We know that older people are more likely to lose some of their capacity to perform activities of daily living (ADLs) during a hospital admission than those who are not hospitalised (Lafrenière et al, 2017; Gill et al, 2004). While functional loss may be the reason for hospital admission in many instances, the deconditioning effects of prolonged bed rest, postural instability and environmental barriers, such as medical devices, can further restrict independence and ability to self-care during a hospital stay (Resnick et al, 2016). This results in approximately one third of older hospital patients experiencing functional decline during their stay (Lafrenière et al, 2017). As this loss of function occurs over the course of care, it may be considered an iatrogenic disability (Lafont et al, 2011).

Deconditioning is one of the most common reasons for delayed discharge from acute hospitals (Lim et al, 2006). Prolonged immobility is associated with a decline in muscle strength and muscle mass, as well as in physical and cognitive function (Falvey et al, 2015; Krumholz, 2013). Hospitalised older adults may also experience decreased stamina, reduced appetite and increased fatigue, which may further diminish their capacity to perform ADLs (Falvey et al, 2015). This can result in reduced mobility, functional incontinence, low self-esteem and loss of confidence, as well as an increase in the risk of falls and pressure ulcers (Covinsky et al, 2011).

Rethinking hospital activity
Older adults with hospital-acquired deconditioning form a varied population with complex care needs (Falvey et al, 2015). Loss of function in ADLs not only increases the risk of institutionalisation (Portegijs et al, 2012), but is also predictive of mortality (Sleiman et al 2009). Reducing iatrogenic disability must therefore be a priority. This may require a rethinking of hospital activity around the older patient (Lafont et al, 2011).
Multidimensional assessment and multi-agency management of older people in hospital lead to better outcomes, including fewer re-admissions, fewer admissions into long-term care, and greater patient satisfaction (British Geriatrics Society, 2012). Barriers to keeping active in hospital are outlined in Box 1.

All members of the healthcare team should feel empowered to use any possible interaction with patients as an opportunity to improve their rehabilitation potential and minimise their risk of functional and cognitive decline (Mendes et al, 2016; McKillop et al, 2015).

From the time of admission, patients need to actively participate in strategies aimed at preventing a deterioration of their functional capacity and targeting mobility, nutrition, hydration, continence, sleep, orientation and cognitive stimulation (Lafrenière et al, 2017). How each of these is assessed and managed needs to be personalised, as each patient requires an individualised approach to their care (Schofield et al, 2012).

To encourage older hospitalised patients to participate in their care, help them retain their mobility and independence, and minimise the risks linked with increased activity (such as the risk of falls), staff need to use a skilled approach, implement individualised patient assessment and supervision, and make a conscious effort not to perceive or label patients as ‘risk generators’ (Schofield et al, 2012).

Changing practice in Nottingham

Immobilisation after a hip fracture is associated with a slow recovery, long-term loss of function and mortality. However, early ambulation is an effective strategy to improve patients’ outcomes and reduce their fear of falling (Kronborg et al, 2016). Davenport et al (2015) report low levels of activity in hip-fracture patients, with an average of 16 minutes of standing or walking activity per day. This highlights the need for early targeted rehabilitation to minimise patients’ risk of functional decline (Kronberg et al, 2016) and speed up their discharge, as higher levels of mobility are associated with shorter lengths of stay (Shadmi and Zisberg, 2011).

At the surgery division of Nottingham University Hospitals Trust, new ways of working were needed to help patients stay mobile and independent. In May 2017, an enhanced supervision model of care was developed and implemented. This coincided with the local adoption of the #EndPJparalysis campaign (Box 2).

The pilot site for these two initiatives was an acute 28-bed acute trauma orthopaedic ward with a typical staff ratio of four or five nurses on the ward for the day shift, chosen because of its typical population of older patients with orthopaedic injury likely to affect mobility, confidence and independence.

Enhanced supervision

The enhanced supervision model of care worked through a short daily multidisciplinary ‘huddle’ to identify patients who needed enhanced levels of supervision – as opposed to using the traditional cohort method of supervision. The cohort approach identifies patients who are at increased risk of falls and cares for them in a designated bay with other patients with increased risk of falls. A member of staff would be present in the bay at all times to observe the patients in an attempt to reduce the number of falls.

The team then identified interventions or activities likely to foster independence without increasing the risk of harm, and agreed on an appropriate level of supervision, along with an individualised care plan. Regular assessments allowed the team to identify which interventions or activities were helping, and decide whether to increase or decrease supervision (Bostwick and Hallman, 2013).

#EndPJparalysis

The local version of the #EndPJparalysis campaign started with physical activities such as getting up, getting dressed and being mobile. Relatives were encouraged to bring patients’ own clothes; alternatively, appropriate clothing could be sourced from a clothes bank set up as part of the venture. The initiative soon evolved to include fresh approaches to routine activities; for example, at meal times, patients were encouraged to ‘dine out’ – that is, eat together in the bay areas of the ward instead of by their bed. The aim was to make meals a social and enjoyable activity.

