DEVELOPING A GUIDELINE IN EARLY MOBILIZATION FOR MULTIDSCIPLINARY TEAM USE ASSIGNED IN GERIATRIC LONG-TERM CARE WARDS IN DOHA, QATAR

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ABSTRACT

This study aims to develop a guideline for early mobilization of older adults admitted in long-term care facilities in Doha, Qatar. The guideline will be designed for use by a multidisciplinary team to optimize patient outcomes and quality of life. The importance of early mobilization in improving functional outcomes preventing complications and enhancing quality of life for older adults is well-established. However specific considerations are necessary for geriatric populations in long-term care settings. This guideline addresses these considerations and provides a framework for the multidisciplinary team to collaboratively assess, plan, implement and monitor early mobilization for each patient. This study encompasses: a brief discussion of the benefits of early mobilization for geriatric patients. Outline the specific roles and responsibilities of each multidisciplinary team member in the early mobilization process. Describe key factors to consider during patients' assessment for early mobilization, including functional status, cognitive abilities, and potential risks. It would also provide a range of safe and effective early mobilization interventions tailored to the specific needs and limitation of geriatric long-term care patients. This study also outlines methods of regularly monitoring patient progress and adjusting interventions as needed. This also addresses cultural aspects relevant to early mobilization practices in the Qatari context. In developing this guideline for multidisciplinary team use assigned in geriatric long-term care wards it would promote optimal health outcomes and quality of life for geriatric long-term care patients.

Keywords: Geriatrics, long-term care, multidisciplinary team, level of acceptability

INTRODUCTION

Early Mobilization are activities performed with the appropriate intensity, that produce physiological benefits on blood circulation throughout the body, breathing and cognizance once the patient is vitally stable (Arias-Fernández et al., 2018). It includes, but not limited to activities such as bed mobility, range of motion exercises (PROM, AAROM, AROM), sitting-to-standing, transfers and ambulation. Early mobility is considered an expertise of physical therapy to restore musculoskeletal strength and function including practices such as passive range of motion, active range of motion, bed mobility, sitting balance, standing, standing transfer, and gait re-education (Opgenorth et al., 2022). In the study of Alaparthi et al. (2020) they explored how early mobility has been linked to decreasing morbidity and mortality demonstrating that inactivity has a profound adverse effect on the brain, skin, skeletal muscle, pulmonary system, and cardiovascular system. Although turning the patient every two hours is considered the standard of care (McNett et al., 2020) in the geriatric setting, a greater degree of mobility may be warranted to prevent the risk that immobility places on the patient (Jiang et al., 2022). In the current project, there is a need for a comprehensive evidence based early mobilization guideline for MDTs assigned in geriatric

long term care wards. Not only is a guideline important to standardize practice in quality improvement projects. Guidelines also help interdisciplinary involvement and outline the roles of those involved. If healthcare providers know what is required of them to carry out an intervention and what their involvement in the process will be, success and sustainability of the guidelines are improved. Currently, there is no known standardized guideline in early mobilization for geriatric long-term care cases that is being used in the target hospital. In developing this guideline religion and cultural sensitivity of the host country (Qatar) and the people living here must be taken into consideration. This study would provide a useful and valid information to support the clinical practice within the multidisciplinary team in geriatric long-term care wards. Developing a standardized guideline in early mobilization for geriatric long-term care that is culturally and religiously competent can improve the knowledge deficit of the health care team and result in an enhanced multidisciplinary treatment strategy which can increase patient satisfaction.

LITERATURE REVIEW

Safety and Care

Mobilization of critically ill geriatric patients must be performed based on safety criteria. Rehabilitation for these patients depends on a number of factors such as previous physical strength, function, level of cooperation, devices connected and prevalent mobilization culture in each facility. Conceição et al. (2017). Early mobilization in the critically ill patients can be performed effectively and safely with consideration of the cancellation criteria and in accordance with specified daily goals as determined by collaboration among the multidisciplinary team members in accordance with appropriate guidelines. Sakai et al. (2020).

