

2017

Improving Mobility for Older Adults in the Acute Rehabilitation Setting

Joan E. Kucienski

University of Massachusetts Amherst, jkuciens@nursing.umass.edu

Follow this and additional works at: http://scholarworks.umass.edu/nursing_dnp_capstone



Part of the [Nursing Commons](#)

Kucienski, Joan E., "Improving Mobility for Older Adults in the Acute Rehabilitation Setting" (2017). *Doctor of Nursing Practice (DNP) Projects*. 87.

http://scholarworks.umass.edu/nursing_dnp_capstone/87

This Open Access is brought to you for free and open access by the College of Nursing at ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

Improving Mobility for Older Adults in the Acute Rehabilitation Setting

Joan Kucienski

UMass College of Nursing

Capstone Chair: Dr. Raeann LeBlanc

Capstone Committee Member: Dr. Elizabeth A. Henneman

Capstone Mentor Donna Feinstein

Date of Submission: March 28, 2017

Table of Contents

| | |
|--|----|
| Abstract..... | 4 |
| Introduction and Background..... | 5 |
| Problem Statement..... | 6 |
| Review of the Literature..... | 6 |
| Theoretical Framework..... | 11 |
| Project Design and Methods..... | 13 |
| Settings and Resources..... | 13 |
| Description of the group, population or community..... | 14 |
| Organizational analysis of project site..... | 14 |
| Evidence of stakeholder support..... | 15 |
| Goals, Objectives and Outcomes..... | 15 |
| Implementation Plan..... | 15 |
| Timeframe for Implementation of Project..... | 16 |
| Sample..... | 17 |
| Data Analysis..... | 17 |
| Ethics and Human Subjects Protection..... | 18 |
| Results..... | 19 |
| Outcomes..... | 18 |
| Staff Participation Getting Patients Out of Bed..... | 19 |
| Facilitators and barriers..... | 23 |
| Discussion..... | 24 |
| Suggestions and Future Recommendations..... | 25 |
| Conclusion..... | 26 |

References.....27

Appendix A.....32

Appendix B.....33

Abstract

Purpose: This Doctorate of Nursing Practice (DNP) scholarly quality improvement project focused on implementing a Get Up and Go exercise program to increase mobility in an acute 80 bed rehabilitation facility. The goal of increased exercise was for patients to return to their pre-hospital level of function. *Methods:* This quality improvement projects' purpose was aimed at increasing mobility to three times a day in patients over the age of 65. Caregivers were educated on the exercise Get Up and Go, along with the documentation of the increased mobility in the electronic medical record. The DNP Project took place over four months. *Results:* The outcome of this DNP Project was the recognition by staff (including physical therapists) of the importance of their role in getting patients out of bed. The outcomes measured included how often patients participated in getting out of bed on a daily basis. *Conclusion:* This DNP project's original goal was to have patients return to pre-hospital function status. This goal was not met due to the project changing goals as the actual implementation unfolded. The final goal that was achieved became educating staff on the importance of increased mobility. Overall participation towards this goal increased.

Keywords: mobility, exercise, Get Up and Go, rehabilitation, nursing, function, older adults

Introduction and Background

It is widely recognized that regular physical exercise contributes to healthy aging and that a loss of mobility can cause a significant decline in the overall health of older individuals. (Mulasso, Roppolo, Settanni, & Rabagliett, 2013). Twenty-seven percent of older adults discharged from a hospital require care in skilled nursing facilities (SNFs) or rehabilitative care facilities, with an additional 15% requiring home health care services (Institute of Medicine [IOM], 2008). The current “state of the science” related to mobility is that regular physical exercise is key to good health (CDC, 2015).

Bed rest and lack of mobility contribute to functional decline in the older hospitalized person. This has been shown to be one of the leading complications in the hospitalized older patient. Research suggests that 30-50% of the inpatient older adults experience functional decline during hospitalization (Presley & Johnson, 2016). Improving mobility as a nurse intervention has shown reduction in: falls, skin breakdown, venous thromboembolic disease, and delirium in the older patient. The need to improve mobility in an acute rehabilitation facility was identified through observation while teaching nursing students in the facility. A chart audit conducted on two rehabilitation floors of approximately 40 patients revealed approximately 40% of patients over age 65 were out of bed three times a day.

The Timed Get Up and Go (Presley, C., Johnson, S., 2016) test is both an activity and a measurement of mobility. It involves physical moves such as standing from a sitting position, walking, turning, stopping, and sitting down. These exercises are needed for a person to be independently mobile. A mobility program using even a short intervention such as the get up and

go will promote strength and endurance when consistently performed among older adults in the rehabilitation setting (Presley, C., Johnson, S., 2016).

Clinical Quality Measures (CQMs) are tools that measure and track the progress, outcomes, and quality of care within our healthcare system (CMS, 2016). Measuring and reporting quality measures, provides evidence that healthcare providers are providing safe, cost effective, patient centered, quality care. Reimbursement from Medicare and Medicaid to healthcare settings has been effected by the quality measures. The Centers for Medicare & Medicaid Services (CMS) announced in April 2016 that it has incorporated five new quality measures that will be included in determining a nursing home (NH) Five-Star Quality Ratings. Three of the measures included: (1) Percentage of short-stay residents who were successfully discharged to the community, (2) Percentage of short-stay residents who made improvements in function, and (3) Percentage of long-stay residents whose ability to move independently worsened. All these quality measures require an increase in functional mobility making this quality improvement project a priority.

Problem Statement

“Risk of functional decline” among people over age sixty five who require rehabilitation after a hospital stay is indicated by increased dependency on others for care and is influenced by absence of access to daily physical activity. Reviewing the literature narrowed down this topic to a manageable quality improvement project, and gave this author the idea for implementing the “Get Up and Go” intervention.

