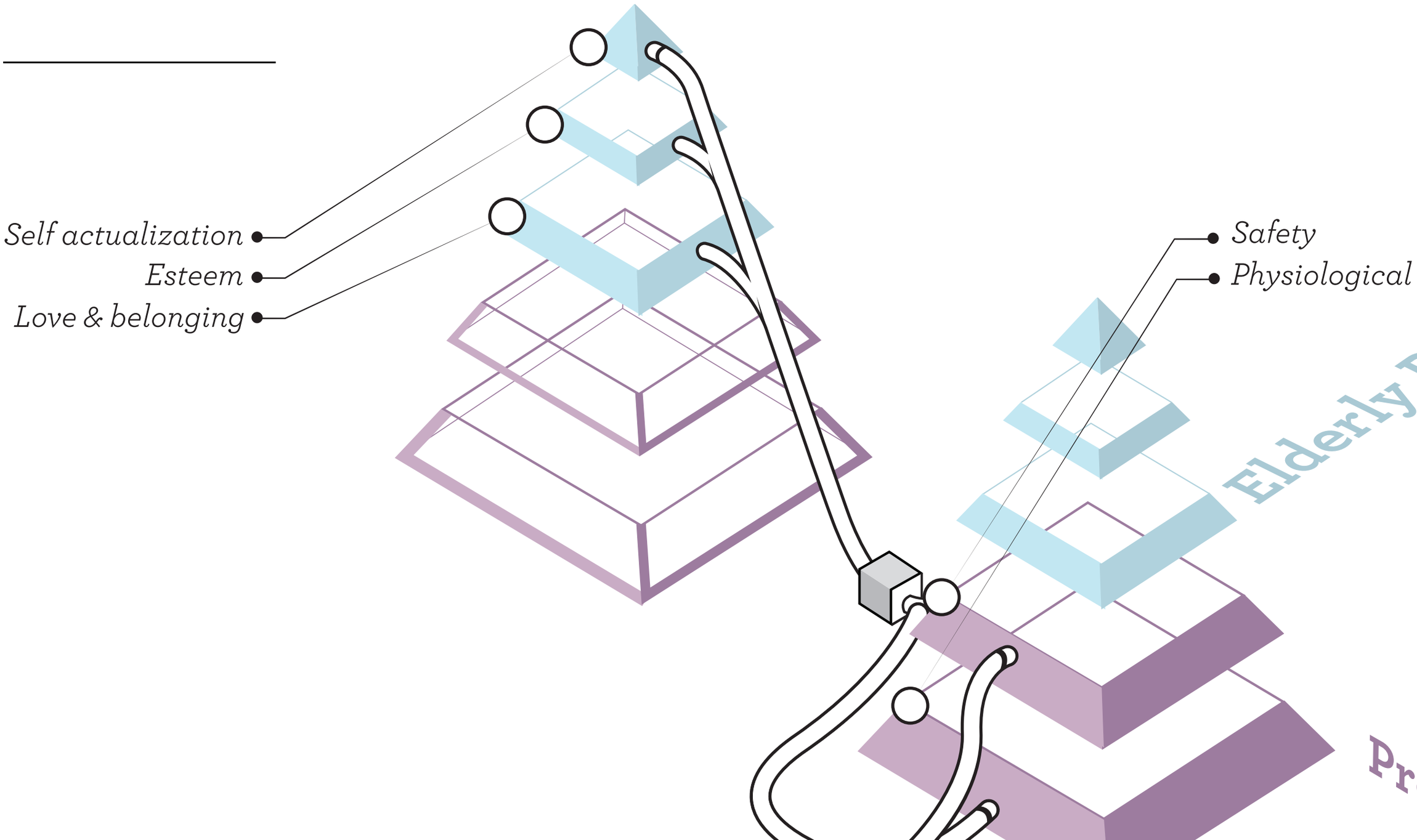
Main concept to branch out from

Reablement buddy



What would this deliver that's not already there?

Reablement buddy



Connecting People

-People might be connected through more points on different levels of the pyramid. The main aim is to link them together building stronger relationships.

