Managing Chronic Conditions in Older Adults Training Course

29 March – 2 April 2027
Porto

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Ref: 1504_211101 **Date:** 29 March – 2 April 2027 **Location:** Porto **Fees:** 5700 Euro

Overview

Managing Chronic Conditions in Older Adults Training Course is a one-week course for elder-care managers, nurses, care coordinators, social care supervisors, and family-support professionals, who leave with an Older Adult Chronic Care Coordination Pack. The course connects person-centered care planning, multimorbidity care coordination, functional monitoring, self-management support, medication-support boundaries, care transitions, family partnership, escalation, and service-quality governance without teaching diagnosis, prescribing, or treatment decisions. Agile Leaders Training Center presents chronic condition management in older adults as coordinated support practice.

Who Should Attend

- Teams responsible for coordinating support around multiple long-term conditions
- Functions responsible for observing functional change and maintaining care records
- Supervisors responsible for referrals, handovers, and follow-up controls
- Personnel responsible for medication-support processes within defined role boundaries
- Professionals responsible for family partnership and self-management support

The course assumes participants already influence care coordination or support delivery and leaves out diagnosis, prescribing, treatment selection, and clinical medication review.

Departments and Industries

The course supports departments that coordinate older-adult chronic care across residential, community, home-care, and healthcare services.

- Residential care and assisted-living services
- Community health and home-care operations
- Nursing coordination and social care departments
- Care-transition and discharge-support teams
- Quality, safeguarding, and service-governance functions

Learning Objectives

By the end of this course, participants will be able to:

- Analyze chronic-condition and treatment burden in daily support
- Apply person-centered care planning methods
- Use functional monitoring and warning-sign escalation tools
- Build multidisciplinary handover and transition records
- Evaluate self-management and family-support arrangements
- Prioritize care-coordination and governance improvements

Course Agenda

Day 1: Person-Centered Chronic Care Context

- Older Person Goals and Priorities Profile
- Chronic-Condition and Treatment Burden Map
- Functional Ability and Daily-Life Baseline
- Multimorbidity Care Coordination Model
- Professional Scope and Clinical Decision Boundary Matrix

Day 2: Coordinated Care Planning

- Person-Centered Support Plan Canvas
- Care Coordinator Responsibility Map
- Multidisciplinary Goal Alignment Method
- Family and Caregiver Involvement Agreement
- Referral and Follow-Up Pathway

Day 3: Monitoring and Self-Management Support

- Functional Change Observation Log
- Symptoms and Warning-Sign Escalation Guide
- Self-Management Support Conversation Structure
- Medication-Support Boundary Checklist
- Adherence Concern and Access Barrier Record

Day 4: Care Transitions and Governance

- Transition-of-Care Handover Standard
- Medication Information Transfer Check
- Post-Transition Follow-Up Schedule
- Care Coordination Documentation Framework
- Chronic Care Quality Review Dashboard

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Day 5: Chronic Care Coordination Practice

- Suggested Exercise: Burden and Priority Analysis
- Suggested Exercise: Person-Centered Support Planning
- Suggested Exercise: Warning-Sign Escalation Decision
- Suggested Exercise: Care-Transition Handover
- Capstone Exercise: Older Adult Chronic Care Coordination Pack

Practical Exercises

The course uses suggested activities with fictional residential, community, home-care, and healthcare scenarios.

- Suggested activity: map how multiple conditions, appointments, treatments, and daily routines affect an older person's priorities and function.
- Suggested activity: develop a support plan that separates care-coordination actions from clinical treatment decisions.
- Suggested activity: prepare a transition handover linking current support, warning signs, medication information, responsibilities, and follow-up.
- Suggested activity: present a governance review connecting records, escalation, family partnership, outcomes, and corrective actions.

FAQs

Who suits chronic condition management in older adults training, and what does it assume?

Elder-care managers, nurses, coordinators, supervisors, and family-support professionals suit the training; it assumes responsibility for coordinating support or maintaining care systems.

How does chronic condition management in older adults differ from disease-specific clinical training?

Chronic condition management in older adults emphasizes priorities, function, coordination, self-management support, transitions, family partnership, escalation, documentation, and governance rather than diagnosing or treating one disease.

How can care teams coordinate support for older adults with multiple chronic conditions?

Care teams can agree shared goals, identify a coordinator, maintain one support plan, clarify responsibilities, document warning signs, connect referrals, involve family with consent, and review follow-up.

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What are safe medication-support boundaries in older-adult chronic care?

Safe medication-support boundaries separate reminders, access support, observation, recording, and escalation from prescribing, changing doses, stopping treatment, or judging clinical appropriateness.

How should chronic care transitions for older adults be documented?

Chronic care transitions should record current support, medication information, functional status, warning signs, unresolved concerns, family involvement, receiving responsibilities, referrals, and the follow-up owner.

Conclusion

Participants leave with an Older Adult Chronic Care Coordination Pack containing priority, planning, monitoring, self-management, medication-boundary, transition, escalation, and review tools. The pack creates a traceable route from personal goals to coordinated support. It helps services align responsibilities, manage handovers, involve families, and review whether care arrangements remain workable.