**Short-term care plan *EXAMPLE*** Identification label

|  |  |  |
| --- | --- | --- |
| **Start date:** | Resident identified as frail – slow (potentially reverse) progression of frailty syndrome. Frail NH score: ………… | |
| Goal: | Intervention: *How will we do that?* | Evaluation: *Did it work?* |
| Measurable gain in lean muscle mass in four weeks | * Ensure eats 2g/kg/day protein (sources include milk, supplements, whey powder, meat, nuts) * Assess and optimise physiological and psychological issues impacting on eating (includes tooth and gum health, food modification, preferences, timing, assistance, social eating patterns, mood, self-assessed quality of life) * Monitor food intake (food charting, ‘blue plate’ system, weigh weekly) * Referral for professional assessment * Work with family regarding additional nutritional treats, eg, trip out to eat, bring food in, extra stuff aged residential care can’t supply | **Date:** |
| Measurable gain in strength in four weeks | * Physiotherapy assessment for individual activity plan; includes strength and stamina training * Intense support to implement PT plan * Agree small specific daily activities that increase activity * Measure against baseline activity at weekly intervals |  |
| Optimise medication regime | Work with NP/GP to:   * review BP (lower BPs in frail older adults have worse outcomes) * optimise analgesia * consider mental health prescribing (depression worsens fatigue, as does hyponatraemia ADE) * consider vitamin D prescribing |  |
| Optimise medical management | Review and work with NP/GP to optimise chronic condition management (eg, inhalers and SOB, glucose and DM, fluids and HF, rest and sleep cycle, cognition and activities) |  |