-Link people together through habits (like a cup of tea in the afternoon), common experiences (e.g. same past occupation, mutual friends or historic events), hobbies (fishing, playing sport), passions (supporting the same football team).

-Can their physical problems be solved together?
Do they have mutual habits/ hobbies/experiences/passions

-Older people can share their home, or share the home of another.

Professional organizations which specialize in these arrrangements match the two parties based on needs on one side with abilities to provide on the other side. They screen before matching and follow up afterwards to help the match work out. Most organisations who do this are non-profit.

http://www.seniorresource.com/house.htm#share

-A 70-year-old widow lives alone. She finds that her house is difficult to maintain, and she worries about having someone close by in case she falls. An 85-year-old woman is living in an unlicensed boarding home. She wants to move because she is expected to remain in her small room most of the day.

-They find each other. The 70-year-old feels more secure and the 85-year-old has found the independence she wants. They collectively say, “We are so fortunate to have found each other.”

-These are two of a growing list of older persons who have found shared housing to be a much more desirable alternative than living alone, living with children, living in a senior citizen high rise apartment building or transferring to a long-term care facility or nursing home. “family of choice”.

http://extension.missouri.edu/p/GG13

Naturally occurring or "free market" models exist when homeowners with extra bedrooms to share get together with people seeking a shared living arrangement (home-seekers).

Agency-assisted models are designed to perform matchmaking services between people with homes to share (home-sharers) and individuals who are searching for a home (home-seekers).

Referral models are purely a housemate referral service. Once the referral is made, little or no follow-up contact is maintained.

Counselling models provide many more personal services such as:
-Personal interviews and questionnaires that might include a review of personal references and attitudes as well as a lifestyle inventory to assess client needs and preferences
-Get-acquainted sessions where potential home-sharers get together for the first tine
-Advisory assistance in the negotiation of homesharing agreements
-Follow-up assistance in resolving any problems between matched clients. This model is attractive to people who are trying the shared-housing option for the first time or those who are unable or unwilling to independently find a satisfactory match

Agency-assisted models generally make the following types of matches:

One-to-one peer matches between an older homeowner and an older tenant sharing housing costs

Intergenerational
matches involve an older homeowner sharing his/her home with an unrelated younger person or vice versa

Group
Residences where three to eight people rent or purchase a home, each having his/her own bedroom and sharing common areas

Barter
Arrangements involving an exchange of service (cooking, house work, or gardening) for reduced room and board or some other financial agreement.
Most clients using the matchmaking model view shared housing as a short term solution to a problem.

Agency-sponsored models do it all. They operate a group residence where agency staff interview, screen and select prospective residents. They also provide hired personnel who perform necessary household tasks (i.e., housekeeping chores, provision of food, transportation, laundry services and household financial management).

http://extension.missouri.edu/p/GG13
- loads more info on the website!

Main Points Gained from Edinburgh Council's Reablement Evaluation

-Clients and staff noted the speed of response to the new system, in terms of how quickly the care package was put together and how quickly adaptations (new chairs and walking frames) were delivered to their homes.

-OT's thought that the new system was very similar to the work they were already doing, in the fact that they were getting clients to do as much for themselves as possible.

-Most clients that were discharged from hospital and said that they would not have been able to cope without the support they had in

the first few weeks after being discharged.

-The new system was goal based not task based, staff said goals change through out the service to progress the client, some older clients however were reluctant to try out this new service.

-Not all clients were aware that they were working towards goals.

-Most clients were happy with their new plan and reduced care hours, but some families were unhappy with the reduction of hours.

-The flexibility of the new service benefited both job satisfaction for staff and care delivered for clients.

-Several clients raised the issue of the lack of cleaning and housework

services being offered with the new service.

-Clients receiving the new service require fewer hours of care, saving in terms of time and money.

-Over the first six weeks care needed did not reduce it increased by 1.6% before any savings were made.

Our developed service should ...

-Keep up the speed of care delivery and delivery of adaptations.

-OT's should have somewhere to feedback about what techniques work best to reable someone, especially people that are reluctant to get involved.

