

WIRRAL STAR



AN INTRODUCTION TO SHORT TERM ASSESSMENT AND REABLEMENT

WELCOME



INTRODUCTION

THE AIMS & OBJECTIVES



- ❖ **An understanding of what STAR is**
- ❖ **To understand the structure of the service**
- ❖ **To understand the role of the enabler**
- ❖ **To understand each role within the structure**
- ❖ **To fully appreciate the concept of reablement**
- ❖ **To change the mind set**
- ❖ **To fully understand the importance of documenting evidence**

WHAT IS STAR?



- ❖ **Short Term Assessment and Reablement**
- ❖ **Integrated service between DASS, Wirral Hospital Trust and Independent Providers**
- ❖ **Promotes Independence and Wellbeing**
- ❖ **Assessment for OT aids and Assistive Technology**
- ❖ **Continuous Assessment**

OBJECTIVES OF WIRRAL STAR



- ❖ **To maximise users long term independence, choice and quality of life**
- ❖ **To appropriately minimise ongoing support required and, thereby, minimise the whole-life cost of care**
- ❖ **Helping people ‘to do’ rather than ‘doing’ to or for people**
- ❖ **To ensure that the provision of ongoing care packages are more accurately assessed and not purely defined by a one off assessment but by skilled observation over a longer period in the home environment**
- ❖ **To be outcome focused with a defined maximum duration of input**

CORE PRINCIPLES OF THE SERVICE



- ❖ **Assume that the person is able to be independent until it is proved otherwise**
- ❖ **The needs identified on the initial care plan act as a trigger for the assessment**

CHANGING THE MINDSET



- ❖ **The historical approach of doing things for people has to be replaced by one that seeks to enable people to do as much as they can for themselves**
- ❖ **This needs to occur with all those involved with the service user**

WHY REABLEMENT?



- Independence is key to well being
- Underpinning approach in Green Paper, 'Independence, Well Being and Choice'.
- White Paper – 'Our Health , Our Care, Our Say'
- Change in approach for all staff accessing/delivering services

WHY DO IT ?



- **The demand for Homecare has increased in recent years and this is projected to grow, as those aged over 85 yrs is forecast to rise 12% by 2012 and 4% by 2022.**
- **Recruitment and retention of care staff will be increasingly more difficult due to demographic changes**

WHY DO IT CONT..



- **Contributes towards personalisation**
- **Less intervention in peoples lives**
- **Delivers service efficiencies in service delivery**

BACKGROUND



- **2004 - Wirral Enablement Discharge Service, Partnership between DASS and Acute Wirral Hospital trust**
- **2007 - Wirral Home Assessment and Reablement Teams established**
- **2011 - Wirral STAR**

STRUCTURE



HOSPITAL TEAM	WALLASEY LOCALITY TEAM	BIRKENHEAD LOCALITY TEAM	BEBINGTON WEST WIRRAL LOCALITY TEAM
Team Manager	Team Manager	Team Manager	Team Manager
OT/OTA	ITP	ITP	ITP
Assessment Reablement Officer	Assessment Reablement Officer	Assessment Reablement Officer	Assessment Reablement Officer
Reablement Support Worker	Reablement Support Worker	Reablement Support Worker	Reablement Support Worker
Housing 21	Professional Carers	Local Solutions	Housing 21

ROLE OF TEAM MANAGER



- ❖ **To ensure that all referrals accepted by STAR are appropriate**
- ❖ **To allocate case load to Assessment Reablement Officers (ARO's)**
- ❖ **To manage the STAR budget**
- ❖ **To provide relevant data and statistical information to the department**
- ❖ **To liaise with other professionals**
- ❖ **To ensure that all Social Services Policies and Procedures are adhered to**

ROLE OF ASSESSMENT REABLEMENT OFFICER



- ❖ **To assess initial needs and provide intervention plan**
- ❖ **To review and monitor the individuals progress in conjunction with the rest of the team**
- ❖ **To liaise and work closely with other agencies and professionals**
- ❖ **To commission ongoing care as required**

ROLE OF REABLEMENT SUPPORT WORKER



- ❖ **To support enablers to deliver service effectively and efficiently**
- ❖ **To problem solve with the team**
- ❖ **To relay information (two way process)**
- ❖ **To support the Assessment Reablement Officers**

ROLE OF INTEGRATED THERAPY PRACTITIONER & OCCUPATIONAL THERAPIST



TO ASSESS

- ❖ **FUNCTION** – achieving activities of daily living – washing, dressing, bathing, toileting, cooking, eating
- ❖ **MOBILITY** - Indoors, outdoors, with or without equipment, stair mobility
- ❖ **TRANSFERS** – Chair, toilet, bath, shower, bed
- ❖ **RISK** – Around the home, access indoors and outdoors
- ❖ **COGNITION** – Memory, medication, appliances, fires

TO ANALYSE AND PLAN TREATMENT - INTERVENTION PLAN

- ❖ **TO EDUCATE** - Individuals and family
- ❖ **TO LIAISE** – with individuals, family and other professionals
- ❖ **TO PRESCRIBE EQUIPMENT** - Grab rails, equipment e.g. chair raisers, trolleys, perching stools, moving and handling equipment
- ❖ **TO REVIEW** – the individual and evaluate their progress
- ❖ **TO DISCHARGE**

ROLE OF PROVIDER ENABLERS



- ❖ **Support individuals to meet planned goals**
- ❖ **Encourage and motivate individuals**
- ❖ **Follow intervention/care plan**
- ❖ **Record and feedback all relevant information**
- ❖ **Can participate in multidisciplinary team working to support individuals**

DEFINITION OF REABLEMENT



‘Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living’

