

Five steps to a big impact



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A radical change to how one adult social care team handles new cases meant they were readily able to shift assessments online during the COVID-19 pandemic, hears

Andrew Mickel

There has been a rush of occupational therapists looking to start virtual assessments since the COVID-19 pandemic began, but the adult social care Reigate and Banstead locality team in Surrey managed to complete their first assessment over FaceTime just before the crisis began.

It marked the latest in five years of fundamental changes to how the team treat new cases and decides how to work with clients. New tools have been deployed to deal with overwhelming workloads, and a lot of work to gather information on client environments is now done by the clients themselves.

It represents a big shift in what the occupational therapist is responsible for – a shift that has cleared waiting lists and freed up staff time to focus on more complex cases and preventative work.

‘The biggest thing to overcome with this is fear – we occupational therapists have to trust our instinct and our experience and trust what our

clients tell us. We are facilitators in the lives of our clients – they are not victims and we are not rescuers,’ says Jonè Vosloo, the assistant team manager.

They were necessary changes. Six years ago, the team had lengthy waiting lists, an £85,000 annual bill for outsourced assessments, and was supposed to focus its work on a costly online assessment tool that was little used.

‘In order to survive we had to think outside the box and adopt smarter ways of working,’ says Jonè. ‘We took risks and acted on our ideas, even though they were controversial. We had to adapt our services to overcome the ever-changing challenges until eventually we developed our five-step programme for referrals.

‘As a result, we have no waiting list and we are chasing clients for information rather than them chasing us.’

The five-step process

The first three steps are handled by the duty occupational therapy team. The first step is signposting. ‘We have a strength-based conversation with the client to identify what may help them and we give them the options of how their needs can be met,’ says Jonè.

‘If they want something more glamorous than what we can provide, they are usually happy to buy it themselves. It is also at this stage where we consider whether our service is the best service to meet the client’s overall needs or whether we need to refer to our health colleagues.’

If the client does need something from the adult social care team, then the second step sees the occupational therapist establishing a basic level of need via a telephone conversation, and where possible, order the equipment straight away.

The duty occupational therapist may ask the client or their carer for photographs where needed. ‘This enables us to meet the clients’ needs at the front door,’ she adds.

The third step is where the real innovation begins. If the team is not fully confident that a piece of equipment can just be ordered and they want more insight into the environment, then they send out a special notebook they have designed for a client or carer to fill out the information.

The 27-page EQuip notebook is now on its ninth version, and provides a way to gather information on the client’s environment and needs. ‘It gives us better insight, especially if there are multiple needs to enable us to discuss the best intervention options with the client – and it can all be done remotely,’ says Jonè.

After the client returns EQuip to the team, the duty team contacts the client to discuss possible interventions. It’s proving to be more time efficient, client-centred and is freeing up time for more complex cases. And it also means that clients are not sat on a waiting list, but instead

are able to contribute to the solutions they need.

If the EQuip notebook isn’t quite enough support for the client, then they instead can go to step four: attending the MeAssured clinic, held in Mersham.

Jonè says that, although the processes are now firmly embedded in the team, it took effort on her part to ensure staff were referring people to the clinic, rather than expecting that an occupational therapist would visit them.

And that is a cultural shift that affected clients too. Says Jonè: ‘The majority of clients have had the mindset that an occupational therapist needs to visit. However, we would ask them if they can go to the shops or the GP – if they can, they can come to the clinic. It’s a case of being firm, but friendly.’

She notes that finding a suitable venue and a confident and experienced staff member to run it may be challenges for other areas to follow this model. However, the clinic has proven to be cost effective and time efficient.

By 2016, 206 clients were seen at the clinic in six months, negating the need for outsourcing. ‘The feedback from clients attending MeAssured has been overwhelmingly positive,’ she says. ‘The venue has a positive atmosphere and is conducive to a friendly and dynamic service, utilising partner organisations.

‘EQuip and the work on duty have enabled us to respond quickly and efficiently to the clients requiring less complex intervention, giving the team capacity to give more time to complex clients and pursue various projects.’

Developing virtual assessments

Those earlier steps now handle a huge proportion of clients, meaning that only the most complex cases require step five: occupational therapist allocation.

And, as elsewhere in the country, some of these are now being handled via video call. The team actually had their first virtual assessment a couple of months before COVID-19, but the arrival of the virus meant the team received the green light to roll them out more fully.