-Information can easily be delivered to older people in hospital, we need to make sure those not in hospital get the same information and opportunity to get involved in the reablement service.

-Use stepping stone goals to reach one main goal, positive feedback after each goal reached will motivate the client even more to reach the main goal.

-Make sure these goals are clear and are agreed with the client, make sure they are clear on what is to be achieved.

-Deliver as much information to the clients families as the clients are getting, explain the long term benefits to people that might be short sighted on the matter.
-Keep this flexibility to maximise potential.

-Use care hours and money freed

up by reablement to improve these domestic services that may have been forgotten.

-Time and money saved should be put back into the service or other services to improve more care.

-Explain the long term benefits for everyone to see, stop short sightedness from hindering reablement's potential.

Reablement Now

Service awareness

Improve service awareness so everyone knows about reablement and know that it is an option of care.

Eligibility, self referrals, clear assessments

If people are aware of reablement, we could generate self referrals, handling problems that might have been missed before

Clear options of how reablement can be delivered

Not all forms of reablement will work for everyone, creating diverse forms of reablement will allow the maximum amount of people to get involved.

Individual should tailor goals for their needs

For results to be achievable and realistic it is important that the individual works with a professional to create their own personal goals.

Put into practice, progression should carve a new shape into the service as time moves on

The individuals goals and service should continuously be reviewed to ensure maximum success.

Log/praise success, use success to breed success within the service

Positive feedback is very important, this feedback will motivate clients and again improve success.

Older people can create social enterprises using their skills/ knowledge, maybe generate income.

Using the skills or knowledge gained from the service(buddy) older people could set up social enterprises,this would raise esteem with those involved and has the potential to give back to the service.

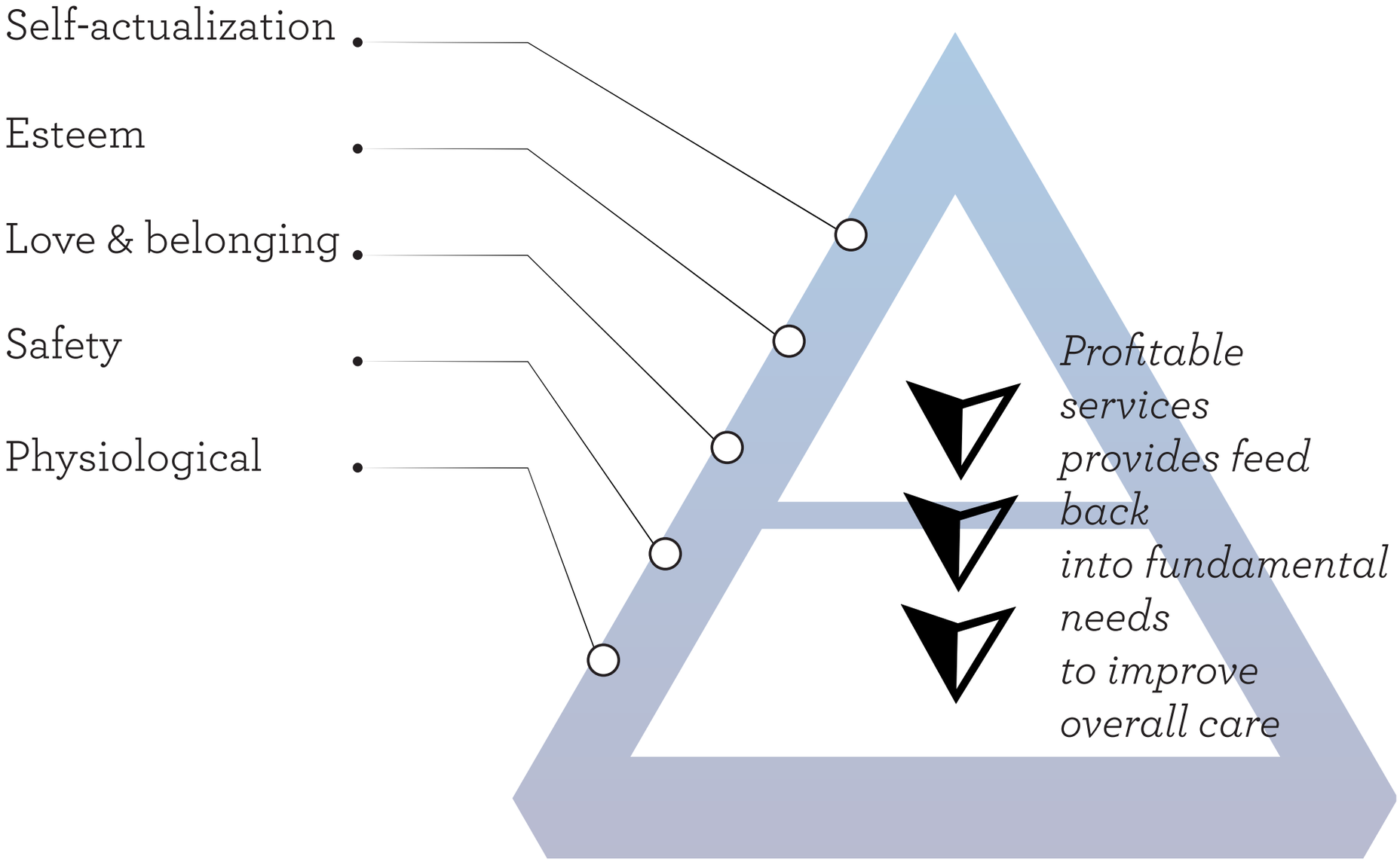
Money or time made can be put back into the service

