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Feature Article

Improving person-centered mobility care in nursing homes: A feasibility study



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ABSTRACT

Person-centered care is often equated with quality nursing home care. At the same time, quality mobility care contributes to residents' independence and quality of life. Realist evaluation and mixed methods were employed to evaluate the feasibility of a multi-faceted training intervention focused on person-centered mobility care. Staff and ambulatory residents of a ninety bed Australian nursing home with 3 units—one dementia-specific—participated. The intervention consisted of training sessions, weekly mobility care huddles and reflective practice sessions with individual staff. This study demonstrated the feasibility of an intervention aiming to improve person-centered mobility care in nursing homes; it was practical and well accepted. Study methods and outcome measures were suitable. Outcome measures demonstrated capacity to determine the effectiveness of the intervention in a larger randomized controlled trial. Focus groups provided insights regarding the context and mechanisms of change. Future research is recommended to evaluate intervention effectiveness and sustainability.

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Background

Person-centered care is often equated with quality nursing home care¹ and involves consideration of residents' choice, autonomy, independence and control.^{2,3} The need for person-centered care is evidenced by calls to share best practice in personalized dementia care in the United Kingdom,⁴ within national guidelines for dementia care in Sweden,⁵ and through consumer-directed care recommendations enshrining choice and control for older people in Australia.⁶ At the same time, mobility is an aspect of residents' daily activities that contributes to their independence and quality of life.^{7,8} Many residents require some form of staff assistance—referred to as mobility care—to achieve activities of daily living, but staff promotion of residents' autonomy, independence and control during mobility is frequently absent.⁹ This can result in

dependence being imposed on residents with consequent physical deconditioning, reduced mobility, skin breakdown, and falls.^{9–11}

To the best of our knowledge, no studies have evaluated the use of person-centered approaches during mobility care. Person-centered strategies and support for staff have reduced agitation in people with dementia¹² and enhanced residents' and staff's experiences during hygiene care.¹³ Functional training designed for staff to conduct in addition to usual care can improve residents' mobility,^{14,15} however this approach has not been widely adopted, possibly due to inadequate staffing.¹⁵ Person-centered approaches may improve the quality of mobility care and resident mobility outcomes.¹⁶

Person-centered approaches incorporate individualized care.^{16,17} Individualized mobility care requires staff to understand residents' mobility capacity and to safely meet residents' mobility needs through use of mobility enhancing strategies that encourage and allow residents to move themselves where possible.^{9,18} This is particularly important during transfers on and off furniture, a function that determines residents' continued safe ambulation.¹⁹

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Person-centered mobility care has a broader focus than individualized care²⁰; the quality of the resident–staff interaction is the primary consideration with staff being ready to respond flexibly in the moment to the needs of the resident as a whole.^{21,22}

Inadequate staff training and support can act as barriers to person-centered mobility care but may be addressed by multi-faceted interventions based on collaborative training approaches.²³ Traditional didactic models of training are less successful in securing staff behavior change than when combined with collaborative and interactive models of training.²⁴ Facility cultures based on relationships and an enriched and supportive environment are also recommended for effective practice change.^{22,25} Huddles—small gatherings of staff for learning purposes—have been successfully employed to ensure safe manual handling practice.²⁶ Reflective practice can also facilitate practice development.^{22,27} In particular, reflective practice may improve nursing home staff's situation awareness and intuitive decision-making that are important when high levels of uncertainty and unpredictability exist, as they often do during mobility care.^{28,29} Motivational interviewing,³⁰ promoted as a tool for knowledge translation,³¹ is a further means of working with staff's change process through active listening and use of reflections.

The purpose of the current study was to evaluate the feasibility of an intervention to improve person-centered mobility care during resident transfers.³² Specific purposes of the study included to test recruitment, resources, methodologies, acceptability and outcome measures as well as to estimate sample sizes for a randomized controlled trial. Analysis of outcomes provided information regarding potential effect sizes. As a study's feasibility is also dependent upon interventions being contextually appropriate,³³ we evaluated the context of the current intervention.

