Putting healthy ageing into practice

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13 September 2022
Why Healthy Ageing
• Addressing the Fitness Gap / Move to Prevention
• Design for Prevention & Good Governance
• Develop a Growth Mindset
• Adopt a Healthy Ageing / Multidisciplinary Team
• Address Low Physical Activity / Frailty / Decline Early
• Scheduled Weekly Prevention Meetings
• Recognising Signs of Frailty
• Use of Recovery Plans / Goals / Progressive Resistance
• Short Term Recovery Plan / Maintenance Plan
• Healthy Ageing Measures for Success
Is it difficult to put the components of healthy ageing into practice?

No...but for some reason we don’t do it, consistently or with commitment.
Healthy ageing an easy choice

Steep decline in health, due to factors such as inactivity, can be reversed at any age. Our aim is to address the fitness gap of older people (see ❶ below) by encouraging and supporting them to participate in exercise based activity.

Exercise based activity can assist older people to remain above the disability threshold (see ❷ ).

Plus focus on exercise + good nutrition
A move toward Risk Prevention

What do we need to do differently for early detection/prevention of risks and to promote healthy ageing?
# Design Good Governance Systems

## Clinical Governance Framework – overview of core elements

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<tbody>
<tr>
<td>Person centred &amp; health promoting leadership drives CCH Positive Ageing commitment and culture</td>
<td>Promote engagement in planning, decision making and review of clinical care, quality, and safe services</td>
<td>CCH Governance Charter, Documentation &amp; Risk Framework guides clinical and organisational practice</td>
<td>Provide clinical quality and safety information to identify trends, emerging issues or risks, areas for improvement</td>
<td>Recruit, train and develop the workforce that supports clinical quality &amp; safety</td>
<td>Are open, respectful and in-line with CCH code of Conduct and Positive Ageing commitment</td>
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<tr>
<td>Respectful, capable, and kind staff, partner with residents and clients to achieve outcomes</td>
<td>Support individual needs, preferences, and ways to improve their health and wellbeing</td>
<td>Planned, proactive &amp; best practice approach to clinical quality and safety for resident / clients and staff</td>
<td>Services Committee assess clinical quality and safety performance, experience of resident / client</td>
<td>Guide staff practice and focus on early risk identification and Positive Ageing</td>
<td>Have good record keeping systems to support clinical quality &amp; safety</td>
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<td>A resilient and accountable culture, always seeking ways to improve</td>
<td>Promote feedback about their experience and information is used for improvement</td>
<td>Action contributes to clinical quality &amp; safety and address the risks that exist for resident / client and services,</td>
<td>Enables a rapid review of clinical quality and safety for high-risk issues</td>
<td>Support employed, contracted, and visiting practitioners to have appropriate qualifications and experience to provide</td>
<td>Reduce the risk of harm to residents / clients providing; effective handover &amp; transfers to and from hospital</td>
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Develop a Growth Mindset

**GROWTH MINDSET**
- I can try a different strategy.
- Is this really my best work?
- This may take some time and effort.

**FIXED MINDSET**
- I can’t do this.
- This work is good enough.
- This is too hard.
A multidisciplinary team is nimble and creates a network of support to tackle problems or barriers to a resident's improvement or quality of life within 48 hrs (this is the timeline for a rapid review).

This high functioning Multi D team builds a sense of excitement and enjoyment that contributes to high-quality results and amazing resident/client outcomes.
Address low physical activity, decline or frailty early

What is the cause of decline? What can we do to address it quickly?

Check Engagement in Activities that Promote Physical and Social Engagement

Ask What’s important to you? Develop Meaningful Goals

Healthy Literacy Conversation with Resident/Family – (understanding of risks)

Check Pain Management (Background – assess on movement)

Involve GP / Specialists / Allied Health / Personal Trainers

Monitor Nutrition Eating/Drinking Bowel/Urine output

Design What’s important for you? Develop Individual Resistance based Exercises

A Action Changes Things
What are the components that give rise to healthy ageing?

1. Everyone on the same page, working toward the recovery goals

The Multi D team will meet weekly and discuss resident/client physical and social decline.

Where there is risk of decline (socially and physically) a Recovery program will be initiated.
What are the components that give rise to healthy ageing?

2. Recognising Frailty or general social or physical decline.

Staff members report any signs of resident/client decline – losing weight or muscle, unsteady on their feet, weaker or not moving around as much, tired all day, loss of appetite or not eating, needing more support, incidents; falls, disengagement, increased behaviours. **Referral to Healthy Ageing team for multidisciplinary review.**
The Multi D team approach: Partner with resident/representative to develop goals based on what is important to and for them. Provide health literacy. Implement a Recovery plan (slow stream rehabilitation) and evaluate weekly.

Everyone is working towards the resident's goal.
Progressive Resistance

Resistance Exercise

1. Strength Training at least three times a week (Unless CVD risk)
2. Increasing resistance using the RPE scale.
3. Giving paracetamol before the exercise for those with joint or muscle pain can improve outcomes.

