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Reablement.

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

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Introduction reablement.

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.

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Introduction reablement.

What does it do?

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

Introduction reablement.

How it differs.

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

People involved in the reablement services.

Who is needed?

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

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Hospital
(Fast track)

24hrs

24hrs

4-6 weeks

Paitent is Due to be discharged
from Hospital
Refered to Rehabilitation team.

Assessment
while in Hospital
Discuss needs
and aims.
(reason behind the
aims)

Discharged from
Hospital, with
support package
in Place 4-6
weeks depending
on needs.

Discharged

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)

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

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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.

Workshop.

What did we do?

First step - icebreaker

To get the Clients and carers to relax. We showed pictures of activities to inspire them into thinking about what they enjoy.

Workshop.

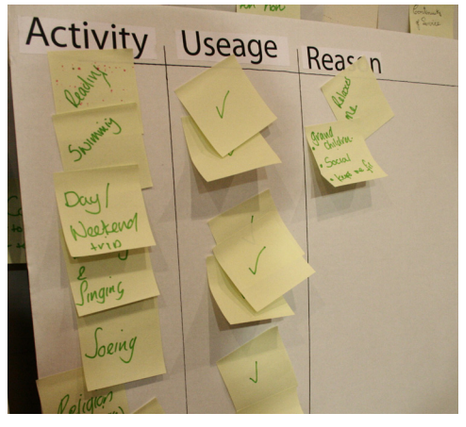
What did we do?

Second step - three questions

What Matters most to you?
What gaps are their in the Services you Recive?
What would they want to Change?

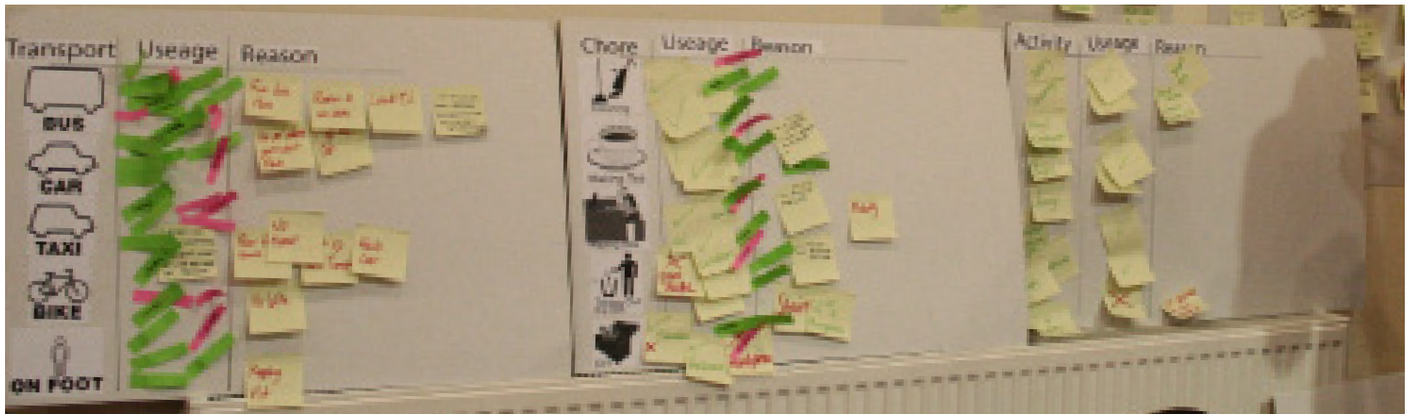
Workshop.

What did we do?



Third step - ability mapping

Activities
Transport
Chores



The personas characters.

Personas

"Henry"

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

"Doris"

Carer for her sister who became paralyzed. Though the sister was mentally fit, she was stuck in her living room because of the vast cost of adapting her house. Ultimately Doris quit her job to take care of her sister.