Method

Realist evaluation³⁴ and mixed methods in a convergent parallel design³⁵ were employed to evaluate the feasibility of this complex intervention. Realist evaluation is a pragmatic approach that considers relationships and the social environment and explores study context, mechanisms and outcomes to better understand what worked, for whom, in what circumstances, in what respects and how.³⁶ The context of this study was person-centered mobility care improvements in a nursing home setting. The mechanisms were the intervention and use of mixed methods including a usual care controlled, pre-post design. Kirkpatrick's hierarchy of educational outcomes guided evaluation at 4 levels: (1) participant reaction; (2) participant learning; (3) participant behavior change; and (4) outcomes.³⁷ Focus groups provided qualitative data to assist with evaluation of the study.

Setting and participants

The study was conducted in a ninety bed nursing home with 3 high care units, including one that was dementia-specific, in Melbourne, Australia. Purposeful samples of staff and residents were recruited. Inclusion criteria for residents were to be consenting, ambulant with or without gait aids, permanent stay and classified as requiring high care services as assessed by regulated Australian Aged Care Assessment Teams. Residents who were short stay and non-consenting were excluded. Inclusion criteria for staff were to be consenting and employed to provide direct care. Casual and agency staff were excluded. Management assisted with recruitment by distributing explanatory statements to residents, their families and staff.

Ethical issues

Ethics approval from Monash University Human Research Ethics Committee and organizational permission were gained for the study. Participant staff and residents provided written informed consent. Third party consent was gained from residents' proxies when residents had a diagnosis of dementia or cognitive impairment. Unit coordinators, who knew the residents well, deemed when proxy consent was necessary. The first author (ww) approached some residents, with management permission and following advice from unit coordinators regarding who was able to give informed consent, to assist with recruitment. Participants in focus groups consented to sessions being audio-recorded. Facility consent was obtained for unobtrusive observations of staff and residents in public areas.

The intervention

The intervention was a collaborative training program conducted over sixteen weeks. Person- and relationship-centered frameworks,^{21,25} consistent with the notions of transformational learning and appreciative action,^{38,39} guided development of the intervention. Two researchers conducted the intervention. The primary intervention facilitator had twenty-six years' of experience as a physiotherapist in nursing homes and an emic understanding of the culture surrounding mobility care. She was assisted during training sessions by a dementia care consultant trained as a social worker and dance therapist. Neither had a relationship with the facility or staff beyond this study. The intervention underwent preliminary testing in another nursing home.

Content

Staff were trained in the use of person-centered approaches and mobility enhancing strategies during mobility care including how to approach, interact and communicate with residents and how to promote the correct biomechanics for independent transfers. Key features of the multi-faceted program included: reinforcement of safe manual handling; use of a mobility care decision tool; provision of person-centered and mobility enhancing strategies; and environmental considerations such as the need for appropriate seating and correct use of gait aids.

Format

Table 1 illustrates the timing and key aspects of the intervention. Training formats included: two 1-h training sessions; weekly mobility care huddles; and reflective practice with individual staff. Facilitation methods during training and in huddles varied but the focus was on use of experiential and interactive methods and included the plan-do-study-act cycle⁴⁰ (Table 2). Motivational interviewing was employed during reflective practice sessions. Both motivational interviewing and reflective practice are consistent with the notions of transformational learning and appreciative action.

Data collection

Staff measures

Staff satisfaction (training) (Kirkpatrick's level 1 – reaction) – measured using a fourteen item questionnaire designed to determine whether staff's expectations were met, how they rated the training and what they learned from it. Response items included items with a 5 point Likert scale and open-ended questions (See Appendix).

Staff satisfaction (program as a whole) (Kirkpatrick's level 1 – reaction) – measured using a twenty-six item questionnaire designed to determine whether staff's expectations of the program

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