Review of the Literature

A comprehensive literature search was done using the following databases: Pub Med, National Guideline Clearinghouse, and the Cumulative Index to Nursing and Allied Health

Literature. The Nursing Subject Headings terms employed in Cumulative Index to Nursing and Allied Health Literature included: *exercise, mobility, elderly, programs, alternating with rehabilitation*. The source type included academic journals, dissertations, magazines, and Geriatric Protocols for Best Practice. The journal subsets included peer-reviewed biomedical research articles. Two hundred and twenty-nine articles were retrieved, and twenty-five were chosen for this study along with recommendations on mobility from the Center for Disease Control, National Institute of Health, and the Institute of Medicine. Studies were eliminated if they were not within the last ten years, they did not include exercise, mobility, older people, and rehabilitation, and they were not from a research study. The four peer-reviewed journals were; Age and Aging, Journal of the American Geriatrics Society, Journal of Preventive Medicine and Public Health, Journal of Aging and Physical Activity. The remaining articles/guidelines were from the Institute of Medicine, the National Institute of Health and the Center for Disease Control and Prevention.

A synthesis of all twenty five articles included: one prospective observational study, a secondary analysis of data collected for an RCT, a two arms assessor-blind pilot RCT, a descriptive study, and three expert opinion/clinical guidelines. The articles were each rated using Johns Hopkins research evidence appraisal for strength and quality (Dearholt & Dang, 2012). There were level I-III rated items and good quality power. Participants within the studies included adults ages 65 and over, transitioned between outpatient rehabilitation units, homebound or community dwelling people, day care, and hospital settings. The studies also included the participation of physicians, nurses, inpatient and outpatient physical therapists, home health nurses, pharmacists, and family/caregivers. The synthesis of these studies identified the following themes that guided this quality improvement project.

Frequency of Physical Therapy

The gradual decline in mobility as people age can contribute to additional health problems. Early recognition of decline by healthcare workers can significantly reduce adverse outcomes. By changing physical environments and creating different integrated interventions across various disciplines, we can improve mobility for an older adult (CDC, 2013).

Loss of mobility in hospitalized older adults has been a primary determinate for a referral to an inpatient rehabilitation facility. It has been widely believed that bed rest and inactivity in hospitals are detrimental for mobility and function. Despite the physical activity guidelines for older adults by the American College of Sports Medicine/American Heart Association (2013), there are no definitive clinical guidelines on optimum physical activity levels for older adults undergoing inpatient rehabilitation. The clinical guidelines to promote and maintain health in older adults before hospitalization include: moderate aerobic activity for at least 30 minutes five days of the week, or vigorous aerobic activity for at least 20 minutes three days of the week. (Bassem & Higgins, 2010). It is hypothesized that providing increased physical activity to older people receiving inpatient rehabilitation will lead to better mobility outcomes at discharge (Said et al., 2015).

Physical and occupational therapy are rehabilitation interventions that improve patient outcomes. Few studies have shown an optimal time and frequency of inpatient rehabilitation that correlates with the positive results of increased physical function, quality of life, reduced length of stay (LOS) and health care costs. A recent randomized control study by Parker et al., (2013) included 996 patients in two rehabilitation facilities in Australia. Their study investigated if there was a difference in patient outcomes, by having participants receive physiotherapy and occupational therapy delivered Monday through Friday (five days/week control group) versus

Monday through Saturday (six days/week intervention group). These researchers were able to conclude the intervention group had greater results in all the positive outcomes along with significant functional improvement at a six-month follow-up. This study showed in the acute inpatient rehabilitation setting, more frequent physiotherapy and occupational therapy improves patient outcomes, and will likely reduce the length of stay and costs.

Peiris, Taylor, and Shields, (2012) demonstrated in their randomized control trial that an extra 9 minutes a day of physical therapy significantly improved functional independence and quality of life at discharge. Of the 105 participants, the experimental group received an additional full Saturday of PT and OT, compared to the control group who only went to PT and OT Monday through Friday. Although this study did not have a large sample of patients and they were admitted with orthopedic surgical versus medical problems, the outcomes measured were significant. The experimental group participants took 63% more steps (mean difference, 283 steps; 95% CI, 34-532) and spent 40% more time upright (mean difference, 0.4h; 95% CI, 0.1-0.8) per day than participants in the control group (Peiris et al., 2012). This study shows that increasing physical therapy an additional day in a rehabilitation facility promotes functional mobility and increases endurance.

Exercise and Increased Mobility

Reducing the length of stay is a high priority for our health care industry. A shorter duration of residence is considered an efficient and profitable service. In addition to providing physical therapy to patients, a therapist must also try to ensure the patients can function with some assistance if needed when safely discharged to the home or another facility. Providing quality exercise interventions that improve a patient's mobility function is the goal. In addition to providing therapy, physical therapists have an important role in acute hospitals and rehabilitation

centers to assist with discharge planning and to ensure that patients have adequate mobility to be safely removed.

The HOPE trial has provided valuable information on exercise interventions in the older person (Clegg, Barber, Young, Iliffie, & Forster, 2014). Researchers in the HOPE study performed a randomized control trial comparing the effectiveness of the HOPE program with usual care. The 84 participants in the study included participants from home, members from home with home health aides, and those attending day centers in Bradford, UK. The researchers implemented a 12-week exercise program designed to improve overall mobility. The program consisted of strengthening exercises that enhance mobility. These included the fundamental movement skills (which also mirror the Get Up and Go practice) such as getting out of bed, standing up from a chair or a toilet and walking a short distance. Impairment of these skills in older people results in: increased risk of immobility, activity limitation and potential dependence on others for care. In this study, the length of time of 12 weeks is noted to be the key to success of the intervention. The participants who exercised throughout this intervention showed stronger muscles improved distance and duration of ambulation.

An Australian study done by Said et al. (2015) examined the effects on functional mobility by adding interventions that increase physical mobility. The addition of physical activities such as standing or walking was compared to a control group who performed equal amounts of social events with minimal impact on mobility. The results of this study are ongoing, and they are corresponding extra physical therapy to outcomes of reduction in patient length of stay, improved functional outcomes and quality of life in people. A systematic review by Peiris, Taylor, and Shields (2011), revealed similar outcomes from 16 randomized controlled trials, with 1699 participants. In the trials, the experimental group received more PT than the comparison

group with extra sessions, longer sessions, or both. Their results showed that extra PT reduces the length of stay, improves the rate of improvement in walking ability, and quality of life only to those individuals who were not noted to be 'self-care.' Comparing this with standard PT in 8 trials (n 920), new physical therapy reduced the length of stay by four days in a rehabilitation setting and one day in an acute care hospital.