Money made or donated from these social enterprises can then be put back into the service. Professionals time saved from this buddy service can also be put back in, to improve care further or to take it to those without care.

Long term Goal Enable older people to live an independent life for as long as possible with efficient input.

Relationships gained and formed from this service will have a long term affect on the lives of all involved, making a huge long-term saving for stake holders involved.

Hierarchy pyramid



Older people providing

Provided care

Principal situations

Type of Person	*What they would require* *How to involve them*	*The Form*
Mobile social	Lots of people, very interactive	Anywhere
Immobile Social	Lots of people to them, easy access	Access from home, local
Very Able	Challenging, Active	A provider, Anywhere
The Gossipy	Eventful, lots of people	“The Hub”, Day center
Rich	Higher quality	A club
Poor	Value for money	No perceived cost
Semi Confidant	Encouraging environment, Rewarding	Competition, Bonuses
Time Rich	Able to occupy	A place they can stay
Pushed for Time	Availability, flexible	Comes to them
Reserved and Proud	Change idea of perception, appealing, attractive	A club
Looked down on	Change perception of self, Respect wanted, Invited, help with reason they feel looked down on.	Invited to come
Shy but wants to be included	Given the option, Invite them, peer pressure	Invited to come
Ashamed of themselves	Reassured, gain trust, change own perception,	Friendly group, comes to them
Very unable	People go to them, Hospital wing, Carer, meals on wheels	Within the hospital/home
The Invisible person	Seen at the shops, Carer/GP, Collecting prescription, Nursing home	“The Hub”

Variety of entry points

Informing older people of the system/places they can go to meet new people.

Working round logistics and trust issues.

Places they can meet or talk.

Guidence and reviews by professionals to make sure the person is on track to reablement

Older people build lasting relationships whilst working through and towards their goals.

Social services
Private Care Providers(cordia)
Primary NHS care
NHS referrals
Inpatient
Groups
Clubs
Care Home
Voluntary
Physiotherapy
GP
Rehab
Self referral

The Hub
Phone Buddy
Vitality classes
Day Classes

Participatory service, users shape the outcome, can easily be tailored/ adapted to suit individuals

Enter the system

Find out about the service

Find your local meeting place

Meet up

Build relationships, work through goals with buddy

Reabled with new found confidance.

Concept questions

What are the main aims/goals of our service?
- Tackle areas of wellbeing like self-esteem, friendship, confidence and trust through the rehabilitation of patients. Act as a follow up service to reduce repeated care.

How does this benefit Users/clients?
- This will reinforce goals set, will act as a follow up to avoid repeating care. Motivate clients to work harder towards clear goals, creates relationships whilst working through reablement.

