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Putting healthy ageing into practice

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Overview of Todays Session:
Putting Healthy Ageing into Practice

- 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

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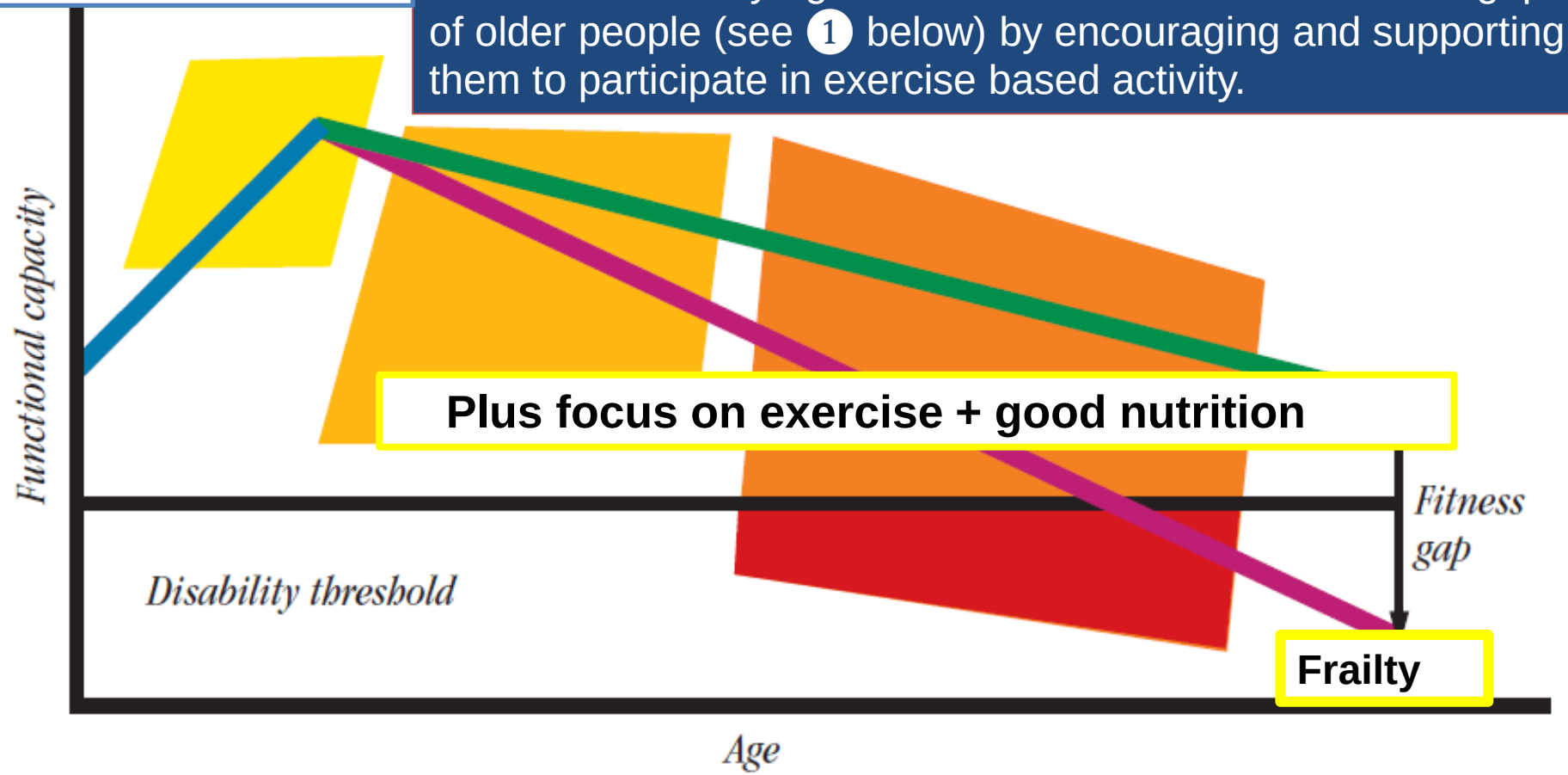
Is it difficult to put the components of healthy ageing into practice?

