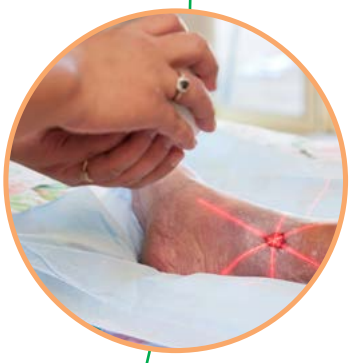
iAgeHealth®

The right care, any time, any place.



Case Study

Mobility

Updated October 2023

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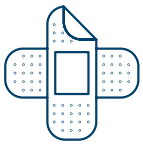
Case Study Mobility

Residential Aged Care Facility at a Glance

- Service commenced iAgeHealth Trial 29.05.2023
- 28 bed site
- Western NSW
- MMM6
- Community of 2500 people
- 1 GP services the community and can only visit service every 6 weeks.
- Consents to the iAgeHealth Nurse Practitioner service for all residents
- Tertiary hospital located 200 kms
- Service has contract with interstate Physiotherapy with pre-scheduled visits every 6 weeks. Unable to have physiotherapist assessment outside of this schedule
- Unable to source services of an occupational therapist
- Unable to source services of a dietician
- Unable to source services of Nurse Practitioner and Wound Care Consultant
- RN who is a new graduate of 2 years employed 30 hours per week – unable to recruit further hours

Client Intro

- Female 82 years
- Lived in the local community all of her life
- Widow: Husband buried in that community
- Family live in same community
- Able to walk independently without walking aid up until 03.06.2023
- Medical Background: Osteoporosis, Heart Failure, Type 2 Diabetic



Problem

- Fall on the night of 03/06/2023: resulted in a fractured left hip
- Transferred to tertiary hospital and surgery performed 08.06.2023
- Post operative orders were to weight bear as tolerated
- Resident left to rest in bed at tertiary hospital for 4 days and transferred back to service 13.06.2023. No rehabilitation or allied health interventions at tertiary service
- Depression due to current health status, dependency and inability to maintain community connections

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Case Study Mobility

iAgeHealth Intervention

- Resident referred to iAgeHealth 15.06.2023
- Referred to physiotherapist, occupational therapist, dietician, Nurse Practitioner, Wound Care Consultant
- Full assessment by physiotherapist, occupational therapist and dietician completed 15.06.2023
- Physiotherapy interventions: Mobility goal setting and rehabilitation program designed that included gait and balance retraining, transfer practice, hip strength and range of movement
- Occupational Therapy Interventions: Review of room layout to minimise risk of falls, prescription of pressure relieving devices, appropriate seating and ADL aids
- Dietician interventions: Assessment of current dietary needs – prescribed high protein diet and dietary supplements to reduce risk of pressure injury and prevent muscle wasting and deconditioning due to restricted mobility
- Nurse Practitioner: Medication and pain management review and assessment
- Wound care consultant: Wound assessment undertaken by silhouette camera and review supported by the RN at the service to ensure effective management of surgical wound.
- New graduate RN supported to be supported by the RN team for clinical decision making
- Support for staff and education on expected progression of mobility post hip fracture and postsurgical precautions provided

Goal

- Return to pre fracture mobility status
- Increase strength and balance
- Prevent pressure injuries
- Prevent infection
- Manage pain
- Prevent further weight loss and manage Type 2 diabetes
- Recommence weekly external town strips to attend hairdressing

Outcome

- **15.06.2023:** Resident immobile and required 2 care workers to assist in transfers
- **23.06.2023:** Resident mobile with 4wheelie walker and 1 assist
- **02.07.2023:** Resident mobile with 4 wheelie walker and 1 standby assist
- **15.07.2023:** Resident mobile with 1 standby assist
- **21.07.2023:** Resident independently mobile and attending local community outings
- No infection in surgical wound and new grad RN supported by experienced Wound Care CNC to attend surgical staple removal/
- No pressure injuries
- BGL within normal range for Lola from 23.06.2023
- 2 kg weight gain and as at 15.07.2023 and now steady. BMI healthy weight range

Quality of Life:

- Resident is now socially active
- Resident has returned and continues to access her external hairdressing appointments, shopping and banking routines
- Resident reports that she feels like she wants to live her life again
- Resident reports good appetite, no pain and is sleeping well

Clinician's Report:

- Resident is now presenting as a happy and contented person

Staff at Service Feedback:

- Staff felt very supported and equipped to provide the care that Lola needed
- Staff felt that the care that they have been providing Lola and other older people at the service has been truly meaningful work.
- The RN states he felt well supported by the iAgeHealth clinical team in clinical decision making and felt very reassured completing clinical procedures such as staple removal. The service RN reported it felt just like another RN was in the room with him.

Ongoing reviews

- Weekly physiotherapy consultations with strength and balance sessions for Lola
- 2nd weekly Occupational therapy consultation for Lola
- Monthly Dietician consultations for ongoing diabetic management
- Nurse Practitioner referrals as required for Lola and other residents
- Wound care consultant referrals as required for Lola and other residents
- Weekly iAgeHealth RN and service RN consultation for emerging issues with other residents