Professor Dawn Skelton

Falls: Time for Movement

Q&A with

Professor Dawn Skelton & Erin Walker

Erin Walker

Question 1: Where does the resistance to adoption of the need to make patients active lie? Is it with management, clinical staff? And why is there such resistance?

Dawn: This is the million dollar question. Time and staffing levels on the coal face will play a part, clinical care will take precedence. There is research on barriers to mobilisation in ICU wards e.g.

https://bmjopenquality.bmj.com/content/7/4/e000339 and
https://www.atsjournals.org/doi/10.1513/AnnalsATS.201509-586CME
But less on mobilising older patients. This paper covers many of the issues -
https://pubmed.ncbi.nlm.nih.gov/17935241/

Content analysis identified 31 perceived barriers to increased mobility during hospitalization. Barriers most frequently described by all 3 groups were: having symptoms (97%), especially weakness (59%), pain (55%), and fatigue (34%); having an intravenous line (69%) or urinary catheter (59%); and being concerned about falls (79%). Lack of staff to assist with out-of-bed activity was mentioned by patients (20%), nurses (70%), and physicians (67%). Unlike patients, health care providers attributed low mobility among hospitalized older adults to lack of patient motivation and lack of ambulatory devices.

This systematic review https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-021-01843-x found 264 barriers and 228 enablers were reported by patients, and 415 barriers and 409 enablers by healthcare professionals. Patient-reported barriers were most frequently assigned to the Theoretical Domains Framework (TDF) domains - Environmental Context & Resources (ECR, n = 148), Social Influences (n = 32), and Beliefs about Consequences (n = 25), while most enablers were assigned to Environmental Context & Resources - ECR (n = 67), Social Influences (n = 54), and Goals (n = 32). Barriers reported by healthcare professionals were most frequently assigned to ECR (n = 210), Memory, Attention and Decision Process (n = 45), and Social/Professional Role & Identity (n = 31), while most healthcare professional-reported enablers were assigned to the TDF domains ECR (n = 143), Social Influences (n = 76), and Behavioural Regulation (n = 54).

Erin: I think that on the whole staff are trying to improve things in this area but there are lots of competing priorities on a busy acute ward environment. We surveyed a small group of staff at Glasgow Royal Infirmary about barriers to getting patients up:

- 30% of Health Care Support Workers (HCSW) and 50% of nursing staff think that patients are too sick to be mobilised.
- 30% of HCSW don't know when it is safe to mobilise patients
- 70% of HCSW and 100% of nursing staff don't think staffing is adequate to mobilise patients
- 30% of staff felt it would be more work
- 90% of staff believed patients required a formal assessment before being mobilised

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Question 2: Today has been mostly focused on unscheduled care - are you aware of any frailty pre-hab for patients who are awaiting an elective admission to hospital?

Dawn: Prehabilitation prior to surgery is a topic covered in Editorials https://www.bmj.com/content/358/bmj.j3702 and narrative reviews https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6899232/

There is a good study coming up – protocol here - https://bmjopen.bmj.com/content/9/12/e031626 which will help us better understand prehab of older patients with osteoarthritis awaiting hip replacement.
And a smaller study showed that patients pain and function before hip or knee surgery improved - https://www.researchgate.net/publication/325977926_Does_physiotherapy_prehabilitation_improve_pre-surgical_outcomes_and_influence_patient_expectations_prior_to_knee_and_hip_joint_arthroplasty

But it was back in 2006 that the first paper showing preoperative exercise intervention improves functional status prior to joint arthroplasty and reduces the odds of inpatient rehabilitation - https://pubmed.ncbi.nlm.nih.gov/17013852/

Question 3: Could the 'I Can' goals be added to discharge letters so carers/care home staff are aware of how the person managed in hospital?

Dawn: I think that would be a great idea, but would need to be consistently added and at the moment perhaps might be up to the Consultant writing the discharge letter and their time to collate this information?

Erin: I agree that this would be great but relies on medical staff consistently providing this info on discharge letters. Something for us to aspire to?

Question 4. Do you have involvement with Nursing and care home staff?

Dawn: The CAPA programme www.capa.scot is all about increasing activity throughout the day for residents in care homes and specifically is about training the workforce.

Erin: We don't have any direct involvement with care home staff but CAPA are doing some really great work with care homes and have had some fantastic outcomes.

Question 5. Does anyone have any tips on how to engage older adults who are functionally declining but are not engaging in your sessions or not getting up and out of bed?

Dawn: You could try speaking to their family/friends when they visit, to try to encourage them to get out of bed, or walk with them to the window to look outside? If the person is in ward with other patients you could quietly talk to them about how much better others feel when they move about more – you could say you may feel better if you get out of bed and move about a bit – but many people feel too unwell, tired or unhappy and won't engage – and we should not force them.

Erin: I agree. You cannot force patient to participate. It's about trying to understand what the barriers are for the patient e.g. pain, fear of falling, scared of strange environment, feeling unwell and usually if you can get to grips with this then you can often make some headway:

- Getting family/carers/someone who knows the person well involved can make a difference.
- Setting goals with the patient that are a compromise for example getting up to sit for an hour over mealtime and then getting back to bed, getting up to mobilise then getting back to bed and then gradually increasing the amount you do.
- Humour often helps and trying to get to know the person – asking about family, hobbies, pets (i.e. what matters to you).
- Being persistent also helps, attempting input daily and trying different times of the day can help
- Being opportunistic e.g. trying to input when the patient needs toileting

Question 6: You mentioned that physios are AW champions, if we are aiming for this to be everyone's business, is there a reason that other MDT members cannot be Champions?

Dawn: I agree – anyone on the ward can be a champion, nursing staff, Health Care Assistants (HCA) – in fact the HCAs may have more time to engage with people to move more.

Erin: I also agree. It would be the ultimate goal to have all MDT members be able to be champions but in the context of my current role with physio practice development they are the group that I am trying to influence at the moment but ideally we want this work to spread throughout staff groups.

Question 7: Is there representation on you SIG from community staff?

Erin: There is representation only from Acute staff groups due to governance arrangements.

Question 8:. Keen to hear how the work is being measured to demonstrate impact

Erin: This is different for different departments and it is anticipated that this will evolve through time. Examples of outcomes are “number of patients up to sit before 11am”, “number of patients with move goal set”. There is no global outcome measure but we are looking at how we can demonstrate through audit that departments are meeting the Active Wards principles but this is a work in progress.