Summary

In conclusion, there is substantial evidence to support the need for increased mobility in rehabilitation facilities. In today's health care system, quality of care is based and compensated financially on positive outcomes. The evidence from these research studies show that increasing mobility in a rehabilitation setting through specific exercises (increased ambulation or out of bed to a chair) along with increased duration (an extra day during the weekend or increased number of times in one day) are consistent with improved outcomes. The results include improved overall function, reduced length of stay, and overall improvement of the quality of life.

Theoretical Framework

One of the most influential models for human process change is Kurt Lewin's Change Theory (McCalman, 2015). Lewin's simple model of unfreezing, changing, and refreezing is the theoretical foundation he used to produce human change. He felt the key to change, whether individual or in a group, was a painful process of unlearning without loss of identity, and relearning by restructuring one's thoughts, perceptions, feelings, and attitudes (Schein, 1999). Lewin felt human behavior is a delicate balance between forces that work together to create equilibrium ultimately. Lewin used the concept of troops known as driving forces, restraining forces and equilibrium to describe the stages humans experience during a change process. Driving forces assist the person/group in the desired direction towards change. The driving

forces in this quality improvement project are to educate patients, staff, nursing students and families on the importance of increased mobility and implementation of the Get Up and Go exercise. Restraining forces in this project, or those forces that hinder change, would include beliefs, values, attitudes, and behaviors of the staff that presently work with the population. Lewin's Change Theory is to avoid equilibrium where driving forces equal restraining forces thus experiencing no change. To promote change in this setting, it was proposed in creating the intervention that the participants would understand the exercise program Get Up and Go. Next, they would assist patients with the use at least an additional ten minutes each day of increased mobility, six days a week. Lastly, they would promote increased functional mobility in patients with the goal of discharging home versus a long-term care facility or readmission to a hospital setting reflecting a return to pre-hospitalization functional levels.

Lewin's Change Theory has three important stages: unfreezing, movement and the process of refreezing. This initial change process is often the most challenging and stressful. Challenging the "way things are done" evokes strong reactions in people such as resistance, complaints, and many negative reasons why "change" should not occur. The key to effective change management, then, becomes the ability to balance the amount of threat produced by the change, allow the change target to accept the information, feel the survival anxiety, and become motivated to change (Schein, 1999).

Movement is the second stage of Lewin's change theory is movement, which is to persuade participants that the current policy is not beneficial. . Communication and understanding of apprehension are expected emotions during this phase.

Refreezing, the final stage of Lewin's theory integrates the new mobility project into the daily routine of the nurses and staff. Refreezing will occur when all members of the patient's

health care team will have the Get Up and Go Mobility program part of their care plan for all patients.

Project Design and Methods

Setting and Resources

A specialty acute care hospital with rehabilitation services was the setting for this DNP quality improvement project. The hospital serves patients in New England and the New York area. Admissions include patients directly discharged from acute care hospitals, direct admits from Emergency Rooms, physician offices and SNF facilities. It is certified as a long-term acute care (LTAC) facility along with being licensed as a specialty acute care hospital. The hospital's unique ability is to provide specialized critical care over an extended recovery period. The Medically Complex/Acute Rehabilitation Program is for patients who have been discharged from an acute hospital but continue to require rehabilitation services. The program specializes in pulmonary and acute rehabilitation with the goal of transitioning patients to be discharged home or to a long-term care facility. The hospital services include ventilator support/weaning, wound management, and hemodialysis. The aim of the pulmonary rehabilitation team is to assist in weaning off ventilators, breathing retraining and helping the patients towards their maximum potential in recovery. The specialized rehabilitation programs help patients achieve and maintain their highest possible level of independence and quality of life. The interdisciplinary team led by the attending physician includes nurses, pharmacists, nutritionists, occupational therapists, speech and language pathologists, wound nurses as well as physical therapists. The health care providers collaborate to maximize patient goals, mark progress and coordinate the care to provide best possible outcomes.

Description of the group, population or community. The patient population has three to six concurrent active diagnoses, multiple co-morbidities, often have experienced multi-organ failure, and have physically deteriorated to require total care. The average length of stay is 25-30 days. The patients are often admitted needing the support of ventilators, dialysis, cardiac telemetry, wound management, IV antibiotic therapy and extensive rehabilitation. Many of the patients are also on precautions (MRSA, contact, VRE) due to their multiple co-morbidities. The average age of the population is in their seventies, although they accept patients over the age of 18 years. Most of the patients are discharged, but there are a few who utilize palliative care and end of life services.

Organizational analysis of project site. This facility provides physical therapy, including mobility once a day excluding weekends to all patients who are able to get out of bed. Each patient has forty five minutes scheduled daily to participate in physical therapy. The patients do not have schedules to be out of bed for all meals, nor to get up and ambulate daily. The Director of Nursing supported the implementation of this DNP project as a great addition to their facility and rehabilitation program. In a patient- centered culture, the Director of Nursing hoped incorporating the elements of this quality project would result in more positive patient experiences and was vested in its success.

Evidence of stakeholder support. The stakeholders in this project were: patients, family members, nurses, therapists, pharmacists, dietary, managers including the Chief Nursing Officer, the owners of the facility, and the government. The patient and family members had the most to gain from this project. Education focused on the importance of increased physical mobility including all the positive outcomes. A shorter length of stay, faster healing time, and the ability to independently care for self were the motivating factors. Greater understanding of the positive

outcomes related to getting out of bed was shown through the support from staff. Earlier discharges and fewer complications were the motivating factors for corporate re-imburement. This level of stakeholder support was a key factor in meeting the goals of this project and critical to the initial stages of change. As the project moved forward the most important stakeholders became the nursing staff because they were the ones who would either accept or ignore the project. Convincing or “unfreezing” their previous notions about increasing mobility with patients was going to be the key to success for this project.

Goals, Objectives, and Data Analysis. This DNP scholarly project focused on implementing a mobility program in an acute rehabilitation setting. A simple “Get Up and Go” exercise for older participants was implemented with the goal of increasing mobility a total of three times per day, six days a week. The objectives of this project were to educate nursing staff on the importance of increased mobility, and to have nurses participate in the project and not just the nursing assistance and physical therapists.

Implementation

Implementation of this DNP project initially began with identifying the patient population who would participate in the program. The participants were identified by the staff and met the inclusion criteria. The inclusion criteria for this project were: patients over 65 years old, able to already get out of bed and ambulate with minimal assist or with assistive device. The patients that were excluded were those who were cognitively impaired or unable to follow direction, were unable to ambulate on own or with an assistive device, and were not anticipated to return home.