Skills that reable



- ❖ **Good clear communication**
- ❖ **Assertiveness**
- ❖ **Positive attitude**
- ❖ **Negotiation**
- ❖ **Patience**
- ❖ **Enthusiasm**
- ❖ **Problem solving**
- ❖ **Lateral thinking**

REABLING V CARING ENABLER PERSPECTIVE



POSITIVES

REABLING

- ❖ Using initiative and judgement
- ❖ Being listened to
- ❖ Job satisfaction
- ❖ Not time restricted
- ❖ Variation
- ❖ Seeing fruits of labour
- ❖ Worthwhile, making a difference
- ❖ Integrated working
- ❖ Working closely as a team
- ❖ Being creative

CARING

- ❖ Feeling needed/useful
- ❖ Worthwhile
- ❖ Job satisfaction
- ❖ Being told what to do (prescriptive)
- ❖ Routine

REABLING V CARING ENABLER PERSPECTIVE



NEGATIVES

REABLING

- ❖ Having to stand back
- ❖ Confidence in decisions
- ❖ Being creative

CARING

- ❖ Time restricted
- ❖ Prescriptive service (no control)
- ❖ No variation

REABLING V CARING INDIVIDUALS PERSPECTIVE



POSITIVES

REABLING

- ❖ Independence
- ❖ Self worth
- ❖ Free service
- ❖ Being given time and opportunity
- ❖ To do for self
- ❖ Able to have say, being in control
- ❖ Shorter stay in hospital
- ❖ Not being restricted long term

CARING

- ❖ Being looked after
- ❖ Company
- ❖ Safety, well being check
- ❖ Able to stay at home
- ❖ Having someone to do for you (power)

REABLING V CARING INDIVIDUALS PERSPECTIVE



NEGATIVES

REABLING

- ❖ **Having to do for self**
- ❖ **Social isolation**
- ❖ **Feeling vulnerable**
- ❖ **Personal choice compromised**
- ❖ **Lifestyle changes**
- ❖ **Personality clashes**

CARING

- ❖ **Taking independence away**
- ❖ **Having to pay**
- ❖ **Restricted to times long term**
- ❖ **Failure**
- ❖ **Personal choice compromised**
- ❖ **Lifestyle changes**
- ❖ **Personality clashes**



CASE STUDY

CRITERIA



HOSPITAL

- .Over the age of 18 years**
- .Individuals who were, prior to admission, independent in all ADLS, who through illness, needs support on discharge**
- Individuals who need substantial increase in existing package or who through reablement have the potential to improve**
- Individuals who have been in hospital for two weeks or longer and existing package is cancelled and whose needs have changed**

LOCALITY

- .Over the age of 18 years**
- . Not previously known to the department and now has presenting needs**
- . Request for change of care needs in existing package**
- . The possibility of reablement potential to reduce ongoing care needs**

Hospital Process



- ❖ **ARO attends Multi Disciplinary Board rounds on the Ward**
- ❖ **ARO identifies, early on, individuals with potential for STAR**
- ❖ **Level of support needs agreed via a functional assessment on ward and potential discharge date**
- ❖ **Contact with provider agency regarding availability, intervention plan and discharge date.**
- ❖ **Confirmation with ward of discharge date.**

Process cont..



- **ESCR6, Initial Assessment and Intervention plan to agency**
- **Agency implement service user file**
- **ARO visits individual at home**
- **Assessment/Reablement process**
- **Weekly reviews and quality assurance**

Process cont..



.Service ends

**/ **
Aims Achieved interim package

/
Paperwork imported to ESCR

**If ongoing package implemented, swift contact
to support planning team to be made**

Locality Process



- **Contact to CADT**
 - **Launch to appropriate Locality Access team**
 - **Screened by STAR and Access Team Managers**
 - **STAR appropriate, TM allocates to ARO**

Cont..



- **ARO visits, initial assessment, intervention plan completed**
- **Contact agency, arrange support plan and start date**
- **As Hospital process**

Process cont..



- **Following each review of service delivery, service is adjusted accordingly.**
- **This can mean reducing calls as the individual regains independence in tasks, or increasing service if their ability reduces.**

Case Study



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Intervention Plan



- **What is an intervention plan?**
 - **Who completes this?**
 - **Who is the information for?**
 - **What relevance has it got?**
 - **Where is it kept?**

Triggers For Assessment



- **Personal Care**
- **Meal Provision**
- **Medication**
- **Assistive Technology**
- **Mental State**
- **Motivation/ Confidence**

Triggers cont...



- **Mobility – does the individual appear to be struggling with**
 - **Getting in/out of bed**
 - **On/off chair**
 - **On/off toilet**
 - **On/off bed**

It doesn't matter what the underlying condition is, it's what the individual can do for themselves

COMMUNICATION – Health Warning!!



**It is vital that we have good clear
unambiguous communication within
the team because poor communication
causes mistakes, which lead to
problems which can lead to
complaints!!**

Communication



**If it wasn't written
down,
it didn't happen!**

Communication



- **Enablers have to give an accurate, clear written account of daily events in the log sheets in service user file.**
- **This is evidence for the assessment**
- **Feedback is vital to move service forward**

KEY POINTS FOR GOOD COMMUNICATION



- ❖ **Always check individual's understanding**
- ❖ **Use writing/drawing/body language**
- ❖ **Ensure individual is wearing glasses/hearing aid**
- ❖ **No background noise or distractions**
- ❖ **Give plenty of time**
- ❖ **Speak face to face**
- ❖ **Slow speech if hard of hearing**
- ❖ **Simplify sentences**

GOLDEN RULES OF REABLEMENT



- ❖ **Follow intervention plan**
- ❖ **Encourage independence**
- ❖ **Don't step in too soon, watch and observe**
- ❖ **Think outside the box and problem solve**
- ❖ **Communicate clearly with the individual and team**

Any Questions??????