Indications and Benefits of Early Mobilization

The use of early mobilization is seen as difficult, despite the fact that there is enough evidence to support its benefits and specialists are aware of them. Aquim et al. (2020) suggest that enhancing awareness and providing application guidelines may aid in mitigating obstacles to the extensive, easy, and secure enforcement of this approach.Early mobilization is a care process that involves initiation of mobilization activities as soon as hemodynamic and respiratory stabilization is achieved. The goal is to prevent loss of muscle strength and prehospital mobility capabilities to improve post-hospital functional status. (Munir, Fromowitz, Goldfarb., 2020)

While the physiotherapists should determine the optimal intervention model, as well as its frequency and intensity, the multidisciplinary team should be in charge of determining the criteria and contraindications for early mobilization. The MDTs should prioritize minimizing patients' length of stay and facilitating their successful reintegration into the community. Older people, and in particular frail older people, acute illness and hospitalization are associated with significant potential harm. One of the major drivers of iatrogenic harm in older adults is hospital-induced immobility, the so-called “pajama paralysis.” Older people in hospital are often confined to bed even after their acute illness has improved; not only by physical factors such as potentially unnecessary urinary catheters and monitoring equipment but also by the culture often found in hospital of keeping patients in bed for most of the day. Bed rest is associated with sarcopenia, infections, and greater length of stay, and early mobilization of patients is often overlooked as an intervention, despite being inexpensive and effective. (Surkan, Gibson., 2018). Stakeholders in improving inpatient mobility include

patients; nurses; nurse's aides; physical, occupational, and speech therapists; physicians and providers. Each of these stakeholders plays an integral role in changing the hospital culture to prioritize mobility from the time of admission. Patients are the primary beneficiaries of such a change. It is likely that physicians, providers, nurses, and therapists will serve as the architects of that change by developing mobility programs for their hospitals. It is likely that nurses, nursing aides, and therapists will conduct the mobility assessment and interventions. (Wald et al., 2019). The nurses who are most of the time with the patients need to understand the importance of early mobility and prioritize this action in the care of patients. (Powers, 2011)

In a study done by Linke, Chapman, Berger et al. (2020) the development and implementation of an early mobilization guideline that focuses on interdisciplinary collaboration to restructure workflow and optimization and coordination of task created a mobility guideline toolkit that can be used in a broader health system. This single centre project demonstrated increase mobility of ICU patients without addition of manpower resources using an early mobility guideline using an interdisciplinary approach.

Barriers and Challenges of EM

Early mobilization is important to prevent post intensive care syndrome. It has been shown that conducting a program for early mobilization leads to beneficial outcomes. Inpatient mortality and total hospital costs are reduced after the introduction of a progressive early mobilization program which is significantly associated with decreased mortality. Cost savings were realized early after the intervention and sustained.(Liu et al., 2019). In the study conducted by Anekwe, Koo, de Marchie, et al. (2019), it showed that the perceived barriers to early mobilization are largely influenced by the training and expertise of professionals. The barriers mostly highly rated by the clinicians were medical instability, nurses' safety concerns, limited PTs and insufficient equipment (Koo et al., 2016). Their study further highlights the need for knowledge translation interventions that will augment the clinicians knowledge of the potential benefits of early mobilization while enhancing their skills to safely and effectively mobilize mechanically ventilated critically ill patients. (Anekwe et al., 2019.

Despite the positive body of evidence on early mobilisation, translation of research evidence into clinical practice has been slow. Perceived barriers which emerged included lack of professional autonomy or boundaries, motivation, and clinical skills. Perceived facilitators to early mobilisation included the availability of guidelines, good communication, adequate staff, and mobilisation equipment. (Tadyanemhandu,, van Aswegen, Ntsiea, 2022).