Prior to engaging patients in the project, education was done with staff during mandatory staff meetings on all shifts. Staff attendance included: nurses, nursing assistants, the Director of

Nursing, the staff educator and the nursing supervisor from all three shifts. The presentation of the DNP project lasted approximately one hour for each group (total three) with a poster presentation, a handout, explanation of the project, and a question and answer session. A short questionnaire was given to all attendees in regards to knowledge base of the benefits of mobility (See Appendix B). The DNP project was explained to be a simple process. The explanation was in hope to alleviate the barrier of concerns by staff in regards to adding “more work” to their day.

The patient’s educational intervention was encouraging statements to “Get Up and Go” written as a reminder on their whiteboards in their rooms, along with the “Get Up and Go” pamphlet at their bedside. The month of February, the physical therapists placed activity orders on all patients white boards, which also reminded patients and staff of the importance of getting out of bed. Throughout the shifts staff reminded and encouraged the patient to “Get Up and Go” in the room or hall, and get out of bed to the chair for all meals. The nurses and nursing assistants documented in the EMR how many times the patients got out of bed. This researcher then examined the charts of patients that met stated criteria. Each patient’s activity varied according to the doctor’s order. “Get Up and Go” criteria were met as long as the patient got out of bed with minimal assistance.

Table 1

Timeframe for Implementation of Project

| Task | November | December | January | February | March | April |
|--------------------------------------|----------|----------|---------|----------|-------|-------|
| Recruitment of eligible participants | | | X | X | | |
| Educational Intervention | X | X | | | | |

| | | | | | | |
|--------------------------------------|--|--|--|---|---|---|
| Post-test and Analysis of outcomes | | | | X | X | |
| Results presented to local providers | | | | | X | X |

Sample

This convenience sample size each month included all patients 65 years of age and older, who were able to ambulate with minimal assist. The sample size changed each week depending on the census of the two floors. The average census over January was a total of forty two patients on both units, with a sample of (N=20). In the month of February, the average census was 44 patients, with a sample of (N = 16). The staff who participated in the project included 27 registered nurses, 19 nursing assistants, and three physical therapists.

Data Analysis

To audit the implementation of the data all participants from the two floors were identified as viable participants who could benefit from the study and met the inclusion criteria. Documentation by nursing, nursing assistance, and physical therapists was noted in the nursing orders section of the chart. The orders were noted as: activity out of bed, out of bed daily, or activity as tolerated. In this section, the care givers charted if they “performed” or “not performed” the out of bed activity, which was shown with time and initials of the caregiver. The DNP candidate documented all participants, each day in January and February, the time of day they were out of bed, and the caregiver who provided the activity. At the end of the project, the results were shared with staff, gift cards presented to those staff that got the most patients out of bed.

Ethics and Human Subjects Protection

This DNP Project used the patients in the rehabilitation facility as the human subjects, which is implemented in agreement with federal, institutional, and ethical guidelines. Each stage of implementation was done without risk to patients, family, students or staff. Patient information required to participate, was used with confidentiality in accordance with the Health Insurance Portability and Accountability Act. Surveys used for purposes of evaluation were void of names and any other personal information in keeping with the protection of human subjects.

The data collected was analyzed and maintained at the DNP candidates' personal computer and password protected. All information obtained from medical records was deleted of identifiable information. Based on the DNP requirements for Determination of Human Subjects, research was designed to improve performance of a practice in relation to an established standard. The activity was conducted to access, analyze and critique a standard of practice for mobility in a rehabilitation setting. Based on the design of this quality improvement project, a full Institutional review Board approval was not required.

Results**Outcomes**

This DNP project was implemented and results collected from December of 2016 to of March 2017. Information was collected via the electronic medical record (EMR), observing patients out of bed, and from interviews with staff members. The information was collected via the EMR by observing patients getting out of bed and from interviews with staff members. The census fluctuated weekly along with participants due to admissions or discharges. The first month of data collection was done prior to the projects commencement. Data was retrieved from the EMR which showed the total eligible patients (n=18). The percent of patients out of bed one

time /day was 28%, two times/day 45%, and three or more times/day 27%. The first month of the project there was an average of 20 patients who met eligible criteria out of an average census of 44 patients. The percent of patients who were out of bed three times or more/day was 35% (n=20), the percent of patients out of bed two times/day was 56% (n= 20), and the remaining 9% (n=20) of the patients only were out of bed once a day (see Figure 2). The next month there was a positive change noted in participation. The average number of participants was 16 in an average census of 40 patients. The positive change was noted with 80% (n=16) of the total patients getting out of bed three or more times /day, 18% (n=16) were out two times/day and 2% (n=16) only once a day (See Figure 3).

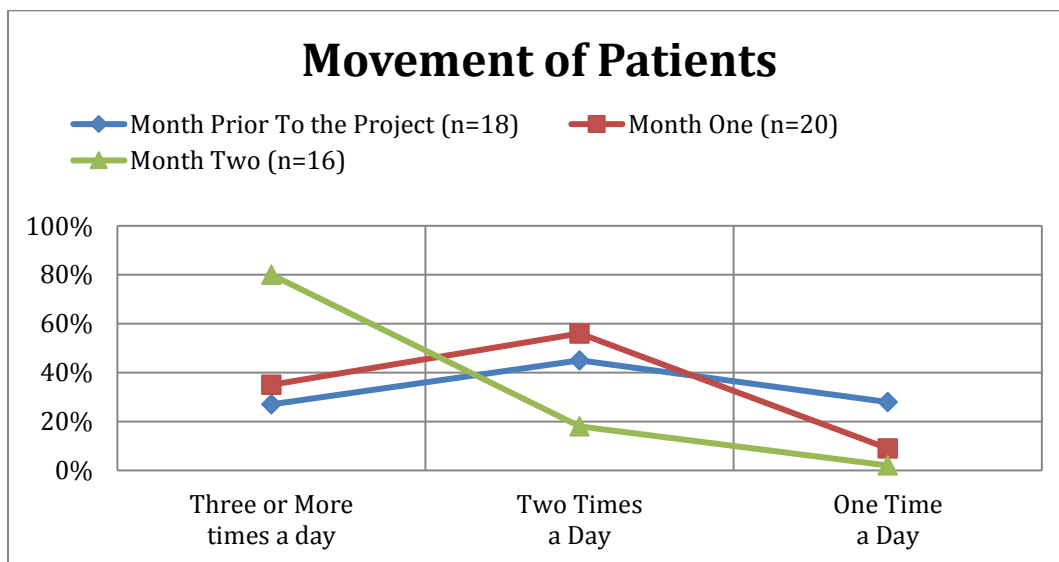


Figure 1. Comparison of patients out of bed prior to and during project.