Rate of Perceived Exertion

<table>
<thead>
<tr>
<th>Effort</th>
<th>Rate of Perceived Exertion</th>
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<tbody>
<tr>
<td>1</td>
<td>Least effort</td>
</tr>
<tr>
<td>2</td>
<td>very, very light</td>
</tr>
<tr>
<td>3</td>
<td>very light</td>
</tr>
<tr>
<td>4</td>
<td>fairly light</td>
</tr>
<tr>
<td>5</td>
<td>somewhat hard</td>
</tr>
<tr>
<td>6</td>
<td>ENDURANCE TRAINING ZONE</td>
</tr>
<tr>
<td>7</td>
<td>hard</td>
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<tr>
<td>8</td>
<td>ENDURANCE TRAINING ZONE</td>
</tr>
<tr>
<td>9</td>
<td>very hard</td>
</tr>
<tr>
<td>10</td>
<td>Maximum</td>
</tr>
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Recovery Plan

- **REFERRAL**
  - Discuss the resident’s suitability for Early Intervention
  - Engage in Root Cause Analysis for residents who are admitted to Early Intervention

- **ASSESS**
  - Allied Health completes Berg, Walk & Wellbeing assessment within 2 weeks
  - Health Promoters (fitness) provide Allied health with grip strength within 2 weeks
  - Lifestyle provide Allied Health with activity participation within 2 weeks

- **2 WEEKS**
  - Recovery Pathway is finalised and implemented
  - CM / RMS direct RNs to update the Care Plan

- **4-6 WEEKS**
  - Monitor progress by considering any adverse events and adherence to the Recovery Pathway by staff / resident: including progress with fitness program and activity participation
  - Allied Health / Lifestyle record progress note in iCare after each meeting

- **10 WEEKS**
  - Monitor progress and discuss preparations for transitioning the resident to a Maintenance Pathway
  - Allied Health / Lifestyle record progress note in iCare after meeting

- **12 WEEKS**
  - Review progress and facilitate transition of the resident to a Maintenance Pathway
  - CM / RMS direct RNs to update Care Plan
  - Allied Health / Lifestyle record progress note in iCare after meeting

- **14 WEEKS**
  - Discharge resident if progress is stable and only when the Care Plan has been updated (progress not in iCare)
  - If Care Plan is not updated, CM / RMS are to ensure that RNs complete this by the next meeting to allow discharge to occur (progress will need to be reassessed at the next meeting)
  - Allied Health complete Berg, Walk & Wellbeing assessment within 2 weeks
  - Health Promoters (fitness) provide Allied Health with grip strength within 2 weeks
  - Lifestyle provide Allied Health with activity participation within 2 weeks

- **ASSESS**
  - Allied Health completes Berg, Walk & Wellbeing assessment within 2 weeks
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**Earlier maintenance / discharge**
- Residents can be moved to a Maintenance Pathway and discharged before 14 weeks if progress is good and they have achieved their goals
- EIWP should consider if the goals were challenging enough and consider revising the goals and Recovery Pathway and reassessing at 10-12 weeks

**Residents not on maintenance by 14 weeks**
- Residents who cannot be moved to a Maintenance Pathway at 14 weeks should continue have their progress monitored at each meeting
- Suitability for a Maintenance Pathway should be reassessed monthly (i.e., every second meeting)
Progressive Resistance – Sunbeam Project

**Static standing balance**
1. Bicep curl (with resistance bands) (3 x 10)
2. Shoulder retraction (with resistance bands) (3 x 10)
3. Standing feet together (progress to semi-tandem then tandem) 3 x 30 seconds

**Dynamic standing balance**
4. Heel raises (2 x 6)
5. Toes raises (2 x 6)
6. Recovery steps (1 x 10 each side and behind)
7. Reaching outside base of support (10 x each side)
8. Grapevine steps (holding groups leaders’ hands)

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**Progression of hand support for all balance exercises**
- Holding back of chair/table with 2 hands
- Holding back of chair/table with 1 hand
- Not holding on
- **TRIGGER FOR PROGRESSION:** Participant reported perceived exertion was “somewhat easy”

**Other progressions of for static exercises**
- Eyes open
- Eyes closed
- Count backwards from 50 by intervals of 5
- Increase heel/toes raise exercises to 2 x 10
- **TRIGGER FOR PROGRESSION:** Participant reported perceived exertion was “somewhat easy”

**Progression for dynamic exercises**
- Increase speed of recovery steps and grapevine
- Increase repetition
- **TRIGGER FOR PROGRESSION:** Participant reported perceived exertion was “somewhat easy”

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*INSTRUCTION:* “Step out quickly as if catching yourself from falling, slowly step back to neutral”
Multi D team approach: Review Recovery plan. What's working, not working?

Recovery Plan should run for 5 to 14 weeks with 6x daily interventions to support key rehabilitation needs (May need to be progressive).

What are the components that give rise to healthy ageing?

4. 5 to 14-week Recovery Plan is actioned & monitored closely.
Healthy Ageing Team (Multi D team) - Encourage engagement in more active activities.

Ensure there are more activities that promote exercise and strength workouts across your Lifestyle program.

What are the components that give rise to healthy ageing?

5. Recovery Plan finishes, if successful, moves to a Maintenance Plan
Healthy Ageing Measures

- Reduce Falls to below 10 – per 1000 bed days
- Reduce immobility to below 15% of residents
- Residents physically and socially engaged in at least 20 meaningful activities per month – average of 5 per week
3 key Learning outcomes

• View healthy ageing and the interventions that prevent avoidable decline as a human right.
• Put in systems that drive good governance & practices that prevent risk/decline & keep your residents/clients walking
• Normalise Healthy Ageing in your organisation
Thank you

Be supported
Be independent
Be respected
Be you.