Barriers to early mobilization are multifaceted with patient related barriers being mostly cited in the study done by Dubb, Nyadhl, Hermes et al (2016). Studies have identified numerous practical strategies that have been successful in addressing the perceived barriers to early mobilization. Systematic efforts to prioritize early mobilization using interprofessional approach and multiple targeted strategies are important components of a successfully early mobilization in practice. Respiratory therapists and nurses are the primary practitioners of early mobilization during the initial acute phase. The major barriers they encountered were very heavy workload, insufficient equipment and devices, lack of written protocols or guidelines, inadequate training, potential work risks and limited staffing. Organizational support is needed to overcome barriers to the implementation of early mobilization (Wang et al., 2020).

Existing literature on the safety of early mobilization provides evidence to address some perceived patient-related barriers, such as safety concerns or hemodynamic instability, presence of vascular attachments, altered sleep patterns, safety of the patients, lack of communication and teamwork between various professionals, lack of professionals, inadequate time, delirium, extreme sedation, risk of musculoskeletal injury, and extreme stress at work.(Watanabe et al., 2021). Hospitalized elderly adults usually spend most of their time in bed. A clinically significant loss of community mobility was common after hospitalization in elderly adults. Elderly adults who developed mobility impairment during hospitalization had a higher risk of death in a large, retrospective study (Ferre et al., 2021). Critically ill patients that tends to be hospitalized for prolonged period of times tend to develop severe degree of weakness that can decrease patients' quality of life for years. Early mobilization has been proposed as an encouraging technique. Although there is rich literature about its practice and benefits there are barriers that need to be overcome (Nyadhl et al., 2020).

Developing Early Mobility Guidelines

It might be challenging and occasionally superfluous to standardize mobility initiatives in hospitals. Every mobility program should be tailored to the specific hospital culture, as hospital cultures differ. Overcoming the fear of falls requires a culture shift in all hospitals. (Growdon et al., 2017). Early mobilization programs would be successful and long-lasting depending on the culture and priorities of the involved parties. Along with screening patients and directing them to the appropriate members of the multidisciplinary team, these stakeholders in evaluations and improvements must also be capable of screening patients. (Geelen et al., 2021). Since physical therapists are the mainstay of early mobilization, reflexive consultation of PTs may lead to staffing constraints in the department and appropriate care might be delayed. (Di Girolamo et al., 2021). In the study conducted by Liu, et al. (2018), elderly adults admitted in hospitals are at high risk for hospital-acquired morbidity related to immobility. The elderly mobilization implementation intervention was multicomponent and tailored to local context at 14 academic hospitals in Canada. This was a large-scale study evaluating an implementation strategy for early mobilization in general medical inpatients in elderly adults (Mudge et al., 2017). Effective interventions to reduce geriatric syndromes remain poorly implemented due to their complexity and require an organized approach to change care practices and systems. (Zang et al., 2020).

Interventions that aim to improve function are therapeutic approaches in which the child actively practises the goal or task they wish to achieve (known as 'goal-directed', 'task-based', or 'whole-task practice' approaches). These interventions encompass similar principles in which individual goals are set, and the goal or task is actively practised by the individual until the goal or desired 'functional' outcome is achieved in a holistic way.Examples of specific named interventions that are 'goal-based' include cognitive orientation to occupational performance, goal-directed training, goal-directed motor coaching, goal-directed home programmes, and hand–arm bimanual intensive training including lower extremity. (Jackman, Sakzewski, Morgan et al., 2021). Nurses with less than 5 years of experience think that they lack the skills and training to safely mobilize patients thus they make referrals to therapists about this. Nurses' attitudes revealed that they see mobility as a priority but new nurses does not and some nurses just pass the responsibility to other discipline (Munir et al., 2021). Guidelines may enhance the rate of out-of-bed mobilizations. Implementing inter-professional guidelines for mobilization is feasible safe and may contribute to an increase in mobilizing patients to out-of-bed (Holroyd-Leduc et al.,

2019). The Mobilization of Vulnerable Elders (MOVE) program was anevidencedinformed early mobilization intervention that was previously evaluated in Ontario, Canada. The program was effective at improving mobilization rates and decreasing hospital length of stay. MOVE is a low-cost, effective and adaptable intervention that improves mobilization in hospitalized elderly adults. The study of Liuet al. (2019) of MOVE found it to be effective at improving mobilization rates and decreasing length of stay on hospital units. MOVE program increased mobilization and these results were replicated across surgery, psychiatry, medicine and cardiology units.

