Moving for Health

Active function on admission to acute hospital

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Objectives

1. Define the problem of functional decline in acute hospital
2. Examine how to assess function
3. What works for maintaining and improving function
Functional Decline

• ‘the decrease in ability to perform the tasks of everyday living because of a decrement in physical, psychological and/or cognitive functioning’

• Loss of independence

• Closely related to ‘frailty’

• Described variably

• Incidence 30-70%

The Problem
Functional Decline in Acute Hospital

*Particularly for older and/or frail people*

- Associated with increased risk of:
  - Mortality
  - Longer length of stay
  - Care home admission
  - Social care use

- **Hospital service design and culture**
- ‘Pyjama induced paralysis’ / ‘iatrogenic disability’

Activity of Older People in Hospital

• 740 steps per day (IQR = 89-1014)
• In the community older people range from 5000-8500 steps per day
• Loss of muscle mass through inactivity (~1kg within 7 days)
• Barriers include symptoms (71%), institutional (43%), fear of injury (18%)

Evans, W.J. (2010)
So, C., and Pierluissi E. (2012)
Assessment
Diagnosis..?

‘Off legs’

‘Reduced mobility’

‘Failed...’

‘Falls’

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Declaring interests

Do you have any declared interests?

No.


Introduction to the problem

In any NHS general hospital, a quick travel through the clinical notes of older patients will identify several with labels, such as ‘acopia’, ‘social admission’, ‘bed-blocker’ or ‘atypical presentation’. None of these are recognized diagnoses and their presence on discharge summaries would cause consternation to clinical coders. Moving from what staff write to what they sometimes casually say - sometimes even within earshot of a geriatrician or (worse) patients or visitors - we hear more value-laden terms (e.g. ‘unstable’, ‘bed-blocker’ or ‘GOMER’). The consultant col-
treatment. The customary diagnostic rigour, which we have been trained to apply as standard, can be misleadingly replaced in older patients by a dualistic view of disease and health, where the former are seen as disease-modifying. Yet professional values and training still overly prioritize the acute, the rare, the high-tech and the curative. If we are providing a public service based on need we must view...
Comprehensive Assessment

• Trajectory
• Pre admission, at admission and between admissions...
• What are the reasons function has decreased?
• How does the person function at home?

• Informs and focuses treatment
Functional Assessment

As part of comprehensive assessment

- Pain
- Delirium (hypo-, hyper-, mixed)
- SOB
- Dizziness
- Depression or other MH

- Address the underlying cause
What to do?
Avoid

- Catheterisation
- Pressure mattresses
- Commodes
- Bed pans
- Incontinence pads
- Waiting...

Procrustean care
Exercise in Acute Hospitals

- Personalised exercise programmes have some evidence
- High proportion of patients not able to do
- Feasibility may be limited
- Extra physio may make a difference

- Activity appears to be more relevant

Improving and Maintaining Function

- Encourage at every opportunity
- Rehabilitative (pre-habilitative) culture
- Sit to stand is the 'cliff edge' of managing at home
- Personalised care plans - 'This is Me'

- Technique and volume
- Practice, practice, practice

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Improving and Maintaining Function

- Part of handover on admission and transfer
- Encourage to wear own shoes and clothes
- Comfort rounds
  - Nutrition
  - Hydration
  - Toileting
- MDT engagement - HCAs
What We Have Done

• Frontloaded therapy services to AAU and A&E
• OT & PT work 8am-8pm
• Prioritise cases to ensure people go home
  AND
• People at risk of functional decline are assessed

• Improved handover process to wards

• MULTI- AND INTERDISCIPLINARY WORKING
  (INCLUDING HCA)
To Conclude

• Functional decline in acute hospital is contributed to by service design and culture of care
• Assessment includes trajectory and focus on reducing barriers / symptoms
• Maintaining and improving function requires repetition and an MDT / IDT focus – empower your HCAs
Damn it, stop saying 'This isn't rocket science!'
References

- Evans, W.J. (2010), DOI: 10.3945/ajcn.2010.28608A