To further encourage patients to socialise, various activities were organised, such as arts and crafts, board games and having hair or nails done. As the ward does not have access to a day room, these activities were held in the central area of the ward on a fold-out table. Other activities such as ‘pimp up my Zimmer’ where patients were able to decorate their Zimmer frame to make it easily identifiable and more appealing to use and film afternoons were introduced in the ward routine to reinforce a sense of belonging and camaraderie among patients and between patients and staff.

All activities were designed for patients’ enjoyment and participation with the aim of improving their confidence, self-esteem, resilience and function. A strong person-centred approach was adopted and all decisions were taken in partnership with the patient. Every patient was offered the choice of what activities they wanted to participate in, when and for how long.

Positive outcomes

Outcomes were measured retrospectively using indicators for falls and pressure ulcers; complaints about nursing care; scores from friends and family test reports; and scores from nursing documentation dashboards. These are all standard metrics collected as part of routine service evaluation and reflecting the quality of care.

Box 1. Barriers to keeping active in hospital

- Fear of bothering staff;
- Not wanting to further over-burden staff;
- Seeking or receiving help is viewed as something negative;
- Not wanting to feel dependent on others (Lafrenière et al, 2017).

Box 2. #EndPJparalysis

#EndPJparalysis is a campaign to get hospitalised patients out of bed, dressed and moving to prevent deconditioning. Patients are encouraged to avoid staying in their pyjamas or hospital gowns unnecessarily (as this reinforces a passive, sick person’s role) and instead get into their day clothes and actively participate in their recovery (as this improves their health outcomes and mental wellbeing and changes how they are viewed by staff and relatives).

#EndPJparalysis started in 2016 and was launched as a national campaign on 7 March 2018 by chief nursing officer for England Jane Cummings at her annual summit.

- To read Jane Cummings’ blog visit: Bit.ly/CNOBlogPJ
- To learn how the campaign began visit: Bit.ly/PJParalysisNHS
- To implement #EndPJparalysis in your workplace visit: www.endpjparalysis.com/resources1 (Lafrenière et al, 2017).
Data was collected for the period from December 2016 to May 2017 (six months before the launch of enhanced supervision and eEndPJparalysis) and from May 2017 to November 2017 (six months after implementation). Over this period we identified:

- 37.5% reduction in the number of falls (pre implementation = eight falls; post implementation = five falls);
- 55.6% reduction in the incidence of pressure ulcers (grade 2 or above) (pre implementation = nine pressure ulcers; post implementation = four pressure ulcers);
- 80% reduction in the number of complaints about nursing care (pre-implementation = five complaints; post implementation = one complaint).

Single data points from the nursing dashboard scores and friends and family scores were not available from before the implementation, so the difference between mean scores before and after implementation was calculated. This showed that net scores from friends and family reports had improved by 34.3% (average pre-implementation net score = 57.52; average net score post-implementation = 77.3) – reflecting an overall satisfaction with the changes to practice.

Scores from the nursing dashboards had improved by 8% (average score before intervention = 89.9; average score after the intervention = 97) – demonstrating an improvement in nursing documentation compliance.

Patients regularly tell us that they feel much better wearing their own clothes. Feedback from nurses and other members of the multidisciplinary team suggest that this has led to a greater readiness to get out of bed, improved nutrition and hydration, and greater willingness to embrace physiotherapy, which in turn has improved patients’ confidence.

Visitors have noticed the positive impact of the changes and have praised the ward’s warm and welcoming atmosphere on the ward. Families have commented on how pleasant it is to see their relative dressed and participating in activities in a setting that feels like a home from home. Among staff, the changes have enhanced teamwork, sparked conversations and ignited a shared passion.

**Next steps**

This evaluation looked at a single ward and outcomes were measured retrospectively and over a short period of time. Future work should seek to evaluate the impact of any changes to practice over a longer time period, look at their impact on patient experience and engagement, and include further key indicators such as physical performance and length of stay.

In future service developments, we will need to evaluate the impact of these innovations across different specialities and assess the efficacy of specific interventions. A prospective analysis of data on patient safety, patient experience, patient flow, and social and financial cost implications would provide further insight.

These initiatives have been implemented across the three orthopaedic trauma wards in the directorate (a total of 74 beds) and plans are in progress to develop this strategy further and implement in other clinical areas across the trust. The enhanced supervision model of care has been rolled out across all wards in the surgical division and is being adopted by other clinical divisions.

**“Patients regularly tell us that they feel much better wearing their own clothes”**

**Conclusion**

The importance of keeping patients mobile and independent in hospital cannot be overemphasised. Patients who have existing functional difficulties or who are already frail at the time of admission are of particular concern (Ponzetto et al, 2003).

Many older people may already be struggling to maintain independent functioning before being admitted to hospital, so even a marginal loss of muscle mass and/or decline in physical performance during their hospitalisation may have far-reaching consequences (Falvey et al, 2015).

The changes to practice on an acute trauma orthopaedic ward in Nottingham have fostered an ethos of work whereby staff endeavour to keep patients physically mobile and socially engaged to reduce deconditioning and maintain the ability to perform ADLs. However, this is only a starting point, as we continue to look for the best approaches to improving health outcomes and reducing institutionalisation among patients in the acute hospital setting.

**References**

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