Implementation of EM programs

In order to facilitate mobility, adequate staffing levels are necessary for transferring ambulation, mobility assisted devices such as walkers and canes, environments with adequate space to mobilize. The team can work together in developing guidelines for early mobilization to assist in restoring and maintain the function of hospitalized elderly adults (Constantin &Dhalke 2018).

The study conducted by Coles, Erdogan, et al (2020) implemented a multidisciplinary mobility guideline. This study represents the impact of implementing a structured progressive mobility guideline in critically ill trauma population.Patients that were included in the program had improved survival rates as compared to the population prior to EM implementation. According to Sigler, Nugent, Alalawi et al. (2016) implementing a progressive mobility guidelineand recruiting physical and occupational therapy may serve as a guide to the creation of a successful early mobilization program.

The importance of early mobilization is increasingly recognized by critical care providers. More nurses must be encouraged to participate in decision making to ensure safety the efficient and quality implementation of early mobilization practices (de Quieros et al., 2018). The complete description of exercise intervention is essential to allow replication in clinical trial and application in clinical practice.

The overall impact of early mobilization needs to be assessed with standardized timing, dosage, intensity progression and duration of physical therapy using a core set of long-term outcome measures collected at consistent times (Piva et al., 2019). It is important to have a robust multidisciplinary team in order to care for the complexity of geriatric patients (Nowak and Berry 2021). We should also need to take into consideration that natural, physiologic changes, premorbid functional (Yamane 2020) status that occur with aging, which will make early mobilization and return to previous functional status challenging and potentially prolonged for the critically ill (Tapper and Curseen 2021).

METHODOLOGY

Research Design

Descriptive developmental research design was employed in the study. This study, determining the developing a guideline in early mobilization for multidisciplinary team use in Doha, Qatar. Internal consistency and effectiveness requirements must be met by instructional programs, procedures, and products, which are developed, designed, and carefully evaluated through a methodical study process. (Shambaugh, N. 2018). An early mobilization guideline for geriatric long-term care units was developed using this approach. The interdisciplinary team members will follow this guideline in addition to physical

therapists. The findings of questionnaires regarding stakeholder preferences, attitudes, and beliefs served as the basis for this study's configuration.

Sources of Data

The primary source of data were the physical therapists, occupational therapists, respiratory therapists and registered nurses as part of the multidisciplinary team assigned in different geriatric long-term care wards in Doha Qatar.

Population of the Study

The respondents of the study consisted of five MDT members specifically physical therapists, occupational therapists, respiratory therapists, and registered nurses who are assigned in geriatric long term-care wards. Inclusion criteria were: a) male and female PTs, OTs, RTs and RNs b) currently assigned in geriatric long-term care facility in Doha, Qatar c) at least having 5 years-experience being assigned in that facility handling LTC and ventilator-assisted cases.

Purposive sampling was used in the study. The time frame for this study was two weeks.

Instrumentation and Validation

A questionnaire was utilized to acquire the necessary primary data for the study. To rate and promote convenience in responding a four-point (4- point) Likert scale was used. The instrument was divided into six parts. Part 1 dealt with evaluation of scope and purpose of the guideline. Part 2 dealt with the evaluation of stakeholder involvement in the guideline. Part 3 pertained to the evaluation of the rigour of development of the guideline. Part 4 concerned with evaluation of clarity in presentation of the guideline. Part 5 was about evaluation of applicability of the guideline. Part 6 covered the evaluation of the overall acceptability of the guideline.