Staff Participation Getting Patients Out of Bed

Staff who participated included RN’s, nursing assistants, and physical therapists. In January the RN’s averaged getting patients out of bed 60% of the time once a day, 35% of the

time they did not get the patients out of bed, and only 5% of the RN's got the patients out of bed two times a day. The nursing assistants averaged 84% of getting patients out of the bed once a day, 12 % two times/day, and 4% did not get any patients out of bed.

In February there was a noted positive change in the RN's participation. The RN's who assisted patients out of bed two times/day was up to 58%, 40 % assisted patients out of bed one time , and only 2% did not get patients out of bed at all. The nursing assistants were similar to the previous month, 80% out of bed once a day, 16% were assisted out of bed two times/day and 4% were not assisted out of bed. The physical therapists documented getting patients out of bed 98% of the time once a day as this was the usual order (See figures 4 and 5).

The data from these two months was encouraging for the "Get Up and Go" program. Over the two months there was a notable increase in staff participation (especially the RN's) and more patients getting out of bed three times/day. The observed positive associations and outcomes of this DNP Project were the recognition by staff (including physical therapists) of the importance

of their role in getting patients out of bed.

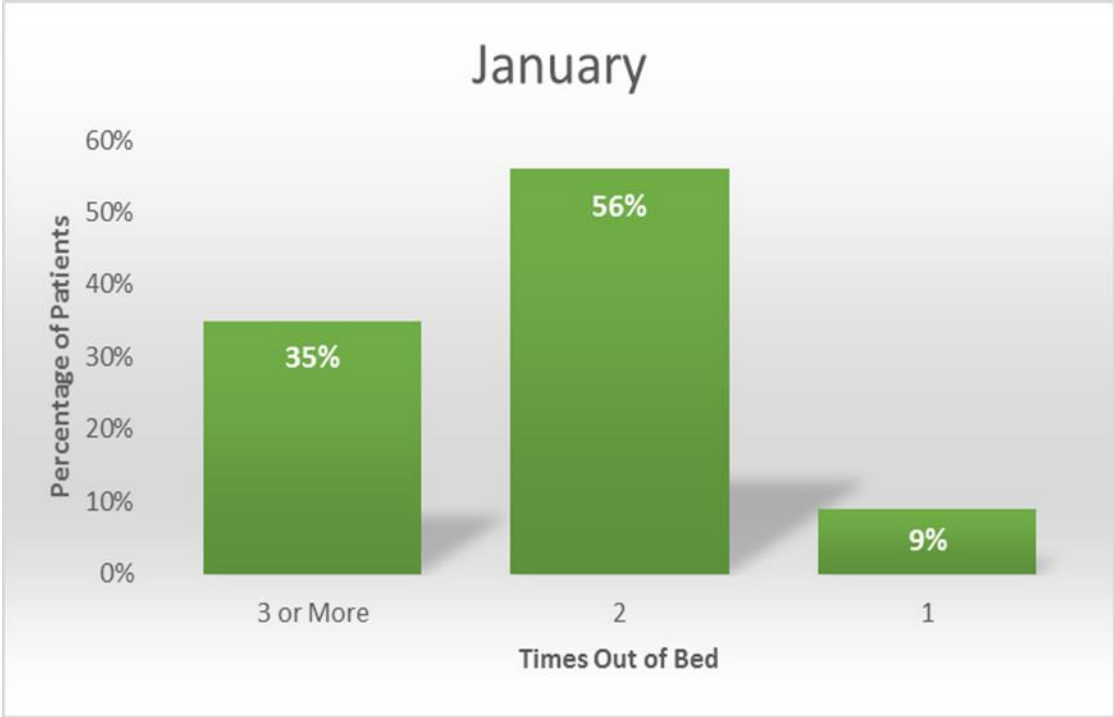


Figure 2. The percentage of patients in January out of bed one, two and three or more times.

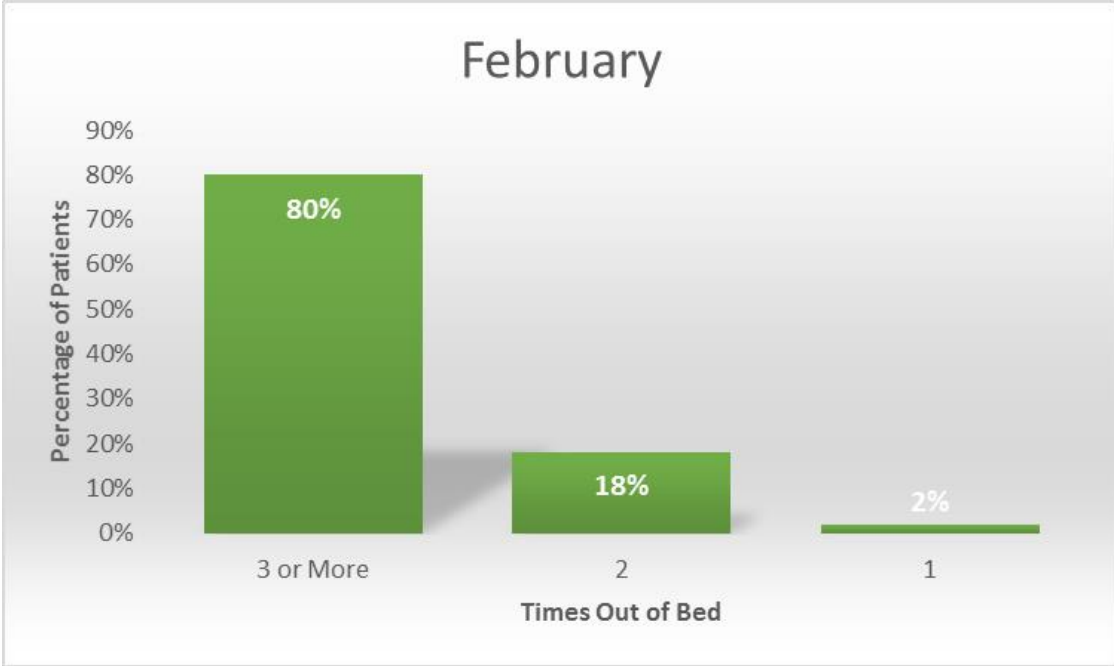


Figure 3. The percentage of patients in February out of bed one, two and three or more times.

