



Northern Sydney Wellness and Restorative Care Project



The HACCC National Forum: Promoting Independence



The HACCC National Forum was held in February 2008 to explore the evidence base, and implications, of adopting Wellness, Capacity Building and Restorative Care approaches in HACCC services.

Presentations of the Forum are available on the website.

<http://www.haccforum08.com.au/program.php>



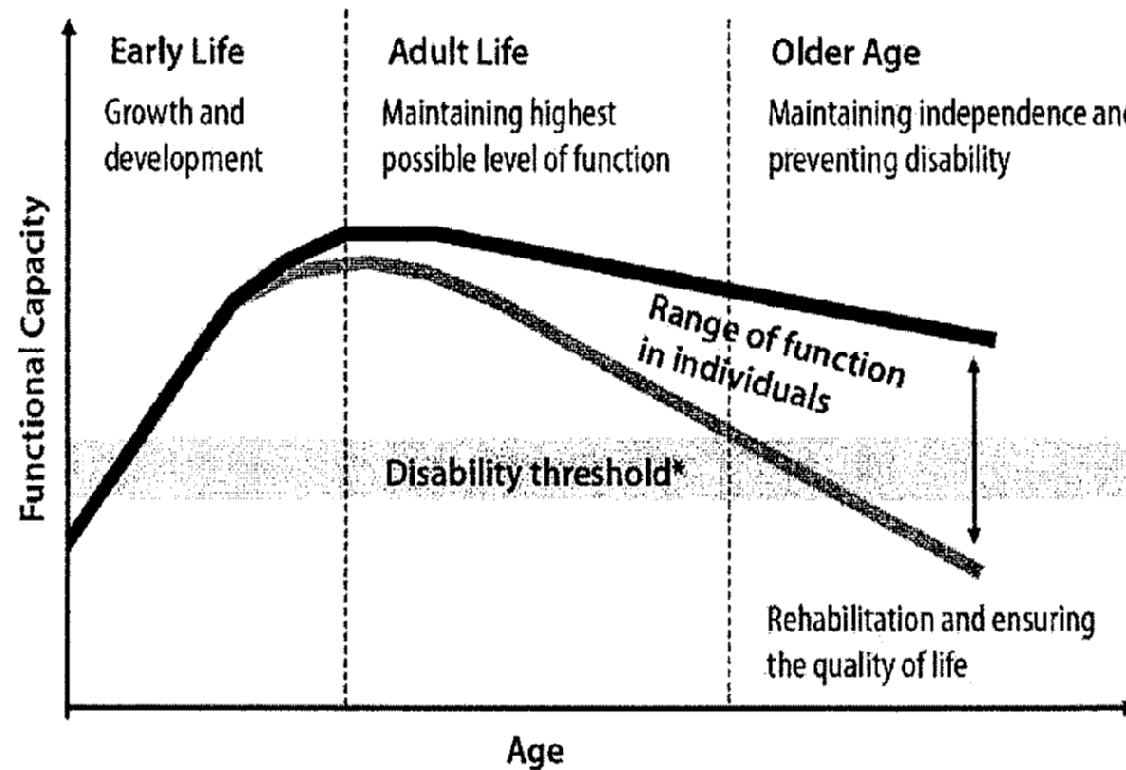