Since the questionnaire was researcher made, it was subjected to validation through presentation to the panel of experts in research, language, teaching and in statistics. Their comments and suggestions were essential for its validity. After some modification, it was shown to the adviser for final approval. The survey instrument also underwent pilot testing for reliability and used Cronbach's alpha measure for internal consistency.

Furthermore, the study's reliability was contingent on the statisticians' ability to comprehend the adequacy of the scale in order to determine whether the expected result will be applied to a statistical formula once the data were gathered. Prior to the release of the questionnaire, their ideas and criticisms were adopted.

Data Gathering Procedure

A letter requesting permission to participate in a survey on PTs, OTs, RTs, and RNs for this paper was given out prior to the data collection procedure.The researcher provided an overview and explained the study, this was followed by signing of consent forms and the completion of the survey questionnaire. Prior to answering of the questionnaire, the researcher discussed to the respondents on how to answer the instrument and for clarification if there would be any unclear on the part of the respondents.

Considering this a descriptive-developmental research study the questionnaire was thought to be the best gathering tool. Prior to data gathering the researcher sent a letter of request to the respondents informing them of the study being conducted.

The questionnaires were sent to the respondents online via Google forms. They were assured of their privacy and animosity of information about their identities. The respondents answered the survey questionnaire via Google forms voluntarily and privately. The information gathered were tallied-and statistically treated.

Statistical Treatment of Data

Since the study was a descriptive developmental research design. The descriptive statistic used was weighted mean as the statistical method for the statistical treatment of data. Weighted mean was used to compute the ratings made by the respondents using the survey instrument provided.

RESULTS

Table 1

Indicator	Weighted Mean	Verbal Interpretation	Rank
Scope and Purpose			
1. The overall objective of the guideline was specifically described.	4.40	Agree	
2. The statement of the problem covered by the guideline was clearly stated.	4.40	Agree	
3. The population for whom the guideline was meant to apply was stated.	4.20	Agree	
Average	**4.33**	Agree	**4**

Table 2

Indicator	Weighted Mean	Verbal Interpretation	Rank
Stakeholder Involvement			
1. The views and challenges faced by the MDTs have been addressed.	2.60	Neutral	
2. The target users of the guideline are clearly defined.	4.40	Agree	
Average	**3.50**	**Neutral**	**6**

Table 3. Evaluation of Rigour of Development in the Guideline

Indicator	Weighted Mean	Verbal Interpretation	Rank
Rigour of Development			
1. The criteria for evidence selection are clearly written.	4.20	Agree	
2. Strengths and limitations of the body of evidence are clearly stated.	4.20	Agree	
3. Methods for formulating recommendations are clearly described.	4.80	Strongly Agree	

4. The benefits side-effects and risks are indicated in the recommendations	2.80	Neutral	
Average	**4.00**	**Agree**	**5**

Table 4

Indicator	Weighted Mean	Verbal Interpretation	Rank
Clarity of Presentation			
1. The guideline is specific and unambiguous.	4.40	Agree	
2. Key recommendations are easily identifiable.	4.40	Agree	
3. Management options of EM based on the patient's status is clearly presented.	4.60	Strongly Agree	
Average	**4.47**	**Agree**	**3**

Table 5

Indicator	Weighted Mean	Verbal Interpretation	Rank
Applicability			
1. The guideline describes facilitators and barriers to its application.	4.40	Agree	
2. The guideline provides advice on recommendations that can be put into practice.	4.80	Strongly Agree	
3. The guideline presents monitoring and/or auditing criteria.	4.40	Agree	
Average	**4.53**	**Agree**	**2**

Table 6

Indicator	Weighted Mean	Verbal Interpretation	Rank
Overall Guideline Acceptability			
1. Overall acceptability of the guideline.	4.40	Agree	
2. The guideline will be recommended for use.	5.00	Strongly Agree	
Average	**4.70**	**Strongly Agree**	**1**

DISCUSSION

Table 1, Scope and Purpose, composed of three indicators. It assesses the overall objectives of the guideline, the health questions covered by the guideline as described and the target population for whom the guideline is meant to be applied.

