Get up, get dressed, get moving! Preventing functional decline is everyone’s business

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Getting up, dressed and moving is important for older inpatients, who are known to rapidly succumb to skeletal muscle loss and mobility/functional decline while in hospital.1 This is not a new concept, with physician Dr Richard Asher writing in a BMJ article in 1947 “Get people up and we may save patients from an early grave”.2 In modern times, those active on social media may have seen the global #endpjparalysis movement, where likeminded health professionals tweet their support for this message. Within our own institution there has been, over the last two years, visible education of both staff and public on the evils of bed rest. A Google search establishes that many other district health boards also promote this concept, with educational videos of physiotherapists and images of staff grouped together in their pyjamas.

Yet is this enough? We recently reviewed the bedside environment of our patients when seen on consultant-led ward rounds. From within a DHB with a strong ‘get up’ message, we were interested in exploring whether our patients were out of bed and dressed, and what physical obstacles may limit getting up and moving. One geriatrician and one general physician reviewed 100 patients aged 75 years or over seen on their respective consultant-led ward rounds, teaching sessions or other opportune moments in September–October 2019. Each patient/environment was only assessed once. Patients seen on post-acute ward rounds were not assessed, due to time constraints. As well as documenting the physical space around the patient, physicians gave an opinion on whether the patient was able to get up and out of bed themselves, and if not, what was limiting them: physical (determined by physical limitation on mobility, provided by bedside mobility-status boards) or environmental factors (subjectively determined and based on whether each individual patient was thought to be able to navigate potential barriers such as tables, or distance from walking aids), or a mixture of both.

The median age was 82 years (range 75–98), 38 were seen on a rehabilitation ward, 62 on general medical ward and 42 had documented cognitive impairment (CI). Seventy-two patients were in bed (18 [25%] had rails up, 13 [18%] had table over the bed), 26 in a chair (16 [62%] with table in front of chair) and two were actively mobilising at time of physician visit. Seventy-three required some form of mobility aid and 26 (36%) had their aid within reach. Twenty-nine patients were in their own clothes and the call bell was accessible for 71 patients. Physicians thought 48 patients were able to mobilise themselves at time of visit. Of the 52 remaining, 11 (21%) were unable to mobilise for physical reasons, 15 (29%) had environmental obstacles, and 26 (50%) had a combination of both physical and environmental factors.

T test or chi-square tests were used to examine differences between those with CI and those without, and those on rehabilitation ward and those on non-rehab wards. While there were no differences in age, ward, gender, being in bed or not, or being in their own clothes, those with CI were more likely to have bed rails elevated (15/30 vs 3/42, p<0.005) and were less likely to be thought of as being able to mobilise at the time of review than those without CI (11/42 vs 37/58, p<0.005).
No differences in age, gender, CI, call-bell accessibility or physicians’ opinion on patients’ ability to mobilise at time of review were seen between wards; however, patients on rehab wards had greater mobility dependency (independent 5/38 (13%) vs 22/62 (35%), supervision 18/38 (47%) vs 23/62 (37%), assistance needed 15/38 (39%) vs 17/62 (27%), p=0.049). Despite this, they were less likely to be in bed (18/38 (47%) vs 54/62 (87%), p<0.005), and more likely to be in their own clothes (21/38 [55%] vs 8/62 [13%), p<0.005).

In summary, a concerning number of older adults were in bed, in hospital clothes and with environmental obstacles present. Differences were seen in those with and without CI, and between rehab/general wards. This was a rapid, small, uncontrolled snapshot of daily ward life with significant limitations, including subjective environmental assessment; however, lessons can be learned. Those with CI are potentially more limited and harmed by their environment (eg, bed rails up, chairs placed in front of bed/chair⁴⁻⁶), so it is concerning that there is evidence of environmental restraint. While those on general wards are probably more unwell, they are likely to be mostly medically stable (not seen on post-acute rounds), and it is likely that much of their medical care can still be delivered while they are out of bed. While there is great enthusiasm for falls prevention, this should not come at the expense of maintaining mobility.⁷

Deconditioning in older adults is a factor in delayed discharge.⁸,⁹ We acknowledge that in the modern ward environment, sometimes bed rails can be enablers to patients, and the importance of table proximity for maintaining hydration. Our findings require further study and will be used to inform future research.

Patients interact with multiple people over the time of their admission, from cleaning and kitchen staff to allied health and medical specialists. Each one of us has a responsibility to leave our patients as enabled and primed for mobility as possible. We can all make a difference by small actions, such as ensuring our patients have mobility aids close by, their bell close, and in considering aspects of the environment that essentially act as restraints. Even better, we could take our patients for a brief walk around the ward during daily rounds. The wider hospital may benefit from the rehabilitation ward philosophy, where the culture is one of enablement and maintaining independence. For those senior staff members working on non-rehabilitation wards, your leadership in encouraging patients to get dressed, sit out of bed, eat meals in a chair, is an excellent place to start role-modelling for the wider ward teams. Work from our Australian colleagues provides guidance to improve in this area.¹⁰ This is everyone’s business.
Competing interests:
Nil.

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