Key Drivers for Change



- Demographic increase in the number & longevity of the older population
 - Changing consumer expectations & choices
 - Increasing cost of health services provision
 - Body of evidence on what constitutes 'successful' & 'active' ageing
 - Decreasing availability of informal carers
 - Workforce availability
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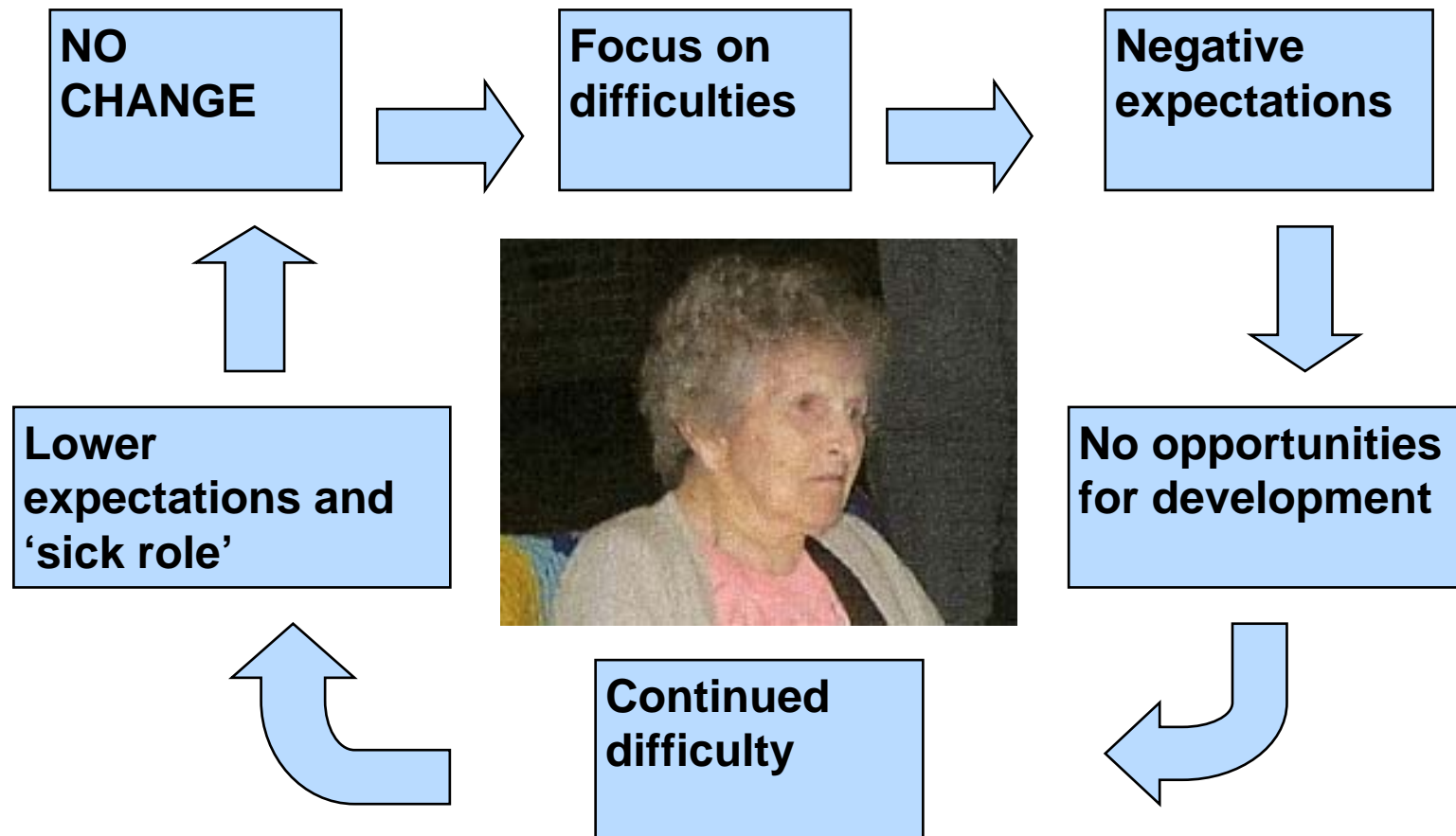
Functional Capacity