The evaluators predominantly rated the guideline with scores of 4 and 5 resulting in a weighted mean ranging from 4.20 to 4.40, which ultimately averaged at 4.33, as illustrated in Table 1. This positioning places it at rank 4 concerning the overall ranking of the indicators. This significance lies in their consensus regarding the guidelines ability to precisely articulate its overarching objective, articulate the problem statement clearly, and define the targetpopulation. Such clarity is instrumental for practitioners, aiding them in understanding the guideline's scope and purpose for effective implementation (Peters, S., Jacobs, K., Van

Wambeke, P., et al. 2022). Table 2 is about stakeholder involvement. This table shows the views and challenges faced by the MDTs and the presentation of definition to target users.

Indicator A scored a low weighted mean, as depicted in Table 2. This is attributed to the guideline providing general solutions without adequately addressing the specific challenges encountered by each multidisciplinary team (MDT) members. On the other hand, the second indicator received the lowest overall ranking.

The involvement of the stakeholders is crucial in ensuring the acceptability and feasibility of a guideline among end-users. Stakeholders can also play a vital role in advocating for equity and human rights considerations while supporting the integration of guideline recommendations into policies and practices. Consequently, this collaboration may enhance adherence to recommended treatment and practices. (Petrovic, Riddle, Akle, et al. 2020).

Table 3 assesses the rigour of each step of guideline development process. It includes methods of evidence search, grading, summary, and formulation of recommendations.

In Table 3, indicators 1-3 exhibited a high weighted mean, indicating consensus among respondents regarding their presence in the guideline. Conversely, the fourth indicator displayed a low weighted mean, suggesting dissatisfaction among respondents with this aspect of the guideline. It is worth noting that this fourth indicator holds particular significance for assessing the quality of the guideline, as it has the most substantial impact on its methodological quality. (Becker, M., Breuing, J., Nothacker, M. et a. 2019)

Table 4 is about the clarity of guideline presentation. This consists of three indicators that assesses the guideline's preciseness and unambiguity. As depicted in Table 4, the weighted mean for the three indicators ranged from 4.40 to 4.60 averaging at 4.47. This positioning ranks it third overall. These findings indicate that the guideline was well-written and easily comprehensible to all respondents.

This observation is pivotal as it enables and effective assessment of the guideline's clarity. It also evaluates the specificity and clarity of recommendations, the clarity of different management presented, and the ease of identifying key recommendations. Furthermore, it assesses whether this guideline is supported by tools for practical application. (Nederlof, Kupka, Braam, et al. 2018)

Table 5 is about the adaptability and feasibility of the guideline. Adaptability is the part that assess whether the guideline describes facilitators and barriers to application and if they provide advice or tools on how the recommendations can put into practice. This also evaluates the resource implications for guideline application and auditing criteria.

In this domain as illustrated in Table 5, the evaluators concur that that this guideline is highly applicable as evidenced by the second indicator receiving a high weighted mean. Fundamentally, two common goals were reported: to improve the quality and consistency of clinical practice (patient care) and to reduce the duplication or ratification of MDT responsibilities specifically PTs and OTs. Furthermore, it achieved a high overall ranking, suggesting its potential applicability and for MDT use with geriatric patients.
Assessing the clinical applicability of guidelines allows us to gauge their acceptance and utilization by the MDTs, identifying those with significant clinical applicability and promoting their adoption. Employing a suitable clinical applicability tool can furnish

essential metrics and insights for continuous improvement of clinical practice guidelines (CPGs) to enhance their clinical acceptability. (Linan, Qiusha, Chuan, et al. 2020)

Table 6 is about the overall guideline acceptability. Utilizing the criteria taken into account during the assessment process, the user must make a determination regarding the quality of the guideline as part of the overall assessment.

Overall, the acceptability of the developed guideline received the highest rating, with respondents expressing their willingness to recommend its use, as evidenced by Table 6, where the weighted mean average is 4.70 and it holds the top overall ranking. This suggests that the developed guideline effectively addresses a clinical or health problem pertinent to the intended target users. Furthermore, there is alignment between the scope of practice of the target users and the populations they serve.