No…but for some reason we don’t do it, consistently or with commitment.

Be you.

Treating Frailty

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 1 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 2).

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A move toward Risk Prevention

What do we need to do differently for early detection/prevention of risks and to promote healthy ageing?

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Design Good Governance Systems

Clinical Governance Framework – overview of core elements

1	2	3	4	5	6
Positive Leadership & Culture	**Strong Resident & Client Partnerships**	**Robust Organisational Systems Support**	**Comprehensive Monitoring Reporting**	**Effective Workforce Systems**	**Effective Communications & Relationships**
Person centred & health promoting leadership drives CCH Positive Ageing commitment and culture	Promote engagement in planning, decision making and review of clinical care, quality, and safe services	CCH Governance Charter, Documentation & Risk Framework guides clinical and organisational practice	Provide clinical quality and safety information to identify trends, emerging issues or risks, areas for improvement	Recruit, train and develop the workforce that supports clinical quality & safety	Are open, respectful and in-line with CCH code of Conduct and Positive Ageing commitment
Respectful, capable, and kind staff, partner with residents and clients to achieve outcomes	Support individual needs, preferences, and ways to improve their health and wellbeing	Planned, proactive & best practice approach to clinical quality and safety for resident / clients and staff	Services Committee assess clinical quality and safety performance, experience of resident / client	Guide staff practice and focus on early risk identification and Positive Ageing	Have good record keeping systems to support clinical quality & safety
A resilient and accountable culture, always seeking ways to improve	Promote feedback about their experience and information is used for improvement	Action contributes to clinical quality & safety and address the risks that exist for resident / client and services,	Enables a rapid review of clinical quality and safety for high-risk issues	Support employed, contracted, and visiting practitioners to have appropriate qualifications and experience to provide	Reduce the risk of harm to residents / clients providing; effective handover & transfers to and from hospital

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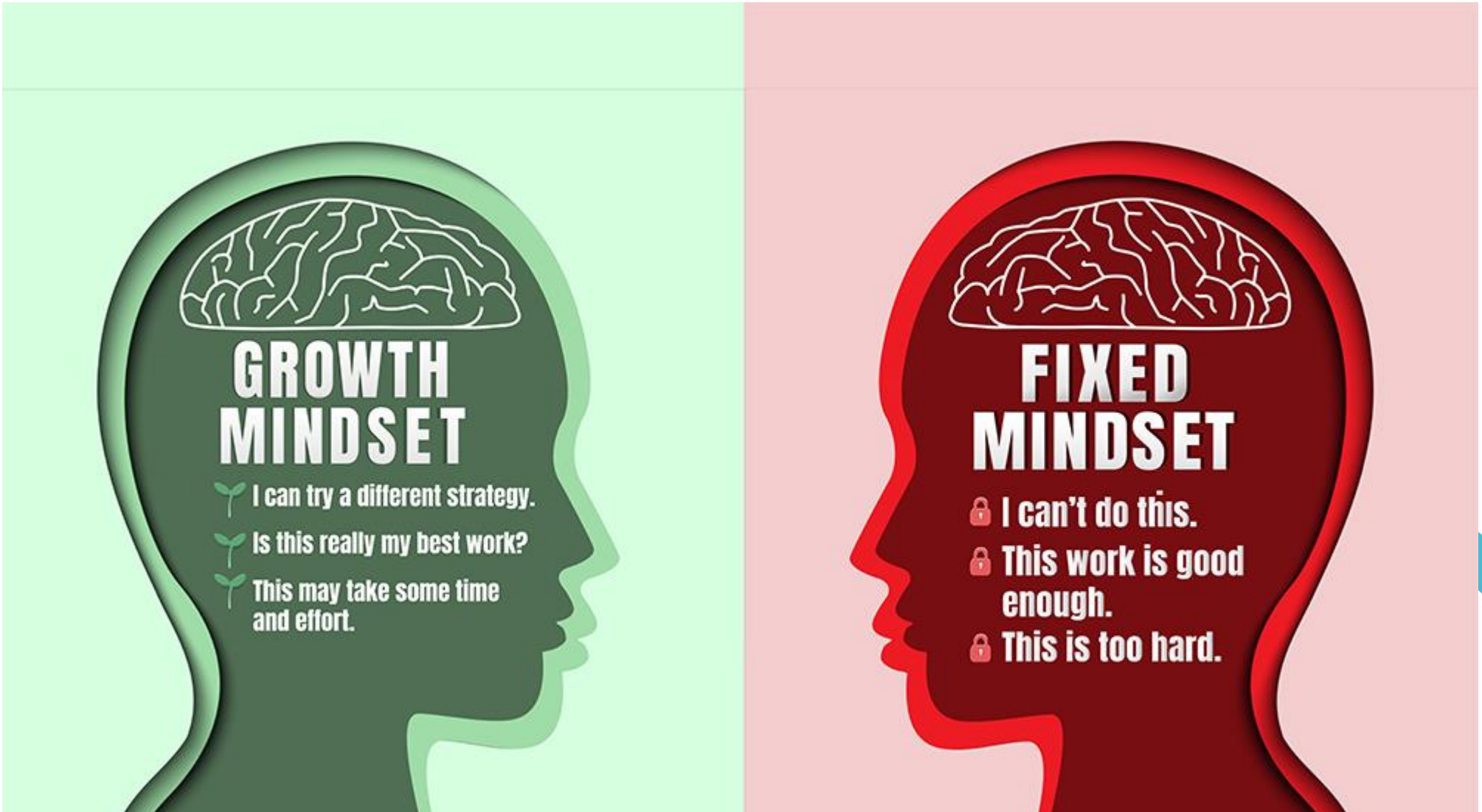
Develop a Growth Mindset