Figure 5: Functional capacity over the life course

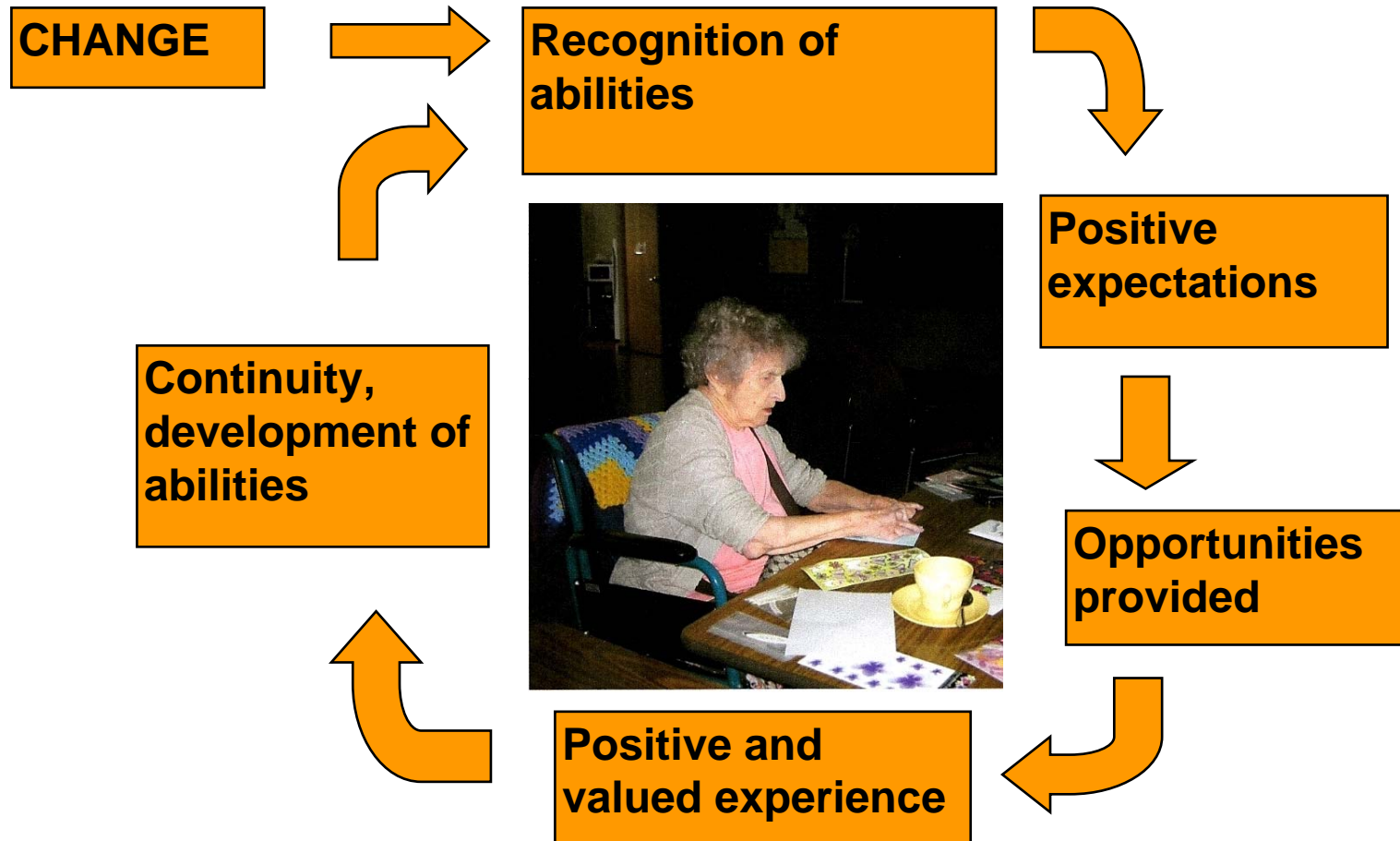


Source: World Health Organization. *Active ageing: a policy framework*. WHO: Geneva, 2002.