The rating also reflects the clarity of recommendations, including their direction (favouring or opposing a particular action), and the consideration of trade-offs between potential harms and benefits. Additionally, it highlights the definitiveness or strength of the recommendations and their associated trade-offs between harms and benefits (Brouwers, M. C., Spithoff, K., Kerkvliet, K., et al 2020).

CONCLUSIONS

Summary of Findings

After analysis of data, the researcher arrived at the following findings:

1. The created guideline's objective and scope were evaluated by the participants. They concurred that the guideline provided a clear description of its ultimate goal. The problem statement addressed by the guideline was expressed in a straightforward manner. It was also specified to whom the guidelines were intended to apply.
2. Stakeholder involvement during the development stage is essential to ensuring end-user acceptability and feasibility of guidelines. In addition to advocating for equity and human rights concerns, stakeholders can also assist in integrating guidelines into policies and practices. Thus, adherence to recommended treatment and practices may be enhanced by this collaboration.
3. The adoption of guidelines based on an incomplete body of data or a biased synthesis and interpretation can result in subpar patient care and outcomes, which is why rigour of development is so crucial. Guidelines are meant to encourage effective and efficient health care.
4. The guideline was clear and precise. The presentation is rationally laid out and easy to understand. This insight is crucial since it makes it possible to evaluate the guidelines' clarity in an efficient manner. It also assesses the recommendations' precision and clarity, the style in which various management approaches are presented, and how simple it is to recognize the most important recommendations. Additionally, it evaluates if this recommendation is backed by resources for real-world implementation.
5. This guideline is applicable for use given that the respondents were satisfied that the guideline describes facilitators and barriers to its application, provides advice on recommendations that can be put into practice and it presents monitoring and/or auditing criteria. By evaluating a guideline's clinical applicability, we can determine whether or not MDTs will accept and use it, helping to find and promote guidelines that have a large clinical application.

6. Overall, the acceptability of the guideline was high. They would recommend it for implementation because of its good intention which was stated on its objective. However, some ambiguity regarding the contraindications, risk and side effects were noted and needs further review and revision.

CONCLUSIONS

Based on the findings the following conclusions were created:
1. The guideline's fundamental goal was explained in detail. The problem statement addressed by the guideline was expressed in a straightforward manner. It was specified which population the recommendation was intended to apply to.
2. Stakeholder involvement is essential in guaranteeing an end-user acceptability and feasibility of a guideline.
3. The guideline should have stated the benefits, risks and side effect of initiating early mobilization to geriatric patients.
4. The guideline is readily understandable and well-written.
5. The guideline is applicable for use, by the multidisciplinary team given that it has satisfied the requirements needed for a guideline that can be put into use.
6. In developing guidelines for multidisciplinary use, it is imperative that consultation and communication within different MDT specialities including representatives of the organization/facility is essential

RECOMMENDATIONS

In light of the findings, the following are suggested recommendations for possible actions:
1. Physical Therapists, enhanced treatment planning. To help physical therapists' tailor interventions to individual clients' capabilities and limitations, leading to a more targeted and effective therapy sessions.
2. Occupational Therapists, focus on functional mobility. This would align occupational therapists' practice, allowing them to integrate their goals into their interventions.
3. Respiratory Therapists, enhanced communication and collaboration. Shared goals for improving resident function can strengthen communication with PTs, OTs and nurses leading to more coordinated care plans.
4. Nurses, improved client care. Clear guidelines would equip nurses a structured approach to implement early mobilization strategies during daily routines
5. Researcher, measure outcomes. Define key performance indicators (KPIs) to measure the impact of the guideline on relevant outcomes.
6. Future researchers, for continuous improvement should regularly re-evaluate the guideline's effectiveness based on user feedback, implementation data and outcome measurements. This would allow for ongoing improvement and adaptation.

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