Kirsten Callander, a senior occupational therapist, is delivering some of the virtual assessments. One recent call was for a profiling bed and standing hoist for a lady who had recently arrived in a supported living home after a long stay in hospital.

‘I completed the virtual review of the standing hoist with the client and carers, with an additional carer holding the phone,’ she says.

‘I introduced myself to the client and gained their consent with an explanation of what was going to happen. I ensured that the client remained at the centre of the assessment. Prior to trialing the standing hoist with the client, I asked one carer to trial it on the second carer first, as I usually do during face-to-face visits.

‘This enabled me to check the equipment was working, assess the confidence and competence of the staff, as

well as giving the staff an opportunity to practise before using the equipment with the client.'

The team has shared their experiences of delivering virtual assessments (see box out) and Kirsten says they offer major benefits in terms of time and social distancing.

'One care agency recently insisted on a face-to-face visit,' she says. 'The visit took 15 minutes, however, the actual time away from my desk was three and a half hours, due to travel from home and PPE kit collection and preparation. The lady has advanced dementia, and I think having an additional person with a mask in her bedroom was more traumatic than a video call.'

'There are of course some cases that would be better handled in person, particularly to see a family's dynamics, or if people don't have access to technology. But many can be handled with video calls.'

The five-step programme is constantly evolving; a new service acting from the front door duty team was due to be trialled before COVID-19, whereby an occupational therapy assistant visits clients with the equipment identified by the EQuip notebooks to trial and review the equipment at the same time. 'This would reduce the pressure on duty and further speed up our service,' says Jonè.

She says that the new system, particularly the notebooks, have taken a lot of investment in staff training, but that the results show it is working, and she is keen to share the notebooks with other teams for them to implement them too.

'The impact of the changes has been phenomenal,' she says. 'It is not just about not having a waiting list – it's also about having boundaries so that other teams know what social care does. In the past we have felt like a tagalong service, but these changes and our projects with our health colleagues have boosted our confidence and helped us see that we are experts in moving and handling and major adaptations.'

'We've found our place and it has given us a renewed sense of purpose, value and worth, rather than being an add-on service.'

The new five-step process has posed a major shift and there is less time spent by staff on face-to-face visits. But particularly in the age of COVID-19, it is opening up more ways to clear waiting lists and do what is best for clients.

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Virtual assessments: what the Reigate and Banstead team have learned

The team at Reigate and Banstead share their tips on virtual assessments

As occupational therapists, we start our assessment as soon as we park in front of the client's house. By the time we enter the door, we have already noted access and started to consider intervention options.

Every step further into the house, we start to formulate a picture about the client and their situation, constantly assessing risk and considering intervention. So when doing a virtual assessment, it is important to note that you will need to be intentional about engagement and about the information you want to gather.

Where in the past your actions and observations may have been automatic and natural, you will now have to think about, and consciously make an effort, to gather information as you enter the client's life through a different lens.

The following tips have helped us to ensure a comprehensive and confident assessment is completed:

- Keep the virtual assessment as brief as possible by gathering as much information in advance by telephone.
- Ensure your phone or laptop is charged before the assessment.
- Ensure you have good internet access and agree that you will call back if the call fails.
- Prior to assessment, inform the client or care staff that an additional person will be required to operate the device used for the virtual assessment.
- Most importantly, the client needs to be at the centre of the assessment.
- This may sound obvious; however, when there is much to think about and when you are not there in person, it is easy to forget to put the client at the centre. Ask the client how they are, and for their views and concerns. Their participation should be encouraged throughout the assessment.
- Introduce yourself, who you are and who you work for; show your badge if needed. Ask everyone in the room to introduce themselves.
- Explain to the client the purpose of the video call and ask them if there are any limitations they wish to place on the call, such as what you can and cannot observe.
- Gain the client's consent for the call and ensure they know you may take photos.
- During the assessment, ask if you can have a look at the room to familiarise yourself with the environment.
- During a review, ask if anyone is familiar with the equipment you are about to trial and how experienced they are with it. It would be good to send information and links to videos prior to the call so that care workers, carers and the client can familiarise themselves with the equipment.
- Ask care workers to demonstrate the use of the equipment on each other. This will allow you to see the level of confidence and competence before the equipment is used with the client.
- You can share links or images in the chat box with clients, carers and care staff.