The Illness/ Dependency Cycle



The Wellness/ Independence Cycle




Northern Sydney Wellness Project



- 12 month project in Northern Sydney 2008-9
- Phase 1 - Advisory Group established
- Literature Review - *The Active Service Model: a new paradigm* for HACCC: A conceptual and empirical review
- Background Paper
- Consultation with Hornsby Shire Seniors Advisory Committee


Northern Sydney Wellness Project



- Consultation with social support and day centre providers to consider where Wellness & Restorative Care approaches could be adopted, and identify options to pilot
 - Survey of service providers, service users - clients, family carers and volunteers
 - Interim Report compiled and submitted to DADHC Dec 08
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Northern Sydney Wellness Project: Phase 2



- Steering Committee established for Phase 2
 - Phase 2 - Pilot in the new Berowra, Brooklyn and Galston day programs in conjunction with an established day program. Jan - Jun 09
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Northern Sydney Wellness Project: Phase 2




- We have just completed the first three months with most of our clients, and will shortly begin the process of reviewing and recording results
- A final report with recommendations based on the consultation and pilot phases will be compiled at the completion of Phase 2 in July 09



Northern Sydney Wellness Project



- The focus is holistic, person-centred and strength based
 - Functional independence, quality of life & social participation
 - Clients attending 1 day / week CBDC facilitated access to engagement for 7 days a week
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Measurement Tools: service level assessment



- ACCNA: Australian Community Care Needs Assessment: This is done at the time of referral
- The measurement tools are used within the first month, when the client has begun to settle in, and a level of trust has been established. These tools provide a baseline and allow changes which have occurred to be measured.
- CHAMPS: social activities & hobbies
- Mod Bartel: physical functional profile
- GDS: Geriatric Depression Scale
- Malsc2: brief nutrition assessment
- Background: History may emerge in the ACCNA; some lifelong interests in the Champs. However, Life Story Books have been invaluable for opening up old passions and interests.

Care Plan: in collaboration with the client and carer



The four measurement tools form the basis for the development of the Care Plan, and inform the goals and interventions.

The Care Plan drives the service provision:

- Physical
 - Social
 - Emotional
 - Financial
 - Spiritual
 - Environment
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Care Plan: goals and timeframes

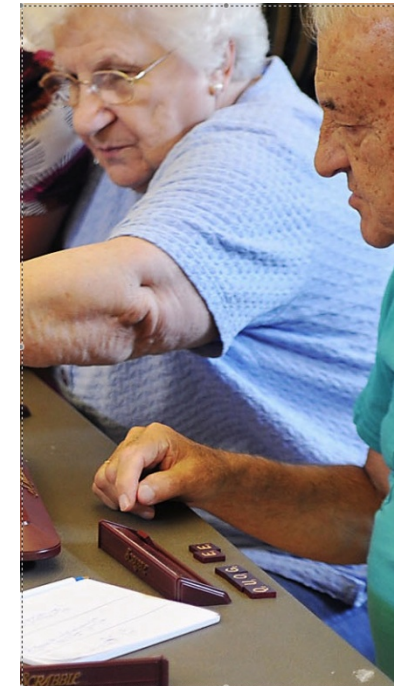
- Goals and timeframes are set in collaboration with the clients.
- These are likely to be a series of small steps.
- May involve a number of different interventions, including physio and social reconnection.
- The manager's role is one of identification and referral - not case management.



Care Plan: outcomes and review


Outcomes and review

- Reviewed every three months
- This document is referenced on an ongoing basis, and will change as circumstances change eg. as health changes
- Can include short-term episodic care. A goal may be reached, and the service no longer needed. However, we continue to remain in contact with the client.