Adopt a Healthy Ageing Team (HAT) /Multidisciplinary Approach

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

Risk Prevention Meetings

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?

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

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Recognising Frailty Early

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.**

What are the components that give rise to healthy ageing?

2. Recognising Frailty or general social or physical decline.

Recovery Planning / Goals

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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.

What are the components that give rise to healthy ageing?

3. Putting a Recovery Plan in place – everyone aware of goal/plan

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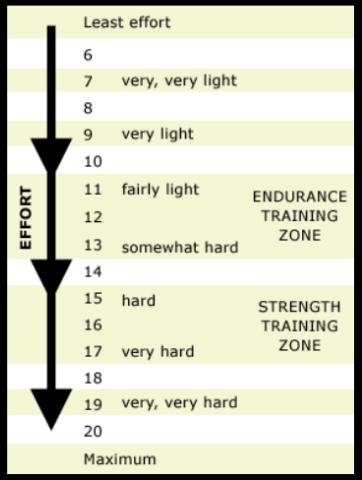
Progressive Resistance

Resistance Exercise



Rate of Perceived Exertion

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.

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 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

iCare: AH complete Commencement Information in Early Intervention Record

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

4-8 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 / RSM to 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 note updated, CM / RSM 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)

ASSESS
- 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

iCare: AH complete discharge Information in Early Intervention Record

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 revisited monthly (i.e., every second meeting)

Progressive Resistance – Sunbeam Project

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Static standing balance

1. Biceps 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 (2x 6)
5. Toes raises (2 x 6)
6. Recovery steps [a] (1 x 10 each side and behind)
7. Reaching outside base of support (10 x each side)
8. Grapevine steps (holding groups leaders' hands)

[a] INSTRUCTION: "Step out quickly as if catching yourself from falling, slowly step back to neutral"

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"

Short Term Recovery Plan

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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 to14-week Recovery Plan is actioned & monitored closely

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Maintenance Plan

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

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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

Measures for Success

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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

***Make healthy normal* in aged care**

Be you.

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Thank you

Be supported
Be independent
Be respected
Be you.

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