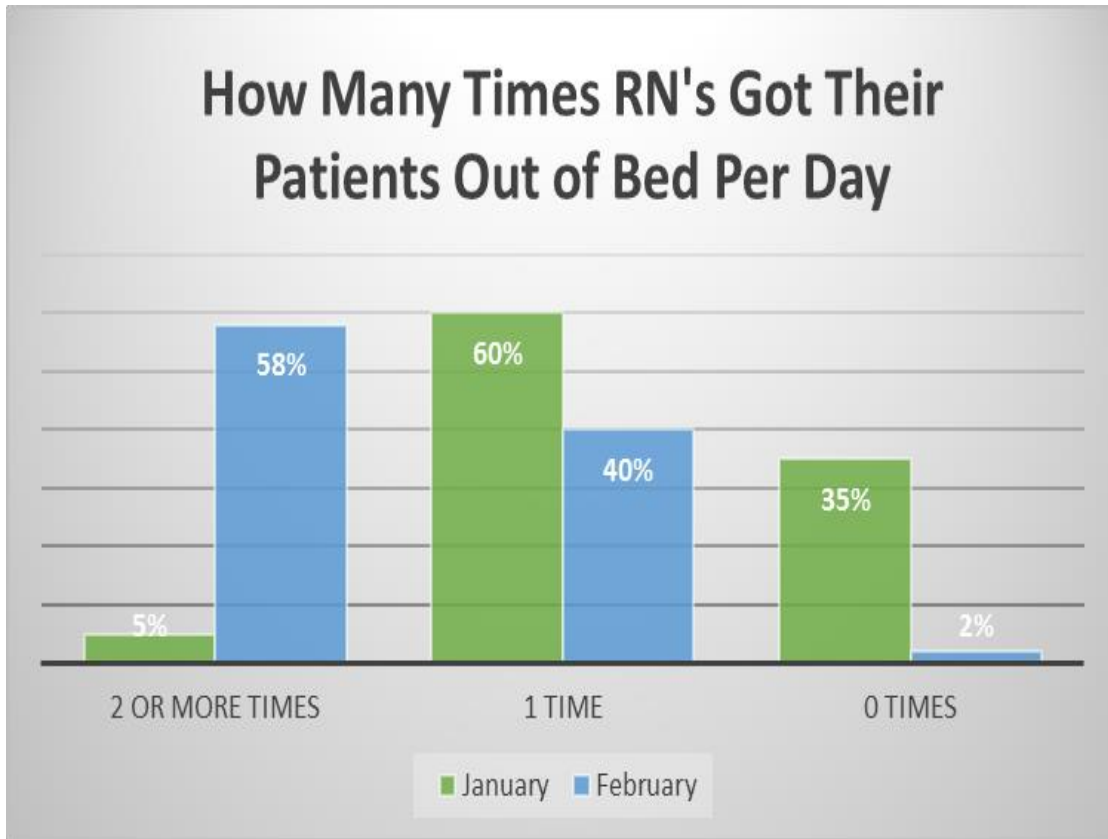


Figure 4. Registered nurses participation assisting patients out of bed in January and February.

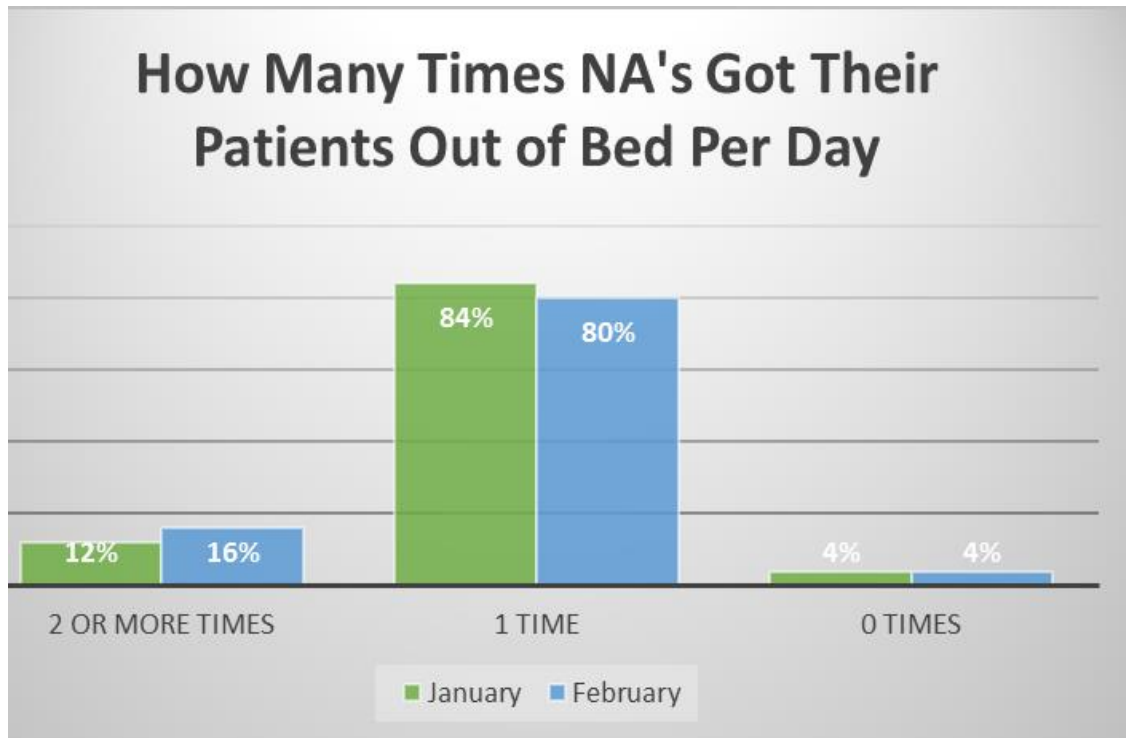


Figure 5. Nursing assistance’s participating getting patients out of bed in January and February.