How does this benefit practitioners?
- Independent older people will require less support over a long time span, time saved here can be fed back into other services, or patients that require more time.

How does this benefit the whole care system?
- This system will act as a follow up service following professional input, this will stop the need for repeated care, and keep people able once reabled.

What are we delivering that wasn't delivered before?
- Addressing higher levels of needs in older life, using first hand expert experience to help both sides

improve their quality of older life.

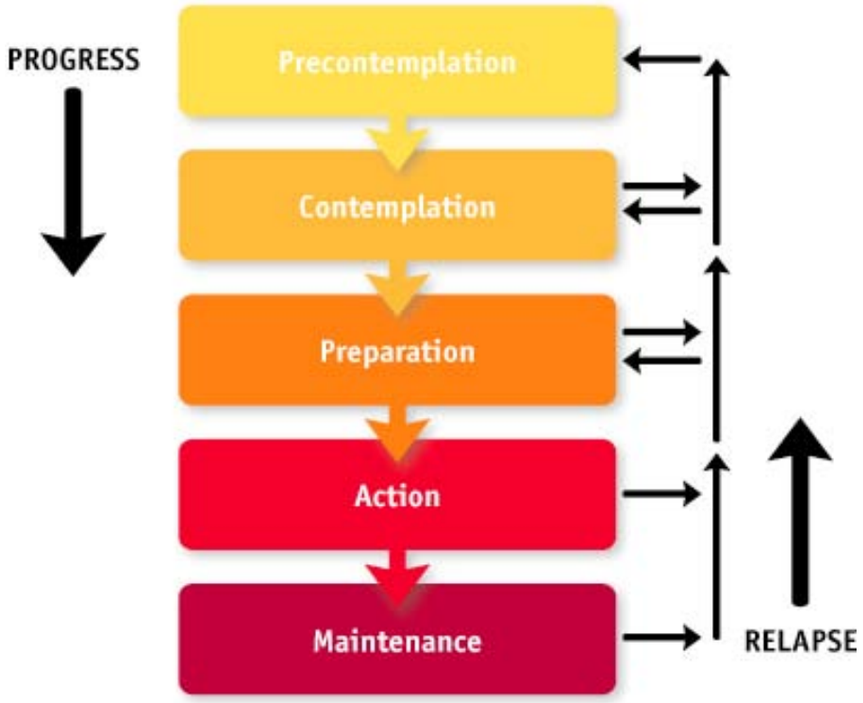
How will this be achieved?
- Grouping older people to work through their reablement problems together. Could either use an experienced reabled patient to pass on their methods, techniques and motivation, or odler people who have similar problems to speed up the reablement process, success breeds success.

How will a grouping be achieved?
-Many ways, using methods used by shared housing associations and that of self help groups. Naturally occurring groups, Agency-assisted models, Referral models, Counseling models, Personal interviews, Get-acquainted sessions, Follow up assistance solving any problems that may occur. One to one peer matches, Intergenarational, Group sessions and Bartering models an arrangement involving an exchange of services.

How would they be informed about the service?
-Information put in existing rehabilitation info packs, posters in GP surgeries and hospital wards. GP referrals, day classes, news papers, radio and word of mouth.

What does this mean for practitioners?
- The manager overseeing the whole process should:
-Set clear, specific expectations and have a dialogue with your pairing to be certain they understand these expectations.

-It is important that they not only understand the goals, but also the reason the team has been created.
-A good manager will allow a team to function without hovering over it, but will be fully involved by eliciting information on a consistent basis, rather than waiting for the deadline to evaluate the results.
-Communicate with the pair, evaluate performance and commitment, and step in to assist when necessary.



For most people behavior change occurs gradually over time, with the person progressing from being uninterested, unaware, or unwilling to make a change (precontemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation). This is followed by definitive action, and attempts to maintain the new behavior over time (maintenance). People can progress in both directions in the stages of change. Most people will "recycle" through the stages of change several times before the change becomes fully established (Zimmerman et al., 2000).