Developing Networks & Referral Pathways



- Critical for the Manager to develop a comprehensive local resource list.
 - Strengthening connections with other local services including local hospitals, GP's, transport, community groups such as church groups & sporting clubs
 - Working in collaboration with other service providers to facilitate timely and appropriate client care
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Developing Networks & Referral Pathways



The referral process becomes easier & more streamlined as these networks & pathways become more comprehensive

- **Functional independence** eg Allied Health, Optometrists, etc
 - **Quality of life** - transport, massage through Health Fund, dining out
 - **Social participation** - CWA, craft group, Men's Sheds, local cricket team
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Care Planning & Referral

CLIENT	QUICK WIN	LONGER TERM GOAL
<ul style="list-style-type: none">• June, 82, widowed. Anglo background.• Severe macular degeneration.• X cultural marriage into Chinese family. Ran restaurants with her husband. Loves cooking. Speaks fluent Cantonese.• Family provides love & care, but no active role.	<ul style="list-style-type: none">• Sharing her history & re-engaging with her skills & knowledge.• Planned a Chinese meal for the Day Centre.• With the help of a staff member to be her 'eyes', she directed the purchase of the ingredients and preparation & sharing of the meal.	<ul style="list-style-type: none">• Move this from the Day Program to a wider context

'June'



Care Planning & Referral



CLIENT	QUICK WIN	LONGER TERM GOAL
<ul style="list-style-type: none">• Dot - 70 year old lady• Thrombocytopenia• Lives on a houseboat with her husband• Keen that she remain fit enough to stay on the river• Isolated through geography	<ul style="list-style-type: none">• Improved social connections through Healthy Heart Moves• Joined ladies she met at Healthy Heart Moves for their craft group on Dangar Island	<ul style="list-style-type: none">• Work on fitness & independence• Develop safety net in case she or her husband become ill



'Change' Management



Manager

- 'Change' leader
 - Lead by example
 - Identification of client issues and referral. Not case management
 - Development of relationships with other service providers and the community. Important that they know what is going on in their community
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'Change' Management

Day Centre team - all actively contribute their expertise

- Daily debrief and meeting of the team
- Contribute other expertise eg drama
- Use questions which open and explore
- Helpful to include men in the team eg cooking classes for blokes, bushwalking

'Change' Management



Volunteers - 14 volunteers over 3 centres

- Support clients in goal attainment
- Connect volunteers and clients according to shared interests
- Volunteers provide the links to much normalising activity eg cricket


Bill: connected into the local cricket team



Education: Staff and Volunteers




Skills: The staff need more in-depth knowledge. However, the volunteers need an understanding as well.

- Tools: first theory, then application & how it links to the Care Plan
 - Care planning
 - Team work
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Education: Staff and Volunteers




Culture-shaping

- Consistent application
 - Persistent application
 - Modelling the change
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Education: Clients and Carers




Skills: These are practical and fun in presentation. They are also an opportunity to create a natural community connection between the attendees.

- 'Healthy Heart Moves'
 - Men's cooking classes
 - Incorporating exercise into daily life
 - Staying active
 - Eating well
 - Fast & easy cooking classes
 - Older people can teach one another eg Anton cooked Croatian pancakes
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Education: Clients and Carers



Culture-shaping

- Find the 'quick wins'
 - Value-add each experience with enjoyment
 - Help the clients to 'imagine better'
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'Merv'

- 92 and lives alone
- Total knee replacement 2 yrs ago
- Retinitis
- The first, and only goal, Merv expressed was to play bowls again. He now does this regularly. In later conversation with our bus driver it emerged that he has a great love of, and expertise with, horses. So we arranged a trip to a horse-riding school.



'Merv'

- Merv spent the day chatting knowledgeably with the staff and being with the horses.
- He had known the previous owners of the property, and created a clear bond with the new owners who invited him to come and spend the day anytime he wanted to 'smell horses'. One staff member told him to give them a call, and they would come and collect him and take him home later.




It doesn't all depend on staff.....



It's not just the employees who are meeting the needs of our clients. Much of what is happening is through volunteers providing a link back to the community - both geographical and interest.

It begins with an interface with HACCC services, increases social participation, and people begin to enjoy being engaged in parts of their lives they thought might be just a memory.



Enquiries



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