Facilitators and Barriers

Both facilitators and barriers were present throughout this project. It is important to remember that this was a very small sample of participants in a small rehabilitation facility. For further quality improvement projects, a larger facility with more participants may be more useful in measuring more realistic outcomes.

During the educational intervention with the staff one important facilitator was the explanation of the new guidelines by CMS in regards to re-imbursement to rehabilitation facilities. Quality measures were explained as tools that help measure or quantify patient perceptions associated with the ability to provide high-quality health care (CMS.gov, 2016).

All five quality measures CMS is instituting in rehabilitation facilities require an increase in functional mobility. Almost all of the staff was unfamiliar with the government agency CMS

including the guidelines. They were very interested in this discussion, asking many questions and expressing agreement with the importance of mobility.

Another unexpected facilitator of this project was the interest by the physical therapists. The month of February the therapists began writing out of bed orders on all patients white boards in their rooms. This order along with the sign “Get Up and Go” proved to be an inspiration for many of the participants because many were found requesting to get out of bed. This was a motivator for the patients and staff to try to accomplish this goal daily. The inclusion of this was started the second month of the project and the overall participation by staff was recognized by an increase in patients out of bed.

The barriers of this quality project were a perceived potential for increased work load by staff, resistance to change by staff, inadequate staffing of physical therapists on weekends, and the lack of consistent out of bed orders. The staff’s resistance was the largest barrier. As stakeholders they must notice positive outcomes from this project or they will not feel the need to participate consequently the project will not continue past the implementation stage.

Currently there are not standardized mobility and out of bed orders for all patients. Specific orders to ambulate three times daily and to get out of bed with all meals were not consistently ordered. This created confusion for the providers who needed to be encouraged to have more specific goals for all their patients. This author is going to do a similar staff meeting presentation throughout the shifts with results and prizes for those who participated in mobilizing in this “Get up and Go” DNP project.

Discussion

As a DNP student this author has learned not only how to do a research and quality improvement project but what it takes to be successful. In recognizing a problem and designing

and implementing a project this author feels she understands Kurt Lewin and his change theory. Change is not easy for many reasons. In this project there were a few obstacles that this author encountered in instituting change. First, at the initial staff meetings, many RN's expressed concern in regards to getting patients out of bed. Many felt it was going to be "more work" in an already full workload, and interestingly they felt getting patients out of bed was for the nursing assistance to do, not part of their job description. The nursing assistants were very excited to hear about the project, with remarks made such as, "great, now the RN's have to help us." The Director of Nursing and the staff educator also expressed some concern in regards to "how difficult" it is to introduce change in their culture. They felt there were many nurses in this facility who have always done things a certain way forever, and change was extremely hard to implement. The Director of nursing and the educator were thrilled about the project, and felt getting patients out of bed was a "basic" health maintenance intervention.

To initiate change is difficult, but to continue to maintain change is tougher. This project has shown change can be done and maintained. The support of the physical therapists in encouraging staff to participate became the change needed to keep staff involved and interested in positive outcomes. Patients expressed the desire to get out of bed, and it was seen when more in more patients were out of bed for meals or walking in the halls with staff other than therapists.

Collaboration between health care teams was the most significant force towards positive change. True collaboration means a work culture where communication and decision making among all members of the healthcare team becomes an ongoing process. It is not an event but the norm for teams to have equal accountability in the care of patients. Communication, effective decision making, adequate staffing and overall leadership ensures positive outcomes in work environments.

Suggestions and Future Recommendations

As a DNP student this author has learned not only how to do a research and quality improvement project but what it takes to be successful. In recognizing a problem and designing and implementing a project this author feels she understands Kurt Lewin and his change theory. Suggestions for future recommendations are to incorporate more staff thus assuring more buy in and future “freeze stage” of Lewin’s theory. Collaboration for future projects would also include physician’s participation. This would have been helpful if there was more standardization in orders for patients to be out of bed,

Future recommendations would include a longer time frame, closer monitoring, and a larger population of patients.

Conclusion

The lack of mobility in acute care rehabilitation hospitals results in patients losing strength and the ability to function independently. This DNP project was aimed at increasing staff participation in order to combat patient’s loss or reduction of functional mobility. Research shows the recognition of regular physical exercise as a contributing factor to healthy aging. A loss of mobility causes a significant decline in overall health of older individuals. This information and the lack of mobility noted at the Rehabilitation Facility made for a perfect project. So, in conclusion, the project is a start to recognition by staff of the importance of mobility to healthy aging and functionality. Staff participation proved that this quality outcome is a goal for all patients. Therefore, the plan of action is to disseminate this information by staff meetings, publication, and poster presentations. Although an ongoing project this dissemination of information was started in March of 2017. Evidenced-based recommendations for further

improvements will be provided, along with encouragement to keep the project ongoing when the DNP student completes the project.

References

- Amaral, A., & Vidinha, T. (2014). Implementation of the Nursing Role Effectiveness Model. *International Journal of Caring Sciences*, 7(3), 757.
- Agency for Healthcare Research and Quality. (2014). Functional Status Preservation and Rehabilitation. Retrieved from <http://www.ahrq.gov/research/findings/nhqrdr/nhqr13/chap3a.html>
- Bassem, E., Higgins, K., (2010). Physical activity guidelines for older adults. *American Family Physician*. 1; 81(1):55-59.
- Bean, J., Kiely, D., LaRose, S., Goldstein, R., Frontera, W. R., & Leveille, S. G. (2010). Are changes in leg power responsible for clinically meaningful improvements in mobility among older adults? *Journal of the American Geriatrics Society*. 58(12), 2363–2368. <http://doi.org/10.1111/j.1532-5415.2010.03155.x>
- Centers for Disease Control and Prevention (2013). *The State of Aging and Health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; PDF and interactive version available at www.cdc.gov/aging
- Centers for Medicare and Medicaid Services (CMS). Del Signore, A. (2016). CMS adds quality measures to nursing home ratings. Retrieved August 20,2016, from <http://www.managedhealthcareconnect.com/content/cms-adds-quality-measures-nursing-home-ratings>
- Clegg, A., Barber, S., Young, J., Iliffie, S., & Forster, A., (2014).The Home-based Older People’s Exercise (HOPE) trial: a pilot randomised controlled trial of a home-based exercise intervention for older people with frailty. *Age and Ageing*. 43, 687–695 doi: 10.1093/ageing

Covinsky, K. E., Palmer, R. M., Fortinsky, R. H., Counsell, S. R., Stewart, A. L., Kresevic, D., et al. (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: Increased vulnerability with age. *Journal of the American Geriatrics Society*, 51(4), 451–458.

