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## Feature Article

# A pilot exploration of the effect of designated Function Focused Care on mobility, functional dependence and falls frequency in Dutch nursing home residents

Eva S. van der Ploeg, MSc<sup>a,b,\*</sup>, Marleen L. Leermakers, MSc<sup>a</sup>

<sup>a</sup> Stichting Argos Zorggroep, Voorberghlaan 35, 3123 AX Schiedam, The Netherlands

<sup>b</sup> Department of Public Health & Primary Care, Leiden University Medical Center, Hippocratespad 21, Postzone VO-P, 2300 RC Leiden, The Netherlands

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## ABSTRACT

In recent years, there has been a gradual change in nursing home care from care providers doing as many things as possible for residents to a philosophy where patients are encouraged to become more involved in their care and activities of daily living. Function Focused Care (FFC) is a methodology to stimulate the involvement of residents on a daily basis that has shown to be safe and effective in improving ADL-functioning. We implemented FFC in four nursing homes with 53 residents. This first pilot project in Dutch nursing homes has replicated the finding that FFC inspires functional independence, but also revealed a reduction in the number of falls among fallers.

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## Introduction

Traditional nursing home care has focused on doing things for rather than providing care with the patient.<sup>1</sup> It has been shown that providing care for residents facilitates functional decline and can cause further deconditioning and disability.<sup>2–5</sup> Reductions in physical activity contribute to muscle mass loss and weakness, which may lead to further decreases in activity.<sup>6</sup> Incontinence, osteoporosis, falling and problems with cognition are also associated with inactivity.<sup>7</sup> In addition to the consequences for elderly individuals themselves, inactivity also has an impact on health care costs as little physical activity may lead to increased health care utilization and consequently to increased health care expenditure.<sup>7</sup>

In the Netherlands, 96% of nursing home residents have a sedentary life style defined as “not being moderately active for 30 min or more on any given day in a calendar year”.<sup>8</sup> An American study also revealed that nursing home residents do not engage in physical activity at a moderate or more strenuous level.<sup>9</sup> Resnick & Galik showed that nursing home residents engaged in less physical activity than those living in residential care facilities.<sup>10</sup> Meeting

Physical Activities Guidelines may (at first) be challenging for older adults, but it has been shown that even small increases in physical activity will have a positive effect on the elderly population regardless of the intensity, duration, frequency and type of physical activity performed.<sup>11</sup> In 2012, it was reported that there is hardly any policy and expertise regarding activity in Dutch nursing homes which is attributed to deficiencies in time, staff and/or financial resources.<sup>12</sup> However, in recent years there has been a gradual change of focus from what care providers do for patients to a philosophy where older patients are encouraged to participate in their health care management as well as to adopt behaviors that may optimize their health and/or quality of life (e.g. in the U.S.A. and the Netherlands).<sup>13</sup> One possibility to increase physical activity is to let elderly perform (parts of) their activities of daily living (such as cleaning their room and washing themselves) which stimulates physical activity as well as autonomy.<sup>7</sup>

To engage residents in performing activities of daily living motivational techniques are needed. Most commonly the theoretical basis for this motivation has been based on the theory of self-efficacy. The theory of self-efficacy postulates that a person's belief in his or her ability to perform a specific action to achieve an outcome influences how hard they will try to perform the activity.<sup>14</sup> Physical activity interventions aimed at improving the perception of exercise self-efficacy can have positive effects on people's confidence and ability to initiate and maintain physical activity.<sup>15</sup>

\* Corresponding author. Stichting Argos Zorggroep, Voorberghlaan 35, 3123 AX Schiedam, The Netherlands.

E-mail address: [esvdploeg@gmail.com](mailto:esvdploeg@gmail.com) (E.S. van der Ploeg).

McAuley et al (2007) described in a sample of 249 community-dwelling older women that increased physical activity lead to improvements in self-efficacy, which was then associated with improved physical function.<sup>16</sup> Approaches that strengthen self-efficacy are: successful performance of the activity; verbal encouragement to perform the activity; seeing other (similar) individuals perform the activity and eliminating unpleasant feelings or sensations that may be associated with the activity.<sup>14,16–22</sup> These self-efficacy approaches are integrated in Function Focused Care (previously known as Restorative Care).<sup>3</sup> Function Focused Care (FFC) focuses on evaluating people's capabilities with regard to function and physical activity and helping them to optimize and maintain functional abilities and increase physical activity. FFC uses core principles such as "less talking, less touching", demonstration and (non-verbal) encouragement, positive reinforcement and breaking tasks down in smaller steps.<sup>1</sup>

A recent literature review regarding FFC included 20 articles describing the use of FFC in long term care for elderly.<sup>1</sup> Thirteen of these studies were conducted in nursing homes. Although half of the studies used a pilot design, the authors carefully concluded that the review provided support for the safety and efficacy of FFC in long term care settings. Outcomes were focused on activities of daily living; of the 15 studies in 9 studies improvement was reported. Psychosocial outcomes, such as depression and quality of life did not improve neither did more physically focused outcomes such as gait, balance and falls frequency. However, the authors noted that no further deterioration of physical function may be a positive outcome in itself.

