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Optimizing physical activity among older adults post trauma: Overcoming system and patient challenges

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KEYWORDS

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Abstract Background: By 2050 it is anticipated that close to half (40%) of all trauma patients will be over the age of 65. Recovery for these individuals is more complicated than among younger individuals. Early mobilization has been shown to improve outcomes. Unfortunately, there are many challenges to early mobilization. The Function Focused Care Intervention was developed to overcome these challenges.

Purpose: The purpose of this paper was to describe the initial recruitment of the first 25 participants and delineate the challenges and successes associated with implementation of this intervention.

Results: Overall recruitment rates were consistent with other studies and the intervention was implemented as intended. Most patients were female, white and on average 79 years of age. Optimizing physical activity of patients was a low priority for the nurses with patient safety taking precedence. Patients spent most of the time in bed. Age, depression and tethering were the only factors that were associated with physical activity and functional outcomes of patients.

Conclusion: Ongoing work is needed to keep patients physically active in the immediate post trauma recovery period.

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Editor comments

It difficult not to focus on the challenges of facilitating physical recovery of older, fragile patients from surgery following bone trauma with the aim of keeping them safe and preventing the complications of immobility and surgery. When nursing and therapy resources are limited, however, there are many barriers to making the remobilization of the patient a priority even though this is a central activity in ensuring their return to independence. This paper not only acknowledge this and many other challenges in remobilization but explores these in detail and offers new ways of thinking about how this problem might be tackled in the future.

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Introduction

By 2050 it is anticipated that close to half (40%) of all trauma patients will be over the age of 65 (Center for Disease Control, 2012; Mullins, 1999). Falls are the leading cause of trauma among these individuals with other causes including motor vehicle accidents, pedestrian-motor vehicle accidents, assault and environmental injuries (e.g., hyperthermia). Compared to younger adults, older trauma patients have higher mortality rates, longer hospital stays and increased long term morbidity and are more likely to be readmitted to the hospital following discharge (Aitken et al., 2010; Ayoung-Chee et al., 2014; Grossman et al., 2003; Taylor et al., 2002).

Once hospitalized, older individuals tend to demonstrate a decrease in performance of activities of daily living (Aitken et al., 2010; Campbell et al., 2001; Covinsky et al., 2003; Ferrera et al., 2000; Fisher et al., 2011; Grossman et al., 2003; Kuys et al., 2012; McGwin et al., 2000; Palleschi et al., 2011; Van Aalst et al., 1991; Zelada et al., 2007; Zisberg et al., 2011). This functional decline is associated with higher mortality rates, longer length of stay (LOS), greater resource consumption, nursing home placement (Chuang et al., 2003; McCusker et al., 2002; Mosenthal et al., 2004; Ponzetto et al., 2003; Volpato et al., 2007; Winograd et al., 1997; Zarzaur et al., 2010), adverse events such as infections (Makris et al., 2010), pressure ulcers (Baumgarten et al., 2006; Cox, 2011) and falls (Tommasini et al., 2008) and rehospitalization post discharge (McKevitt et al., 2003; Nolan and Thomas, 2008).

A primary cause of functional decline among hospitalized patients is bedrest, with older patients spending the majority of time during their hospitalization in bed (Brown et al., 2009; Edmonds and Smith, 2014; Fisher et al., 2011; Kuys et al., 2012; McRae et al., 2014; Payne et al., 2014; Zisberg et al., 2011). Consistently, patients who engage in more physical activity, defined as any bodily movement produced by skeletal muscles that requires energy expenditure (World Health Organization, 2014), have better overall outcomes following an inpatient hospital stay (Bailey

et al., 2007; Burtin et al., 2009; Hill et al., 2013; Hopkins and Spuhler, 2009; Jones et al., 2003; Mundy et al., 2003; Palleschi et al., 2011; Pawlik et al., 2008; Schweickert et al., 2009). Physical activity includes such things as participating in bed mobility, bathing and dressing or walking to the bathroom. When nurses work in an interdisciplinary team and help patients remain physically active, deconditioning and loss of functional skills such as bathing, dressing, transfers and ambulation can be prevented (Bailey et al., 2007; Zelada et al., 2007). Specifically, when nurses encouraged patients to be physically active there was less functional decline than found among patients not exposed to this type of encouragement (Boltz et al., 2012; Zelada et al., 2007).

Reasons for limited time spent in physical activity include patient factors, acute care environments, medical and nursing interventions and insufficient communication between providers about patients' functional status (Boltz et al., 2011; Brown et al., 2007, 2009; Burdick et al., 2005; Buttery and Martin, 2009; Crews, 2005; Edmonds and Smith, 2014; Hopkins et al., 2012; Martin et al., 2005; Payne et al., 2014; Thomsen et al., 2008; Wakefield and Holman, 2007; Zelada et al., 2007). Patient factors include age, sociodemographic characteristics, preexisting disability and disease states, fatigue, delirium, cognitive impairment, anemia, pain, fear of falling, depression, lack of motivation, nutritional status, sedation and polypharmacy.

The acute care environment generally provides limited opportunity for physical activity. The bed is often the only furniture in the hospital room and the height of the bed or chairs may limit the patient's ability to transfer. In addition, there are often no pleasant areas for walking or pleasant destination sites. Patients are further restricted from engaging in physical activity as part of ongoing care as mechanical lifts are routinely used to facilitate transfers and they are not allowed to walk or self-propel to tests and procedures.

Medical factors limiting physical activity and contributing to functional decline include the tethering effects of devices such as indwelling urinary

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