Centers for Medicare and Medicaid Services (CMS). Del Signore, A. (2016). CMS adds quality measures to nursing home ratings. Retrieved August 20, 2016, from <http://www.managedhealthcareconnect.com/content/cms-adds-quality-measures-nursing-home-ratings>

Dearholt, S., Dang, D., Sigma Theta Tau International, & Institute for Johns Hopkins Nursing,. (2012). Johns Hopkins nursing evidence-based practice: Models and guidelines.

Huang, H.-T., Chang, C.-M., Liu, L.-F., Lin, H.-S. & Chen, C.-H. (2013), Trajectories and predictors of functional decline of hospitalized older patients. *Journal of Clinical Nursing*, 22, 1322–1331. doi: 10.1111/jocn.12055

Institute of Medicine, Committee in the Future Health Care Workforce for Older Americans. (2008). Retooling for an aging America: Building the health care workforce. Washington, DC: National Academy Press. Retrieved May 20, 2010, from <http://www.nap.edu/catalog/12089.html>

McCalman, J. (2015). Leading cultural change: The theory and practice of successful organizational transformation.

McDonald, K., Sundaram, V., Bravata, D., et al.(2007). Closing the quality gap: a critical analysis of quality improvement strategies. *Agency for Healthcare Research and Quality (US)*. Conceptual Frameworks and Their Application to Evaluating Care

Coordination Interventions. Available from:

<http://www.ncbi.nlm.nih.gov/books/NBK44008/>

[Mulasso, A.](#), [Roppolo, M.](#), [Settanni M.](#), & [Rabaglietti, E.](#) (2013).

A Multicomponent Exercise Program for Older Adults Living in Residential Care Facilities: Direct and Indirect Effects on Physical Functioning. *Journal of Aging and Physical Activity*, 23(3):409-16. doi: 10.1123/japa.2013-0061.

Parker, A., Lord, R., & Needham, D (2013). Increasing the dose of acute rehabilitation: is there a benefit? *BMS Medicine*, 11:199 DOI: 10.1186/1741-7015-11-199

Peiris, C., Taylor, N., Shields, N., (2012). Additional Saturday allied health services increase habitual physical activity among patients receiving inpatient rehabilitation for lower limb orthopedic conditions: a randomized controlled trial. *Archives of Physical Medicine and Rehabilitation*. 93:1365–1370.

Peiris, C. L., Taylor, N. F., & Shields, N. (2011). Extra physical therapy reduces patient length of stay and improves functional outcomes and quality of life in people with acute or subacute conditions: A systematic review. *Archives of Physical Medicine and Rehabilitation*, 92, 9, 1490-1500.

Presley, C., Johnson, S., (2016). Up times three improves functional mobility in the elderly. 2016 Annual NICHE Conference: Care across the Continuum. Retrieved from nicheprogram.org

Said, C., Morris, M., McGinley, J., Szoeki, C., Workman, B., Liew, D., ... Bernhardt, J. (2015). Evaluating the effects of increasing physical activity to optimize rehabilitation

outcomes in hospitalized older adults (MOVE Trial): study protocol for a randomized controlled trial. *Trials*, 16, 13. <http://doi.org/10.1186/s13063-014-0531-y>

Schein, E. H. (1999). Kurt Lewin's change theory in the field and in the classroom: Notes toward a model of managed learning. *Reflections*, 1(1), 59-74.

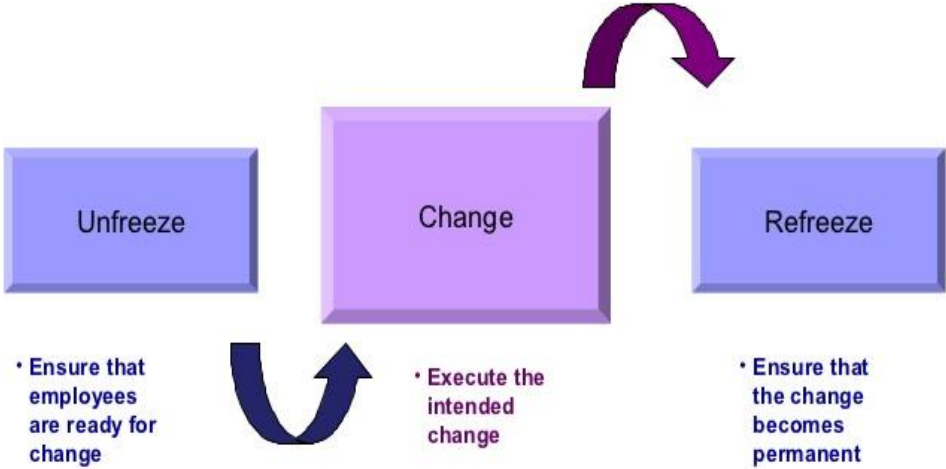
World Health Organization (2011). *Guidelines on Health-Related Rehabilitation (Rehabilitation Guidelines)*. World Health Organization

http://who.int/disabilities/care/rehabilitation_guidelines_concept.pdf

Appendix A



Kurt Lewin's Model of Change



Appendix B

Questionnaire to Staff

| Questions | Responses | | | |
|---|----------------------|--------------------------|---------------------|-------------------|
| Do you feel patients need to get out of bed more? | Yes= 42 | No= 0 | | |
| How often do you think a patient should get out of bed and ambulate or sit in a chair each day? | 1= 0 | 2=0 | 3= 38 | >3= 4 |
| Do you think it is too much work to get patients out of bed and walk three times a day? | Yes=24 | No= 18 | | |
| Do you think increasing mobility improves the patients overall health? | Yes= 42 | No= 0 | | |
| What is the number one reason older person are able to live in their own homes versus a skilled nursing facility? | Help from Family= 38 | Able to Care for Self= 2 | They are Healthy= 1 | Social Support= 1 |