There have been two models of FFC tested, designated vs. integrated FFC. We implemented the designated model, where specially trained nursing assistants perform FFC activities.<sup>23,24</sup> In the FFC review it was highlighted that more research was needed in particular in regards to (success of) the implementation of the methodology as well as a further explanation of the impact of FFC on falls frequency.<sup>1</sup> Hence, we conducted a pilot study with both a quantitative measurements, including falls (especially among people for whom a fall is reported) as well as a qualitative evaluation component (described elsewhere) to provide further insight into implementation and evaluation of designated Function Focused Care in Dutch nursing homes. We hypothesize that the use of FFC will result in stabilization or even improvement over time of falls frequency, functional dependence and indicators of improved mobility such as walking, transfers and balance.

## Methods

### Design

The study was a longitudinal cohort pilot study with a follow-up time of 6 months. Ethical approval was not necessary under Dutch regulations since the introduction of Function Focused Care was considered to be a quality of care standard and part of good medical practice. Therefore, the intervention was for clinical purposes and complied with The Dutch Law of Agreement to Medical Treatment (WGBO). We did obtain informed consent from the participants or their informal caregivers to join in the evaluation tests and to abstract information from the medical files.

### Setting

Four nursing homes participated with one or two wards each. Among those was one somatic ward where people with chronic somatic diseases were cared for, three psychogeriatric wards where people with cognitive disorders resided, and two mixed wards. All

facilities were part of Argos Health Organization which is located in a rural area near Rotterdam, the Netherlands.

### Participants

Data were collected between January and July 2015. We screened all current residents of the six wards ( $n = 114$ ). 22 residents were ineligible because they had not lived in the facility for longer than 3 months ( $n = 7$ ); had an MMSE < 11 ( $n = 7$ ); had a life expectancy shorter than 6 months ( $n = 1$ ), and/or; followed active rehabilitation ( $n = 12$ ). Some people were ineligible for more than one reason, hence the total exceeds 22. Of the 92 eligible participants 39 (42%) did not consent to the study procedures. Thus, 53 residents were enrolled. During the 6 months follow-up period 6 people died and 2 were admitted to hospital (loss to follow-up of 15%). 13 participants were wheelchair-bound and could not participate in the physical tests, but were evaluated in terms of falls frequency and functional dependence.

### Procedure

The Function Focused Care specialists were trained as a group on two occasions (4 h each) within a fortnight. During the following 6 months they met at three peer supervision meetings with each other and the trainers (2 h per session). Specialists were encouraged to contact the trainers throughout the project and the trainers on occasion checked in with specialists to see if they had queries.

### Intervention

We used a designated Function Focused Care (FFC) program, in which designated nursing assistants provided FFC. Our training was based on the videos, theory and slides of the original FFC implementation and research group (Resnick & Galik, University of Maryland, School of Nursing, website: [functionfocusedcare.org](http://functionfocusedcare.org)) adapted with their permission to our setting and country. We also adapted FFC plans to formulate end- and sub goals for participants individually. The main goal of our application of FFC was to improve mobility, either in terms of actual transfer- or walking performance or in ADL-tasks that required a certain level of mobility (e.g. making the bed or doing the dishes, not grooming or brushing one's teeth). The first training session focused on the FFC methodology, principles and application. The second training session partly repeated the core elements of the methodology and upon specialists' request focused on making FFC plans for each resident and possibilities for further implementation. The three consecutive supervision meetings focused on: 1) specialists' case studies; 2) the physiology and haptonomy of assisting someone with functional independence (lead by a physiotherapist), and; 3) specialists' experiences.

FFC specialists received a list of participating residents on their wards for implementation of the methodology. They could implement with other residents and include co-workers if they wanted. The FFC specialists filled in a FFC care plan for every participant. The FFC care plan described personal goals for improving mobility and the steps they needed to make to fulfill that goal. We implicitly tried to ascertain treatment fidelity by requesting and discussing FFC care plans for all participants, asking specialists to fill out dependency scores at time intervals as well as by organizing frequent peer supervision meetings. Staff was instructed to use FFC during all transfer-, walking- and ADL-interactions with the participants, however we did not record how frequent and long the designated staff applied FFC with their participants.

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