"Anne"

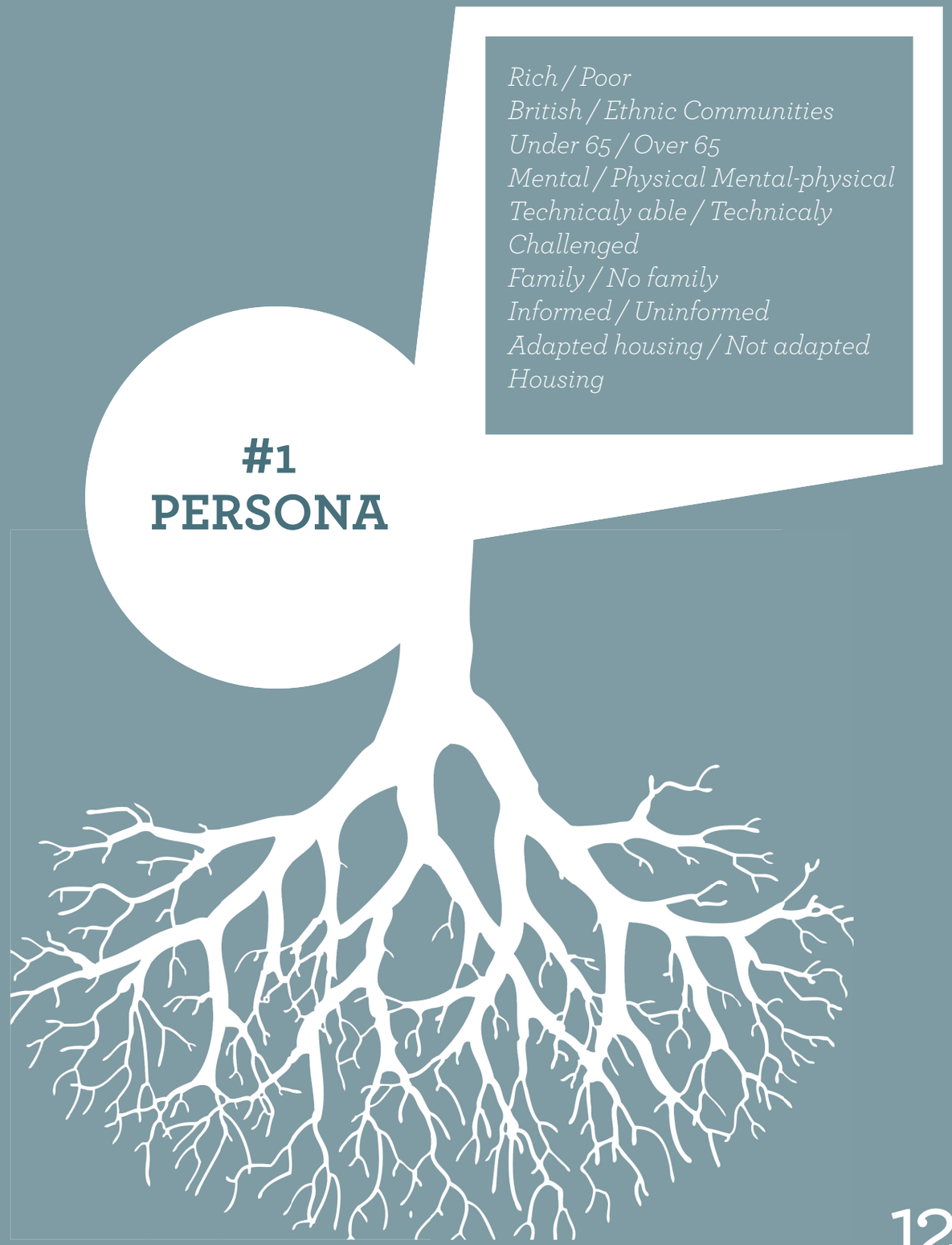
Carer for her husband, who has dementia, and also other family members. She would like her husband to be more independent but feels she lacks the means to make this happen. Anne finds tremendous support from her carer group.

"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 because she is uninformed.

Personas - mapping.

Welth Ethnicity.
Age.
Condition.
Technology.
Family.
knowledge.



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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 ESP GHA.

Improving living aids.

Threats

Capacity.

Housing.

Access.

Budget.

Current mind set.

Poor training.

Insights.

Findings.

Poor ***housing*** is a big obstacle within reablement.
There is a lack of ***carer awareness*** within reablement.
Lack of ***motivation*** from both service providers and users.
Time gap between services can create major damage within reablement.

Opportunities.

Prioritizing housing is often prioritizing 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.

The next step.

What we plan to do.

Contact Cordia regarding their home care service from reablement perspective.

Research in detail our insights and opportunities.

Look for success stories within opportunities.

Gather more users journeies to further highlight insights or create new opportunities.

Try to find the actual costs of reablement structures in the bigger picture.