The Stages of Change model is useful for identifying appropriate interventions to foster positive behavior change (Table 6); by identifying where a person is in the change process, interventions can be tailored to the person's "readiness" to change (Zimmerman et al., 2000). Anything that moves a person along the continuum towards making a positive change should be viewed as a success.

STAGE	CHARACTERISTICS	STRATEGIES
Precontemplation	The person is not even considering changing. They may be "in denial" about their health problem, or not consider it serious. They may have tried unsuccessfully to change so many times that they have given up.	Educate on risks versus benefits and positive outcomes related to change
Contemplation	The person is ambivalent about changing. During this stage, the person weighs benefits versus costs or barriers (e.g., time, expense, bother, fear).	Identify barriers and misconceptions Address concerns Identify support systems
Preparation	The person is prepared to experiment with small changes.	Develop realistic goals and timeline for change Provide positive reinforcement
Action	The person takes definitive action to change behavior.	Provide positive reinforcement
Maintenance and Relapse Prevention	The person strives to maintain the new behavior over the long term.	Provide encouragement and support

Source: Zimmerman et al., 2000; Tabor and Lopez, 2004

Buddying for anyone how it should be done

The benefits of working in pairs or teams:
-More creativity leading to more ideas and better results
-Increased satisfaction
-The opportunity to develop and acquire new skills
-The speed at which things can be achieved
-A support network that you can draw on support e.g. more experienced members can help, mentor and develop the less experienced members.

Social Loafing
-Social Loafing is the phenomenon of people exerting less effort to achieve a goal when they work in a group than when they work alone.
-This is seen as one of the main reasons groups are sometimes less productive than the combined performance of their members working as individuals, but should be distinguished from the coordination problems that groups sometime experience.
-Social loafing is also associated with two concepts that are typically used to explain why it occurs:
The “free-rider” theory and the resulting “sucker effect”, which is an individual’s reduction in effort in order to avoid pulling the weight of a

fellow group member.
Social loafing can be minimized
with careful preparation of group
assignments and group members.

To ensure a successful Buddy system
The manager overseeing the whole
process should:
-Set clear, specific expectations and
have a dialogue with your pairing
to be certain they understand these
expectations.
-It is important that they not only
understand the goals, but also the
reason the team has been created.
A good manager will allow a team
to function independently,
but will be fully involved by eliciting
information on a consistent basis,
rather than waiting for the deadline
to evaluate the results.
-Communicate with the pair, evaluate
performance and commitment, and
step in to assist when necessary.

For Goal setting to work

Objectives will only be clear if they
are SMART

program comes down to them understanding that you have their best interest in mind. Sometimes this comes down to reanalyzing your intentions with the program, but most times it comes down to the way you build your relationship with your athletes. Once they know how much you care for them, they're much more likely to respond to your advice."

http://www.kevinneeld.com/2011/5-ways-to-get-the-most-from-your-athletes

Communication channels

Information could be given at ...

-Rehabilitation meetings
-GP's, (possible prescriptions)
-Practice Nurse
-Buddy up days(Buddy Bus)
-Community centers, information Packs
-Word of Mouth
-Vitality Classes
-Radio
-News Papers
-Day carer visits
-Care homes
-Carer centers
-Clubs
-Day Classes
-Physio
-Provider visits/packs
-Private Care visits/packs
-Social services

What form would the information take?

-Business cards
-Radio advert
-Newspaper advert
-Information pack (folder)
-Leflet
-Booklet
-Verbal
-GP referal
-E-mails
-Phone Call
-Buddy Bus
-Discussions at day centers
-Posters
-Banners
-Baloons
-Stickers
-Pens
-Key Rings
Bags
-T-shirts
-Side of a car/van
-Coffee cup

References

www.communitycarer.co.uk
www.csed.dh.co.uk
www.glasgow.gov.uk/en/yourCouncil
www.seniorresource.com
www.cornerstone.org.uk
www.nanmckay.co.uk
www.glasgowonline.co.uk/communitycenter
www.red-design.co.uk
www.edinburgh.gov.uk
www.direct.gov.uk
www.careuk.com
www.socialcareassociation.co.uk
www.gscc.org.uk
www.bupa.co.uk